Commentary. Health and Behavior CPT Codes: An Opportunity to Revolutionize Reimbursement in Pediatric Psychology

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Recently accepted codes in the Current Procedural Terminology system permit licensed pediatric psychologists to deliver psychological services utilizing billing codes that focus on improving medical and physical health. They potentially allow pediatric psychologists to obtain third-party reimbursement for services within a biopsychosocial model of care without requiring a concurrent psychiatric diagnosis. These codes represent a potential major paradigm shift whereby the services of a pediatric psychologist are provided and billed within the context of physical health care. Information is provided on the history of these codes along with detailed information regarding their utilization. Future directions for implementation, teaching, and research are provided along with a strong encouragement for use of these codes by pediatric psychologists.

Key words billing; CPT codes; health psychology charges.

This paper focuses on the new health and behavior assessment and intervention codes approved by the American Medical Association (AMA) for inclusion in the Current Procedural Terminology (CPT) system. You may read this paragraph and wonder, why should I read an article on CPT service codes when my time is valuable and needed for patient care, research, or teaching (i.e., generating revenues)? CPT service codes, originally developed in 1966 by the AMA, attempt to provide a uniform system for describing and reporting medical procedures and services. In addition to promoting effective communication among patients and physicians, CPT codes are used by third-party payors when providing reimbursement. With these new health and behavior service codes, psychologists and other health care providers can now more accurately bill for psychological services provided to a patient with a physical health diagnosis. These service codes also have the potential to expand the range of services provided by pediatric psychologists to children with acute or chronic health problems and their families insofar as physicians and families feel greater comfort with behavioral health services without a psychiatric diagnosis. They were approved more than 3 years after the initial 1998 proposal coordinated by the American Psychological Association (APA) Practice Directorate, on the part of which the codes represent considerable effort. More general information about CPT service codes can be found at the AMA website, http://www.ama-assn.org/ama/pub/category/3113.html.

Prior to the introduction of these service codes, licensed pediatric psychologists who delivered clinical services and sought reimbursement utilized CPT codes that referred to psychological assessment or psychotherapy (i.e., codes 90801–90899). These codes required a mental health diagnosis using criteria from the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV). Often the types of services provided by pediatric psychologists in relation to reducing distress, improving adherence, and facilitating coping with an untenable situation do not meet formal psychiatric diagnostic criteria. Furthermore, the use of psychiatric service codes labels the child or his/her parent(s) as having a psychiatric problem, even when the focus of the clinical work is a direct result of the challenges associated with a medical illness. The use of psychiatric codes commonly causes parents, children, and members of the primary medical team to feel uncomfortable and may result in hesitancy to request services.
The new codes cannot be utilized when treating patients only for psychiatric diagnoses. Patients who require both psychiatric service codes (i.e., 90801–90899) and the new health and behavior codes cannot receive both types of service on the same day. The pediatric psychologist must report the primary service being provided for each day of service. If a physician uses the new codes, he should not report evaluation and management service codes on the same day for that patient.

These new service codes have been accepted by the Centers for Medicaid and Medicare Services (CMS) and became active in January 2002. The availability of the new codes has the potential to instigate a major paradigm shift that facilitates payment to health psychologists who deliver services within a biopsychosocial model of care (Engel, 1977), or a more contemporary version the bio(psycho) model of care (Dowrick, May, Richardson, & Bundred, 1996). Note that while this paper focuses on use of these codes in pediatric psychology, they can be used by a number of licensed health care providers (e.g., PhDs, advanced practice nurses). While eligible to use these new codes, physicians typically utilize evaluation and management codes when providing these types of services. The CMS have ruled that licensed clinical social workers do not have sufficient training in medical problems to utilize these codes. For this manuscript, the term pediatric psychologist implies a state licensed clinical psychologist.

Psychological services for children and their families when they face the overwhelming demands that are a common consequence of severe chronic, or acute, illness are typically welcomed by children, parents, and all members of the medical staff. As a pediatric psychologist working primarily in hematology/oncology for the past 25 years (first author), I have had numerous opportunities to utilize behavioral, social, or psychophysiological procedures that dramatically improve the health-related quality of life of children and their families.

