Health & Behavior Assessment and Intervention

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Introduction & Instructions for Use

Introduction

Medicare Coverage Summaries are a set of objective and evidence-based behavioral health criteria used by medical necessity plans to standardize coverage determinations, promote evidence-based practices, and support members' recovery, resiliency, and wellbeing for Medicare behavioral health benefit plans managed by Optum®.

Instructions for Use

This guideline is used to make coverage determinations as well as to inform discussions about evidence-based practices and discharge planning for behavioral health benefit plans managed by Optum. When deciding coverage, the member's specific benefits must be referenced.

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member's benefits prior to using this guideline. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this guideline and the member's specific benefit, the member's specific benefit supersedes this guideline. Other clinical criteria may apply. Optum reserves the right, in its sole discretion, to modify its clinical criteria as necessary using the process described in Clinical Criteria.

This guideline is provided for informational purposes. It does not constitute medical advice.

Optum may also use tools developed by third parties that are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice. Optum may develop clinical criteria or adopt externally developed clinical criteria that supersede this guideline when required to do so by contract or regulation.

If there is an absence of any applicable Medicare statutes, regulations, National or Local Coverage Determinations offering guidance, Optum utilizes adopted external criteria as follows:

- Level of Care Utilization System (LOCUS):
  - Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make determinations and placement decisions for adults ages eighteen and older.
- Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS-CASII):
  - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry and the American Association of Community Psychiatrists used to make determinations and to provide level of service intensity recommendations for children and adolescents ages 6-18.
- Early Childhood Service Intensity Instrument (ECSII):
  - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make determinations and to provide level of service intensity recommendations for children ages 0-5.

National criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make coverage determinations regarding experimental and investigation services and treatments. Optum Behavioral Clinical Policies:

- Complementary and Alternative Medicine (CAM) Treatments
- Computer Based Treatment for Cognitive Behavioral Therapy (CBTCBT)
- Neurofeedback
- Transcranial Magnetic Stimulation
- Wilderness Therapy

- Optum utilizes *The ASAM Criteria* to supplement the Medicare National Coverage Determinations (NCDs 130.1-130.7) for all other Alcohol and Substance Abuse Treatment to ensure consistency in making medical necessity determinations.
  - Access the ASAM Criteria *here*

- Use of The ASAM Criteria to supplement the general provisions outlined under 42 CFR 422.101(b)(6)(i) provides clinical benefits that are highly likely to outweigh any clinical harms from delayed or decreased access to items or services.

- Specifically, The ASAM Criteria are consulted when the NCDs do not fully address the type of treatment or appropriate treatment setting that will likely lead to improvement of the member's condition. The ASAM Criteria and/or LOCUS Criteria are also consulted due to the comprehensive multi-dimension analysis to determine if comorbid medical, mental health and substance related factors add to the evidence for services not offered in the NCDs.

These criteria represent current, widely used treatment guidelines developed by organizations representing clinical specialties, or Optum developed criteria based on "acceptable clinical literature" according to 422.101(b)(6)(i). Optum selects and uses clinical criteria that are consistent with generally accepted standards of care, including objective criteria that are based on sound clinical evidence. Optum uses the criteria to make standardized coverage determinations and to inform discussions about evidence-based practices and discharge planning. The use of such criteria is highly likely to outweigh any clinical harms from delayed or decreased access to care.

Health & Behavior Assessment and Intervention

Health & Behavior (H&B) Assessment procedures are used to 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 (CMS A52434, 2024).

H&B intervention procedures are used to modify the psychological, behavioral, emotional, cognitive, and social factors directly affecting the patient's physiological functioning, health and well-being, or specific disease-related problems (CMS A52434, 2024).

Applicable States

Note: Part A services are typically inpatient. Part B services are typically outpatient.

