Optum

Reimbursement Policy
Policy Number 2020P501A

Health and Behavior Assessment and Intervention Reimbursement Policy
Commercial & Medicare

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the procedure code or codes that correctly describe the health care services provided to individuals whose behavioral health benefits are administered by Optum, including but not limited to UnitedHealthcare members. This reimbursement policy is also applicable to behavioral health benefit plans administered by OptumHealth Behavioral Solutions of California.

Our behavioral health reimbursement policies may use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other procedure coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement. This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to services billed on the UB-04 claim form and to electronic claim submissions (i.e., 837p and 837i) and for claims submitted online through provider portals. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.*

This information is intended to serve only as a general reference resource regarding our reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, Optum may use reasonable discretion in interpreting and applying this policy to behavioral health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for behavioral health care services provided to members. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: member's benefit coverage, provider contracts and/or legislative mandates. Finally, this policy may not be implemented exactly the same way on the different electronic claim processing systems used by Optum due to programming or other constraints; however, Optum strives to minimize these variations.

Optum may modify this reimbursement policy at any time by publishing a new version of the policy on this website. However, the information presented in this policy is accurate and current as of the date of publication.

**CPT® is a registered trademark of the American Medical Association*

Applicability

This reimbursement policy applies to all health care services billed on CMS 1500 forms and to services billed on the UB-04 claim form and to electronic claim submissions (i.e., 837p and 837i) and for claims submitted online through provider portals. This policy applies to Commercial and Medicare products, all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

United Behavioral Health and United Behavioral Health of New York, I.P.A., Inc. operating under the brand Optum
U.S. Behavioral Health Plan, California doing business as OptumHealth Behavioral Solutions of California

Policy

Overview

This policy describes the correct coding methodology and reimbursement for Health and Behavior Assessment and Intervention (H&B or HBAI) CPT codes for non physician health care professional services. H&B procedures are services offered to established illness or symptoms. The purpose of the assessment is not for the diagnosis or treatment of mental illness but on the biopsychosocial factors related to the physical health problems and treatment. Health and behavior assessment can be performed in an office or facility setting.

Reimbursement Guidelines

The American Medical Association *Current Procedural Terminology* (CPT®) Professional Edition gives the following instruction for code selection: "Select the name of the procedure or service that accurately identifies the service performed. Do not select a CPT code that merely approximates the service provided."

The American Medical Association (AMA) has developed specific CPT codes intended for use by qualified health care professionals who are not Physicians to report their services. In some instances the intended use of a procedure or service is within the description of the code. For example, H&B assessment codes are to be reported by licensed and qualified, non physician health care professional to report a brief, time-limited behavioral health consultation with patients seen in medical settings.

Therefore, in accordance with correct coding guidelines, Optum will not reimburse non physician health care professional service H&B assessment codes listed in the Code Section below when reported by a Physician, because these codes are intended for use by non physician health care professionals.

Physicians who provide health and behavior assessment/intervention should report these services using the appropriate evaluation and management codes.

Health & Behavior Initial Assessment and Re-Assessment

CPT codes	Description
96156	Health behavior assessment or re-assessment (e.g., 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 services)
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
+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	

Questions and Answers	
1	**Q:** If a Physician reports codes from the Health and Behavior Assessment/Intervention series using CPT 96156-96171 will he or she be reimbursed? **A:** No. CPT 96156-96171 should only be reported by qualified non physician health care professionals. As indicated in the parenthetical note following the Health and Behavior Assessment/Intervention guidelines in the AMA CPT book, Physicians performing health and behavior assessments/interventions should report the appropriate Evaluation and Management.
2	**Q:** Can a non physician health care professional bill for an H&B Service with a Diagnostic and Statistical Manual (DSM) diagnosis of a mental health condition? **A:** No, a non physician health care professional must bill with the appropriate ICD-10-CM medical diagnosis assigned by the member's physician on the claim.

Resources

- American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services
- Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
- American Psychological Association

History	
March, 2023	Anniversary Review; Removed deleted H&B codes
March, 2022	Anniversary Review; no updates
March, 2021	Anniversary Review
January, 2021	Added Q&A 2: Behavioral Health Providers must bill using medical diagnosis code
January, 2020	Updated Q&A adding 2020 H&B codes;
March, 2020	New Reimbursement Policy