Our own clinical work has focused on diverse issues, including:

1. reducing anxiety, distress, and pain for children as a direct result of disease or medical procedures related to either acute or chronic medical problems (Kazak et al., 1996; Walco, Varni, & Ilowite, 1992);
2. helping parents adjust to receiving catastrophic information regarding their child’s health status (Sahler et al., 2002);
3. working with health care teams, children, and their families when, despite honorable efforts, cure is no longer the objective of treatment (American Academy of Pediatrics, 2000; Wolfe et al., 2000; Zwerdling et al., 2000);
4. facilitating efforts by medical treatment teams to improve adherence (Rapoff et al., 2002; Roter et al., 1998);
5. enhancing health-promoting behaviors or reducing health-related risk taking behaviors (Emmons et al., 2002; Tyc, Hudson, Hinds, Elliott, & Kibby, 1997); and
6. improving communication between health care teams and chronically (or acutely) ill children and their families (Bender et al., 2000; Kazak, 1989; Noll & Kazak, 1997).

While these services improve family satisfaction with care (Koontz, Short, Kalinyak, & Noll, 2004) and typically improve the quality of life for children and their families (Bender et al., 2000; Sahler et al., 2002), obtaining reimbursement for these services can be challenging.

The new CPT service codes focus on procedures that assess and treat a wide variety of health-related problems. These new codes permit pediatric psychologists to deliver psychological services utilizing a billing system that matches the services being provided. Third-party reimbursement occurs within a bio(psycho) model of care, which represents a potential major paradigm shift whereby psychological services are provided within the context of physical health care (Engel, 1980). This exemplifies the original biopsychosocial model of health care that has long been espoused but is commonly not utilized because of the mind–body dualism that persists in Western medicine (see Armstrong, 1987, for a discussion of these issues).

There are six health and behavior service codes that can be utilized to bill for psychological health-related services to children with a medical diagnosis. Health psychology services are delivered without a mental health diagnosis for a child (or parent) when the problem is related to a physical illness (“Coding Communication,” 2002). Each charge requires use of one health and behavior code along with the child’s medical diagnosis using the appropriate code from the International Classification of Diseases, ninth edition (ICD-9). When a child has multiple medical diagnoses (ICD-9 codes), the services should be billed with one health and behavior service code and the primary medical diagnosis that resulted in the need for behavioral health services. It is important to utilize only medical diagnoses (ICD-9 codes) that have already been provided by the child’s physician.
In addition to use of the appropriate health and behavior code and a medical diagnosis, documentation must delineate the necessity of service. Charting requirements are similar to current guidelines. Necessity of service is established with documentation providing a review of the problem and a plan of care along with the rationale for the plan. Additional elements must include the location of services and total time involved with the patient present (“Coding Communication,” 2002). When tests are utilized, include the name of the test and the edition/version in your note. If tests are scored with the patient present, this time can be billed; if tests are scored without the patient present, this time cannot be billed. Notes must be completed in a timely manner and maintained confidentially. Chart notes using these codes are not psychotherapy notes. Thus, they should place fewer demands on practitioner time in terms of provisions of the Health Insurance Portability and Accountability Act and can be included in the child’s medical record.

Importantly, the federal guidelines for reimbursement provide that payments will come from medical care and not from the limited funds available for mental health services. Thus, the services are provided around physical health issues and are paid from physical health dollars, not mental health dollars. In addition, federal regulations for Medicare suggest that the reimbursement rate for these outpatient services be 80%, instead of the 50% rate Medicare pays for outpatient mental health services.

In our local region (as of November 2003), five of the six largest third-party health insurance organizations were paying for services delivered using the new health and behavior service codes. The reimbursement rates ranged from 70% to 100%. The sixth carrier stated that these services were a noncovered benefit. The private insurance carriers require a medical (ICD-9) diagnosis with these codes; none requests a mental health diagnosis. This follows federal guidelines.

The acceptance of the service codes by these private carriers did not occur automatically. The division of psychology at this hospital worked with the hospital’s division of payor relations to draft letters to the medical directors of the major private carriers informing them of the availability of these codes. The key points included in the letters from this facility were the rationale for the new codes and that reimbursement for them was intended to be from the “medical pool” of funds, rather than from the “mental health pool.” The letter also pointed out that psychology took the lead in organizing the codes and that the final recommendation from the CMS was that psychologists were eligible to use them. Additional material for such letters might include information provided in this manuscript and/or from APA (an example letter is available from the first author of this manuscript on request).

A gradual introduction of these codes into ongoing services initially, along with meticulous follow-up regarding final disposition of charges, may minimize financial risk for your organization as you explore the capabilities and barriers to their use. Some of our local carriers require certification prior to use of the codes, while others require no precertification. A common problem has been that insurance companies do not understand that billing units are 15 minutes, hence they pay only one unit instead of the specified number of service code units.