CMS L37638/A56562 (All states Part A Inpatient Services and Part B Outpatient Services apply)

- Alabama
- Georgia
- North Carolina
- South Carolina
- Tennessee
- Virginia
- West Virginia

CMS A52434 (All states & territories Part A Inpatient Services and Part B Outpatient Services apply)

- Connecticut
- Illinois
- Maine
- Massachusetts
- Minnesota
- New Hampshire
- New York
- Rhode Island
- Vermont
- Wisconsin

Coverage Indications, Limitations, and/or Medical Necessity

Health & Behavior Assessment/Reassessment (CMS L37638, 2024)

- The Health and Behavioral Assessment, Initial and Reassessment and Intervention services may be considered reasonable and necessary for the patient who meets all of the following criteria:
  - The patient has an underlying physical illness or injury, and
  - There are indications that biopsychosocial factors may be significantly affecting the treatment or medical management of an illness or an injury, and
  - The patient is alert, oriented and has the capacity to understand and to respond meaningfully during the face-to-face encounter, and
  - The patient has a documented need for psychological evaluation or intervention to successfully manage his/her physical illness, and activities of daily living, and
  - The assessment is not duplicative of other provider assessments.
- In addition, for a reassessment to be considered reasonable and necessary, there must be documentation that there has been a sufficient change in the mental or medical status warranting re-evaluation of the patient's capacity to understand and cooperate with the medical interventions necessary to their health and well-being.
- Health and Behavioral Intervention (with the family and patient present) is considered reasonable and necessary for the patient if the family representative directly participates in the overall care of the patient.

Limitations (CMS L37638, 2024)

- Health and Behavioral Assessment/Intervention will not be considered reasonable and necessary for the patient who:
  - Does not have an underlying physical illness or injury, or
  - For whom there is no documented indication that a biopsychosocial factor may be significantly affecting the treatment, or medical management of an illness or injury (i.e., screening medical patient for psychological problems), or
  - Does not have the capacity to understand and to respond meaningfully during the face-to-face encounter, because of:
    - Dementia that has produced a severe enough cognitive defect for the psychological intervention to be ineffective
    - Delirium

        - Severe and profound mental retardation
        - Persistent vegetative state/no discernible consciousness
        - Impaired mental status such as disorientation to person, time, place, purpose; inability to recall current season, location of own room, names and faces; inability to recall being in a nursing home or skilled nursing facility; or does not require psychological support to successfully manage their physical illness through identification of the barriers to the management of physical disease and activities of daily living.
    - Examples of Health and Behavioral Intervention services that are not covered are and are not considered reasonable and necessary include:
        - To provide family psychotherapy or mediation
        - To maintain the patient's or family's existing health and overall well-being
        - To provide personal, social, recreational, and general support services. Although such services may be valuable adjuncts to care, they are not medically necessary psychological interventions.
        - Individual social activities
        - Teaching social interaction skills
        - Socialization in a group setting
        - Vocational or religious advice
        - Tobacco or caffeine withdrawal support
        - Teaching the patient simple self-care
        - Weight loss management
        - Maintenance of behavioral logs

Documentation Requirements (CMS L37638, 2024)

- For the initial assessment, documentation in the medical record by the Clinical Psychologist (CP) must include evidence to support that the assessment is reasonable and necessary, and must include, at a minimum, the following elements:
    - Date of initial diagnosis of physical illness, and
    - Clear rationale for why assessment is required, and
    - Assessment outcome including mental status and ability to understand and respond meaningfully, and
    - Goals and expected duration of specific psychological intervention(s), if recommended.
- For reassessment, detailed progress notes to support medical necessity must include the following elements:
    - Date of change in mental or physical status
    - Sufficient rationale for why reassessment is required, and
    - A clear indication of any precipitating events that necessitate reassessment.
- For the intervention service, evidence to support medical necessity must include, at a minimum, the following elements:
    - Evidence that the patient has the capacity to understand and to respond meaningfully
    - Clearly defined psychological intervention planned
    - The goals of the psychological intervention
    - The expectation that the psychological intervention will improve compliance with the medical treatment plan
    - The response to the intervention and
    - Rationale for frequency and duration of services
- For all claims, the time duration (stated in minutes) spent in the health and behavioral assessment or intervention encounter must be documented in the record.
- All coverage criteria must be clearly documented in the patient's medical record and made available to the A/B MAC upon request.
- Initial assessment should not exceed one hour/4 units.
- Reassessment should not exceed one hour/4 units.

