Commentary: The Use of Health and Behavior Codes in a Pediatric Cardiology Setting

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Congenital heart disease (CHD) is the most common birth defect, occurring in approximately 6 in 1,000 live-births (Hoffman & Kaplan, 2002). Due to advances in diagnostic and surgical techniques and postoperative management strategies, the majority of children with CHD are surviving (Tweddell et al., 2009). However, these children are at increased risk for neurodevelopmental and psychosocial problems, likely due to multiple factors including abnormal prenatal brain development, perioperative management strategies, altered cerebral blood flow and oxygen delivery, and genetic syndromes (Wernovsky Shillingford, & Gaynor, 2005). Children with CHD have lower cognitive functioning and higher rates of attentional, behavioral, and emotional problems when compared to the normal population (Brosig, Mussatto, Kuhn, & Tweddell, 2007a,b; Karsdorp, Everaerd, Kindt, & Mulder, 2007; Snookes et al., 2010). In addition, increased parental stress, as well as impaired quality of life for both children with CHD and their parents has been reported (Brosig et al., 2007b; Landolt, Valsangiacomo Buechel, & Latal, 2008; Lawoko & Soares, 2003; Uzark & Jones, 2003).

Given the aforementioned problems in this patient population, in July 2007, the Pediatric Cardiology Division at our institution employed a full-time pediatric psychologist to help address the neurodevelopmental and psychosocial concerns of these children and families. Cardiologists and nurses asked families about the child’s emotional, behavioral, and academic functioning during routine cardiac follow-up clinic visits. If there were concerns in any of these areas, a referral was made to the pediatric psychologist. Based on the clinical information provided, the psychologist determined whether a separate visit with the psychologist was needed, and what type of intervention was required (e.g., psychological testing, individual therapy, health and behavior intervention, etc.).

The current report summarizes our experience with financial reimbursement for pediatric psychology services in the outpatient pediatric cardiology setting over the past 4 years. We have been using the health and behavior codes at our institution since 2002, and have reported on our experience using them for inpatient pediatric psychology consultation previously (Brosig & Zahrt, 2006). We were interested to learn about reimbursement rates for health and behavior codes as well as mental health codes in the outpatient pediatric cardiology setting, as both types of services are utilized by children with CHD and their families. Results will be used to inform strategies to improve reimbursement rates for pediatric psychology services for this population.

Methods

Procedure

Charts and billing records of all outpatients seen by the pediatric psychologist in the outpatient cardiology setting over the past 4 years (FY 2007–2008 through FY 2010–2011) were reviewed for this study. The study was approved by the hospital Institutional Review Board (IRB). Parents provided consent and children (if age appropriate) provided assent to have their records included in this review.

When a new cardiology patient was referred to the pediatric psychologist for evaluation, an insurance verification specialist contacted the insurance company to verify benefits (including whether the company acknowledged health and behavior codes), and obtained prior authorization for the patient to be seen. Information about which billing codes were authorized was provided to the psychologist before the patient’s visit. Based on the data from the
initial assessment, the psychologist determined whether a mental health or health and behavior code was billed.

Charts were reviewed for referral date and referral question. Financial data were calculated by staff in the billing office of the institution, and included information regarding type of insurance (Medicaid vs. Commercial), billing code used (mental health vs. health and behavior), and payment rate. Charges for new patient visits as well as follow-up visits were included.

Results

During the study period, 165 new outpatients were seen; 98% of patients had a cardiac diagnosis (3 patients were siblings of a child with a cardiac diagnosis). Patients ranged in age from 6 months to 27 years old. Reasons for referral to psychology included: anxiety/depression \((n = 49, 29.7\%)\); attention problems \((n = 32, 19.4\%)\); learning problems \((n = 24, 14.5\%)\); transplant-related care \((n = 20, 12.1\%)\); behavior problems \((n = 19, 11.5\%)\); coping with chronic illness \((n = 11; 6.7\%)\); and developmental delay \((n = 10; 6.1\%)\).

The most frequently used CPT codes by year are depicted in Table I. In general, the focus of the practice was on initial evaluations (90801—Diagnostic Evaluation; 96101—Psychological Testing; and 96150—Health and Behavior Assessment). Since many families lived a significant distance from the hospital, follow-up psychology services were often coordinated with a provider located closer to where the families resided. When follow-up services were provided, a majority of them focused on family interventions rather than individual therapy.

Payment rates for all outpatient psychology services provided in the pediatric cardiology clinic (including follow-up visits) were calculated by year, with separate analyses for health and behavior codes (CPT codes: 96150, 96151, 96152, 96154, and 96155) versus mental health codes (CPT codes: 90801, 90804, 90806, 90808, 90812, 90846, 90847, and 96101); these payment rates are reported in Figure 1. Overall payment rates for mental health CPT codes have ranged from 24% to 34% over the past 4 years, whereas payment rates for health and behavior CPT codes have ranged from 42% to 79%. While payment rates for health and behavior CPT codes have been consistently higher than payment rates for mental health CPT codes, it is important to note that payment rates for health and behavior codes have declined over the years. As the percent of charges based on health and behavior CPT codes has increased (from 8% of charges in FY 2007–2008 to 62% of charges in FY 2010–2011), the payment rate has decreased (from 79% in FY 2007–2008 to 42% in FY 2010–2011).