There are two health and behavior assessment codes and four health and behavior intervention codes (Table I). Clinical examples utilizing these codes in pediatric psychology are provided to facilitate utilization among the readership. Note that while the examples focus on children with a chronic illness, these codes are also applicable for use with children with acute illness.

### Assessment Service Codes

These codes are utilized for initial evaluations or reassessments of patients. The health and behavior assessment might include health-focused clinical interviews, health-oriented behavioral observations, or health-oriented psychological questionnaires.
Initial Assessment (Code 96150)

A 10-year-old female with sickle cell anemia (Hgb SS) is referred for assessment as a result of repeated hospitalizations for pain. During previous admissions, the hospital pain team noted that standard hospital practices for pain management in sickle cell disease were not successful. Concerns were raised regarding the safety of this child, as she had become mildly hypoxic during hospitalization, adequate pain control was obtained only when the child was somnolent, and she had had numerous hospitalizations for pain in the past year. Members of the sickle cell team and pain team are interviewed. During a time frame when the child is not in pain, she is interviewed along with her parents. Since a maternal grandmother commonly provides care for this child, she also is interviewed. Standardized questionnaires are administered (e.g., Pain Response Inventory, Children's Coping Strategy Checklist), along with a Sickle Cell Knowledge Questionnaire (Koontz et al., 2004). The focus of the assessment is on social, biological, and psychological factors related to pain management and sickle cell disease. There is no assessment of the child’s or family members’ mental health condition.

The billing documentation is distinct from previous practice. In the past, psychologists who provided these types of services used a psychiatric CPT service code such as 90801 (psychiatric diagnostic interview examination) for the service provided and utilized a DSM-IV diagnostic code. The current documentation using this example would utilize health and behavior service code 96151 and the ICD-9 code for sickle cell anemia (282.61, 282.62). For the ICD-9 code, we recommend using the same code as the physician who is treating the child’s primary disease causing the behavioral health problem. Obtain the ICD-9 code from the billing coordinator for the treating physician. This should ensure comparability. Finally, be certain to remember that the health and behavior service codes are time based. One unit is 15 minutes, so bill the appropriate number of units.

Reassessment (Code 96151)

This code is utilized after a child has already had an initial assessment (code 96150). An 8-year-old boy with juvenile rheumatoid arthritis (JRA) is seen for reassessment and treatment. The original referral resulted from nausea, vomiting, and panic reactions prior to receiving weekly injections of methotrexate. Treatment with Zofran had no impact. The original assessment included an interview with the child and his mother regarding the child’s history of JRA, when methotrexate was first started, who gives the medication, the child’s reactions, how the child’s responses had been managed in the past, and administration of anxiety and depression questionnaires to the child. The interview also focused on the mother’s problem-solving skills. After four weekly 1-hour treatment intervention sessions (four units for each session), the anticipatory nausea and vomiting remitted, and panic was gone.

Two months after this intervention ended, the arthritis flared and required additional treatments, including surgery, follow-up physical therapy, use of a wheelchair, and additional medications. This boy was dreading his return to school. The psychologist sees the boy and his mother again to reassess his current adjustment and reevaluate physiological responses to the current medications and physical challenges. This reassessment includes an interview with the boy and his mother, along with a repeat administration of anxiety and depression questionnaires to make a comparison with previous responses and the need for further treatment.

Treatment Service Codes

The codes in the following four sections are utilized for treatment-related services that provide behavioral medicine interventions aimed at difficulties related to medical health. Choice of specific service codes is dependent upon whether services are provided (1) individually without other family members present, (2) in a group of two or more patients, or (3) through family interventions with and without the patient present.

Health and Behavior Intervention: Individual (Code 96152)

A 16-year-old female with fibromyalgia has a history of numerous pain episodes, problems with school attendance, and isolation from peers. Prior to the onset of her disease, school attendance was normal and difficulties with peers were not reported. Previous attempts by the rheumatology service and pain team to manage pain and facilitate a positive adjustment in school were not successful.

A pediatric psychologist sees the patient. A treatment plan is developed based upon information from the medical care teams, the patient, and her parents. Weekly intervention sessions teaching problem-solving skills and relaxation/guided imagery occur, and an audiotape is tailored for this patient. Biofeedback is integrated into the relaxation training to facilitate development of this skill. With permission from the teenager and her parents, contact is made with the school. An extra set of books is made available and medications are given to the school nurse. Psychoeducation is provided to key school
administrators regarding fibromyalgia and strategies to help teens with this disease. Social skills training is provided to improve peer relationships.