Coding Guidance (CMS A56562, 2024)

- CPT® code 90901 Biofeedback is not covered as a health and behavioral intervention.

Health & Behavior Assessment/Reassessment (CMS A52434, 2024)

- The Health and Behavioral Assessment, initial and Reassessment may be considered reasonable and necessary for the patient who meets all of the following criteria:
    - The patient has an underlying physical illness or injury, and

- There are indications that biopsychosocial factors may be significantly affecting the treatment or medical management of an illness or an injury, and
- The patient is alert, oriented and has the capacity to understand and to respond meaningfully during the face-to-face encounter, and
- The patient has a documented need for psychological evaluation or intervention to successfully manage his/her physical illness, and activities of daily living, and
- The assessment is not duplicative of other provider assessments.

- In addition, for a reassessment to be considered reasonable and necessary, there must be documentation that there has been a sufficient change in the mental or medical status warranting re-evaluation of the patient's capacity to understand and cooperate with the medical interventions necessary to their health and well-being.
- Health and Behavioral Intervention, individual or group (2 or more patients) require that:
  - Specific psychological intervention(s) and patient outcome goal(s) have been clearly identified, and
  - Psychological intervention is necessary to address:
    - Non-compliance with the medical treatment plan, or
    - 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.
- Health and Behavioral Intervention (with the family and patient present) is considered reasonable and necessary for the patient who meets all of the following criteria:
  - The family[1] representative directly participates in the overall care of the patient, and
  - The psychological intervention with the patient and family is necessary to address biopsychosocial factors that affect compliance with the plan of care, symptom management, health-promoting behaviors, health-related risk-taking behaviors, and overall adjustment to medical illness.

Limitations (CMS A52434, 2024)

- Health and Behavioral Assessment/Intervention will not be considered reasonable and necessary for the patient who:
  - Does not have an underlying physical illness or injury, or
  - For whom there is no documented indication that a biopsychosocial factor may be significantly affecting the treatment, or medical management of an illness or injury (i.e., screening medical patient for psychological problems), or
  - Does not have the capacity to understand and to respond meaningfully during the face-to-face encounter, because of:
    - Dementia that has produced a severe enough cognitive defect for the psychological intervention to be ineffective
    - Delirium
    - Severe and profound mental retardation
    - Persistent vegetative state/no discernible consciousness
    - Impaired mental status such as:
      - disorientation to person, time, place, purpose; or
      - inability to recall current season, location of own room, names and faces; or
      - inability to recall being in a nursing home or skilled nursing facility; or
      - does not require psychological support to successfully manage their physical illness through identification of the barriers to the management of physical disease and activities of daily living; or
      - For whom the conditions noted under the indications portion of this section are not met.
- Health and Behavioral Intervention with the family and patient present will not be considered reasonable and necessary for the patient if:
  - It is not necessary to ensure patient compliance with the medical treatment plan, or
  - The family representative does not directly participate in the plan of care, or
  - The family representative is not present.
  - There is no face-to-face encounter with the patient.
- Health and Behavioral Intervention services are not considered reasonable and necessary to:
  - Update or educate the family about the patient's condition

[1] Family representative is identified as one of the following:
- Immediate family members (husband, wife, siblings, children, grandchildren, grandparents, mother, father),
- Primary caregiver who provides care on a voluntary, uncompensated, regular, sustained basis, or
- Guardian or health care proxy

- Educate family members, primary caregivers, guardians, the health care proxy, or 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.
- Assist in treatment-planning with staff
- Provide family psychotherapy or mediation
- Educate diabetic patients and diabetic patients' family members
- Deliver Medical Nutrition Therapy
- Maintain the patient's or family's existing health and overall well-being
- Provide personal, social, recreational, and general support services. Although such services may be valuable adjuncts to care, they are not medically necessary psychological interventions.