To further explore the reimbursement rate patterns, payments were also analyzed based on payer type (Medicaid or other government funded insurance programs vs. commercial/HMO/PPO insurance programs). These results are reported in Figure 2. Not surprisingly, commercial payers reimbursed at higher rates when compared to Medicaid or other government funded program, for both mental health and health and behavior CPT codes. However, it is concerning that Medicaid reimbursement rates for health and behavior codes ranged from only 8% to 17% (which is even lower than the Medicaid reimbursement rates for mental health codes), given that many children with chronic health conditions have Medicaid as their primary insurance. In our study, the percentage of charges to Medicaid varied by year: 54% in FY 2007–2008; 35% in FY 2008–2009; 50% in FY 2009–2010; and 41% in FY 2010–2011.

Conclusions/Implications

There are several limitations to the current study. It is based on a single psychologist’s experience at one institution, practicing within a very specialized setting (pediatric cardiology outpatient clinic). Therefore, it is not clear whether the findings are representative of what other pediatric psychologists, who work with different pediatric

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<td>28</td>
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<td>90806 Individual Therapy (45–50 min)</td>
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<td>96154 Health and Behavior Intervention (Family with patient)</td>
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<td>4</td>
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Table I. Most Frequently Used CPT Codes by Year

Note. FY = fiscal year.
populations, and practice in other states, have experienced when utilizing health and behavior or mental health codes.

Nevertheless, the results of this report do highlight a number of important issues. While the hope was that using health and behavior codes would result in improved reimbursement rates for pediatric psychology services (Noll & Fischer, 2004), this only was the case for children who had commercial insurance. A significant problem remains in that Medicaid’s reimbursement of these codes in our state was less than 20%. Despite concerted efforts to improve reimbursement rates (by hiring an insurance verification specialist, getting preauthorization for services, and verifying what types of codes are billable), it has been our experience that if a significant portion of the patients seen by the pediatric psychologist have Medicaid as their primary insurance (and this number is increasing, given current economic conditions), the revenue generated will not be sufficient to offset the costs of the psychologist’s salary. Thus, increased access to psychology services for patients with chronic health conditions will only be possible if there are outsides sources of revenue (besides billing) to offset the cost of hiring (and retaining) psychologists.

An additional proposed advantage of the health and behavior codes is that they come out of the patient’s medical benefits, and are not supposed to require preauthorization. We have not found this to be the case. We continue to need to get prior authorization to use these codes, and some insurance companies still do not recognize them, even though they have now been active for nearly 10 years.

It is concerning that reimbursement rates for psychology services have declined over the four year period. Part of
this may relate to the increase in the percent of patients who have Medicaid; because Medicaid’s reimbursement rates are so low, particularly for health and behavior codes, this lowers the overall payment rate. The decrease in payment rates may also reflect changes in contracts with commercial payers. On average, we have increased our charges by approximately 5% per year, but our contracted payment rates have not increased at this rate. Many insurance companies have a set amount that they will reimburse for a particular code, regardless of our charge.

Finally, it is important to recognize that using health and behavior codes will not be appropriate in all circumstances. Even though a majority of the patients in this study had a medical diagnosis, over 80% of them were referred for a mental health reason. Many pediatric psychologists provide traditional mental health services, such as psychological testing, in addition to behavioral health interventions; thus adequate reimbursement for all types of services that psychologists provide is critical.

It appears that there is much work that remains to be done in order to improve patient access to psychology services and improve reimbursement for these services. In our experience, it has been helpful to have an insurance verification specialist to get information about patient benefits and determine which CPT codes are authorized prior to the patient’s appointment. In some circumstances, the insurance verification specialist has been able to educate insurance companies about the health and behavior codes and why they are appropriate to use in certain cases. It has also been important to have designated people in our billing and collections office who are specialists in psychology billing, as billing codes used by psychologists differ significantly from those used by physicians. These billing specialists provide the psychologists at our institution with annual training regarding changes in CPT codes. In addition, they periodically audit our charts to make sure that documentation meets standards to capture charges at the highest rates.

Puente (2011) suggests that in order to remain economically viable as a profession, psychology needs to embrace not only “mental health”, but “health” in general; pediatric psychology already does this. Going forward, psychologists need to be active in forming public policy with respect to how “quality health care” is defined (DeLeon & Kazdin, 2010; Levant, Tanner House, May, & Smith, 2006; Tovian, 2004). With the Patient Protection and Affordable Care Act (2010), there will be increased emphasis on improving access to comprehensive health care services, including services provided by psychologists. As there will also be increased emphasis on reducing health care costs, psychologists need to continue to demonstrate effectiveness as a profession in reducing health care costs and improving health outcomes. It is likely that payment for all health care services, including those for psychologists, will change from the fee-for-service system that we know. There is discussion of “global payments” to interdisciplinary teams who provide services (Nutting et al., 2011). Psychologists need to be involved when team-based reimbursement rates are outlined (Rozensky, 2011). This is a time of great change in health care; it is critical that we continue to advocate for ourselves and our patients as these changes unfold.

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References