The billing for this example would include the health and behavior code (96152), the ICD-9 code utilized by the child’s rheumatologist for fibromyalgia, and the number of units of health and behavior service being provided.

Health and Behavior Intervention: Group (Code 96153)

A 9-year-old female is referred for grief counseling subsequent to the death of a sibling from cancer. The health and behavior assessment reveals that an older brother recently died during extended treatment for lymphoma. Since the brother’s treatment had included a bone marrow transplant at a distant tertiary care center, home life for this girl had been severely disrupted. Relatives and neighbors had provided care during the last 4 months of the brother’s life. During the past 2 months since the brother’s death, the patient’s grades have been falling, she has become increasingly distant from friends, and she has shown less interest in outside activities. The mother and child have agreed that participation in a sibling bereavement group would be helpful. This group includes six sessions that focus on social support (e.g., sharing information about the loss, group discussions, group activities), cognitive-behavioral treatment (e.g., reframing, family sessions, problem solving), and education about cancer and its treatment. Each group session lasts 1.5 hours and includes time with the child participants in a group, time with parents in a group, and time with both parents and child participants in a large group.

Health and Behavior Intervention: Family With Patient (Code 96154)

A 15-year-old female with acute lymphoblastic leukemia recently began the maintenance phase of treatment. This stage of therapy involves numerous oral medications taken at home. Monthly blood cell counts suggested that all chemotherapy was not being taken and the physician spent considerable time with the patient discussing the potential consequences of not taking chemotherapy. Cell counts briefly appeared more satisfactory but again went into decline. A referral is made for suspected nonadherence.

After an initial assessment utilizing interviews with the physician, parents, and the patient, it becomes clear that the patient is not taking all medications. She reports feeling great when she does not take her medications and not feeling as well when she does take them, especially her steroids. She also reports being “sick and tired” of the medical center and of cancer. She is willing to “take her chances” with stopping her therapy; her parents do not see this as a viable option.

A family session is held to discuss findings from the assessment and begin an intervention. The parents have previously allowed this teenager to take her own medications without direct supervision. Psychoeducation is provided for the family regarding the difficulties of taking chemotherapy even for mature adults, and the consequences of relapse are clarified (less chance of cure, even more intensive chemotherapy, longer duration of treatment, physical consequences). Relaxation and imagery are taught to address reactions to chemotherapy, and a tailored audiotape is provided. Both parents are encouraged to assist their daughter in taking medications and to shape adherence. Praise and rewards are to be provided for compliance. Family roles and responsibilities are clarified regarding parental help with medication adherence. Parents are taught how to efficaciously utilize time out and other response cost strategies. Additional work is accomplished focusing on improving family communication, problem-solving training, and conflict resolution. All skills are practiced to facilitate their use with other challenges. Family problem solving regarding adherence suggests that a best friend is supportive, and she is included in some of this work.

Follow-up consultation with the child’s physician suggests that blood counts appear more typical for this phase of treatment. Notes in the chart include a record made by the parents and the teenager of weekly compliance.

Health and Behavior Intervention: Family Without Patient (Code 96155)

A 4-year-old girl has had multiple relapses of neuroblastoma. The health care team informs the family that cure is no longer a probable goal of treatment and attempts to refocus efforts on palliative care. Parents are shocked and angry and do not seem to be able to integrate this new information. They continue to focus on treatments designed to cure, despite the child’s failing health. The psychologist who had already worked with the family to help the parents deal with the shock of the child’s initial diagnosis is asked to see the family again. Using information obtained from the child’s physician and health care team and the parents, along with knowledge of this family from earlier work, the psychologist implements a treatment plan which involves sessions with both parents focusing on psychoeducational factors designed to increase awareness of the disease process. The psychologist reframes parental hope for cure as parental hope for high current quality of family life. Sessions also focus
on parents’ sense of failure and previous losses. Individual differences in coping with loss between parents are highlighted to facilitate parental ability to support one another during this phase of treatment. Training in problem-solving skills is provided to facilitate adaptation to multiple traumatic events. A session with an older sibling (age 11) who recently began having school problems and oppositional behavior at home (no prior history of any difficulties) is included that facilitates a discussion between the parents and this child about loss.

**Code Utilization**

It is imperative that health care psychologists utilize the health and behavior service codes. Other licensed health care professionals can also utilize them. The specialty society that most frequently uses a code becomes the lead organization for the service code. The APA took the lead in developing these codes, especially the interdisciplinary health care advisory group, but the APA will lose control over surveys about the codes and will not be the spokesgroup for all activities about these codes if other licensed health care professionals use them more frequently. Additionally, the relative value units for a CPT service code depends upon who utilizes the code. Psychologists’ services are typically valued higher than other nonphysician practitioners, so psychology leadership will facilitate greater work values for the codes.