- Examples of services not covered as health and behavioral interventions are:
  - Stress management for support staff
  - Replacement for expected nursing home staff functions
  - 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 or caffeine withdrawal support
  - Visits for loneliness relief
  - Sensory stimulation
  - Games, including bingo games
  - Projects, including letter writing
  - Entertainment and diversionary activities
  - Excursions, 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
- Note: Biofeedback is coded as 90901 and will not be covered as a health and behavioral intervention.

Coding Guidelines (CMS A52434, 2024)

- Health Behavior Assessment and Intervention (HBAI) services described by CPT codes 96156, 96158, 96159, 96164, 96165, 96167, and 96168, and any successor codes, are billed by clinical social workers, marriage and family therapists (MFTs), and mental health counselors (MHCs), in addition to clinical psychologists.
- If the initial health and behavior assessment or reassessment is unable to be completed during a single encounter, the date of service indicated on the claim should be the date on which the interview was finalized.
- For health and behavior assessment and/or intervention services performed by a physician, clinical nurse specialist (CNS), or nurse practitioner (NP), Evaluation and Management (E&M) or Preventive Medicine services codes should be used.
- Services to patients for evaluation and treatment of mental illnesses should be coded using a psychiatric services CPT code (90791-90899).
- For patients that require psychiatric services (CPT codes 90801-90899) as well as health and behavior assessment/intervention (96156, 96167, 96168), report the predominant service performed.
- Because it does not represent a diagnostic or treatment service to the patient, there is no coverage for CPT codes 96170, 96171.
- The patient's medical record must contain documentation that fully supports the medical necessity for services included within this LCD. (See "Indications and Limitations of Coverage.") This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures.
- Each claim must be submitted with ICD-10-CM codes that reflect the condition of the patient and indicate the reason(s) for which the service was performed. Claims submitted without ICD-10-CM codes will be returned.

Documentation Requirements (CMS A52434, 2024)

- 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 provider or medical provider responsible for the medical management of the physical illness that the psychological assessment/intervention was meant to address.
- For all claims, the time duration (stated in minutes) spent in the health and behavioral assessment or intervention encounter must be documented in the record.
- Documentation in the medical record must include:
    - For the initial assessment, evidence to support that the assessment is reasonable and necessary, and must include at a minimum the following elements:
        - Date of initial diagnosis of physical illness, and
        - Clear rationale for why assessment is required, and
        - Assessment outcome including mental status and ability to understand or respond meaningfully, and
        - Goals and expected duration of specific psychological intervention(s), if recommended.
- For re-assessment, detailed progress notes to support that the reassessment is reasonable and necessary must include the following elements:
    - Date of change in mental or physical status
    - Clear rationale for why re-assessment is required
    - Clear indication of the precipitating event that necessitates re-assessment
- For the intervention service, evidence to support that the intervention is reasonable and necessary must include, at a minimum, the following elements:
    - Evidence that the patient has the capacity to understand and to respond meaningfully
    - Clearly defined psychological intervention planned
    - The goals of the psychological intervention
    - The expectation that the psychological intervention will improve compliance with the medical treatment plan
    - Rationale for frequency and duration of services.
- Documentation must be available to Medicare upon request.

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 clinical criteria may apply.

Procedure Codes	Description
96156	Health behavior assessment, or re-assessment (i.e., 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)
96170	Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes (Considered non covered by Medicare)
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) (Considered non covered by Medicare)
G2214	Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional

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Revision History

Date	Summary of Changes
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