**Reimbursement Problems: Medicare and Medicaid**

Medicare and Medicaid currently reimburse these codes. If problems occur with federal reimbursement, pediatric psychologists should contact their regional CMS office or APA’s Practice Directorate’s Government Relations Office at (202) 336-5889. Additional information about these codes can be found at the APA Practice Directorate website, [http://www.apa.org/practice/cpt_2002.html](http://www.apa.org/practice/cpt_2002.html).

**Reimbursement Problems: Private Carriers**

It is feasible that some private third-party insurers will have more restrictive payment policies for these codes. At the current time, many large private carriers do not maintain a stable patient base, so they have little stake in future health care savings that might result from use of these codes. Appeals can be made to private carriers following the example we provided above. Additionally, efforts can be made to lobby the insurance industry or the medical director of a specific carrier for acceptance of these codes within federal guidelines. If these types of efforts are not successful, we would suggest collaborating with national patient support groups such as Candlelighters, the National Arthritis Foundation, and the National Neurofibromatosis Foundation or local patient support networks. Involved parents might make lobbying efforts, which might include notification of local legislators or participation in public news-media forums. If a child is referred for these services and her insurance does not cover them, the family must be informed prior to provision of services so that the parents can decide whether they want the services even without insurance coverage. For each private carrier, a determination of whether precertification is necessary should be clearly established.

**Collaborations**

We also encourage collaborations with adult health psychology colleagues regarding use and acceptance of these service codes. While pediatric psychologists may do an exceptional job gaining acceptance of the codes and using them, adult health psychology must also move forward with use. There are more adult patients, so volume alone makes this significant. This type of collaboration can occur at a national level though APA (Division 38 and 54) or the American Psychological Society. Joint presentations at national or regional meetings along with additional publications about use of these codes should be encouraged. At the local level, joint efforts to inform patients and insurance companies about these types of services have tremendous potential to improve access to better care.

We would also recommend partnering across disciplines. Organizations such as the Society for Developmental and Behavioral Pediatrics could be involved with efforts aimed at improving the accessibility of behavioral health services for children and adolescents. Other multidisciplinary groups, such as the Society for Research on Child Development, might provide an additional platform for advocacy (this resource being more useful toward research related to the efficacy of the codes or cost-benefit analyses of code utilization). Multidisciplinary groups focusing on specific diseases such as pediatric cancers (e.g., Children’s Oncology Group) may provide a forum for discussion of key issues related to using these codes to improve the quality of life of children with illness (chronic or acute) and their families.

We also encourage collaborations via state psychology associations. Efforts might include local lobbying, providing information to local practitioners at state and
regional meetings, and including information on state Internet listservers.

Finally, psychologists who specialize in care of children with a specific disease might partner with national (e.g., National Neurofibromatosis Foundation, American Cancer Society, National Arthritis Foundation) or local chapters of parent support groups to coordinate efforts aimed at educating medical providers (physicians, nurses) and families about these codes and their potential utility to improve the lives of children with chronic illness.

Future Directions

Training Issues

Additional work must be done to teach our trainees how to utilize these service codes. Minimally, they should be very aware of the codes and have a solid working knowledge of how to use them when providing services within the frameworks delineated above. Insofar as these codes improve clinical revenues, perhaps some time can be carved out once again for our students who are the next generation of pediatric psychologists. It also seems feasible that trainees could see patients referred for these services when their insurance does not cover these codes. The practitioner might charge the family the standard copayment of their insurance but not bill their insurance for the services. This arrangement would not violate existing contracts with managed care companies and would give our students the opportunity to learn valuable skills related to both the professional and business sides of our profession.

Research

Systematic research is needed to assess the impact of these codes on quality of life, medical adherence, fiscal costs, satisfaction, etc. The availability of these codes provides a significant opportunity for scientist clinicians to evaluate the impact of utilization of the codes on a broad array of health care outcomes. While a number of licensed health care providers can use the codes, health psychologists have unique training that optimizes their ability to be at the vanguard of research examining the impact of these CPT service codes.

Acknowledgments

The authors express their appreciation to Antonio E. Puente, for his contributions to the ideas presented in this paper and his thoughtful editorial assistance, and Lori J. Stark for providing data on the use of the new codes by third-party payors and reimbursement.

Received September 5, 2003; revisions received December 3, 2003; accepted December 11, 2003

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