Commentary: Examination of Health and Behavioral Code Reimbursement From Private Payers in the Context of Clinical Multidisciplinary Pediatric Obesity Treatment

Bethany J. Sallinen,1 PhD, and Susan J. Woolford,1,2 MD, MPH
1Department of Pediatrics and Communicable Diseases and 2Child Health Evaluation and Research (CHEAR) Unit, University of Michigan

All correspondence concerning this article should be addressed to Bethany J. Sallinen, PhD, Department of Pediatrics and Communicable Diseases, University of Michigan, Division of Child Behavioral Health, 1500 E. Medical, Center Drive, SPC 5318, Ann Arbor, MI, 48109-5318, USA.
E-mail: bsalline@med.umich.edu

Received December 15, 2011; revisions received and accepted January 20, 2012

In response to the epidemic of childhood obesity, the University of Michigan Health System developed the Pediatric Comprehensive Weight Management Center (PCWMC). Due to a large demand for obesity services across the economic spectrum, but particularly for low-income adolescents, our health system determined that clinical multidisciplinary weight management services should be accessible to all potential patients without regard to their ability to pay. Subsequently, the PCWMC obtained approval to use the charity care screening exception which allows care to be provided using a sliding scale (starting at zero for low income patients). The charity care screening exception is an institutional policy for patients who do not have insurance and who have an inability to pay for healthcare as determined primarily by the United States federal poverty level guidelines. As such, patients in the program are screened by financial counsellors prior to entry to determine the amount they will be responsible for based on the sliding scale, over and above their insurance copays and deductibles. For example, patients may qualify for 100% adjustment of charges if their household income does not exceed 250% of the federal poverty level guidelines, and 55% adjustment if their household income is between 250% and 400% of the guidelines.

Following financial screening, all patients are scheduled for a comprehensive multidisciplinary initial assessment in the PCWMC. The multidisciplinary team includes a medical director (i.e., pediatrician), pediatric psychologist, exercise physiologist, dietitian, and social worker. Following a feedback session to review results obtained from the initial assessment, a decision is then made about joining a 6-month behavioral family-based weight management program. The adolescent program (Michigan Pediatric Outpatient Weight Evaluation and Reduction; MPOWER), described elsewhere (Woolford, Sallinen, Clark, & Freed, 2011), first started accepting patients in April 2007. Briefly, patients currently attend weekly 2-hr sessions for six months. One hour always includes group exercise for adolescents, led by an exercise physiologist. The second hour of the program includes a rotating schedule of group visits, with the monthly family nutrition group led by the dietitian, the parent behavioral group led by the psychologist, and the youth behavioral group led by the social worker. Families also participate in two 45-min individual sessions per month where they meet with two of the following providers: psychologist, exercise physiologist, dietitian, and social worker. In 2008, the PCWMC expanded its services by implementing the MPOWER JR program for patients 7 to 11 years old. This program is also six months in duration with weekly 2-hr sessions. The program is held at the local YMCA, which allows for parents to also exercise during the first hour with their children. The second hour of the session rotates between groups (i.e., separate for parents and children) and individual sessions. A comprehensive assessment of patients’ progress (including repeat laboratory tests, psychological measures, exercise testing, and determination of body composition) is performed by the team at three and six months to provide feedback for families and to inform treatment decisions.

When the PCWMC was first created, it was decided that health and behavior codes would be the most appropriate way to bill for behavioral health services provided by
the psychologist. This was informed in part by the seminal commentary by Noll and Fischer (2004) about use of health and behavior Current Procedural Terminology (CPT) codes in pediatric psychology. The medical diagnoses billed are typically abnormal weight gain and obesity. The psychologist provides initial assessments to all patients entering the program (charged as CPT 96150) and reassessments after three and six months of program participation (charged as CPT 96151). Interventions provided by the psychologist include behavioral group sessions once per month for each age group (charged as CPT 96153), and individual sessions with patients and/or their families to assist with tailoring behavior change techniques to promote achievement of healthy weight status (charged as CPT 96152, 96154, or 961155, depending on who is present).

**Health and Behavior Code Collection Results From One Pediatric Psychologist**

For the purpose of this commentary, data about collection for services billed by the pediatric psychologist using health and behavior codes was obtained for financial years 2008 through 2011. Michigan Medicaid (fee-for-service) does not enroll pediatric psychologists as health care professionals and thus does not reimburse health and behavior codes. As a result, description of collection obtained from health and behavior codes will be limited to private insurance carriers only, and will not include Medicaid (managed care or fee-for-service).

Figure 1 shows that total charges for all health and behavior codes combined (96150–96155) increased from Financial Year 2008 through 2011. Percent collection from private insurance for health and behavior codes also increased over the 4 years, from 21% in 2008 to 26% in 2011. Figure 2 shows the average percent collection from private insurance carriers for each CPT code charged across the 2008–2011 financial period. Percent collection was calculated by dividing the amount charged by the amount collected. On average, assessments had higher collection rates (35%) compared to interventions (23%) during this time period. It is unclear why we collected more from reassessments (40%) than initial assessments (30%). With respect to intervention, inspection of CPT codes reveal differences based on type of intervention. Overall, a lower percentage of charges were collected for groups (CPT code 96153) and interventions with parents alone (CPT code 96155), compared to individual interventions including patients (either CPT code 96152 or 96154). Interestingly, much of the empirical support for behavioral family-based weight management treatment grew out of randomized controlled trials examining group interventions (Epstein, Myers, Raynor, & Saelens, 1998). There is also emerging evidence to suggest that intervening with parents alone as the agent of change provides meaningful improvements in child weight status (Golan & Crow, 2004; Golan, Kaufman, & Shahar, 2006; Janicke et al., 2008; Janicke et al., 2009). Despite evidence for these approaches, reimbursement is lower compared to individual interventions including either predominate the patient (CPT 96152) or the patient and his/her family (CPT 96154).

**Future Directions**

**Private Insurance Carriers**

Overall, the rates of collection for health and behavior codes were higher than expected. Our pediatric weight management center does not currently obtain preauthorization for services. It is possible that enacting this practice would increase the percentage of charges.
collected; however, the extent to which this would be impacted by payer mix and other factors such as benefit restrictions, patient cost share, copays, and deductibles is unknown. We plan to explore this moving forward.

**Medicaid**

The state of Michigan does not reimburse health and behavior codes to Ph.D level providers, such as psychologists. In light of the fact that obesity disproportionately affects low income populations, there is certainly a need for psychologists and other leaders to support efforts for reimbursement of behavioral health services for obese children who are recipients of Medicaid. This will likely require presentation of data to Medicaid. Efforts may be bolstered by involving and partnering with the American Psychological Association (APA) Practice Directorate, as similar advocacy campaigns are underway. Specifically, their website offers a section dedicated to health and behavior codes. Included in this section is a sample letter to insurance companies to assist with advocating for reimbursement. Similarly, psychologists are encouraged to contact the APA Practice Directorate’s Government Relations Office with any difficulties experienced with billing these codes.

**Health and Behavior CPT Codes**

Collection rates appear to vary in our weight management center for different types of assessments and interventions. It is interesting that our 3- and 6-month reassessments obtained greater rates of collection compared to our initial assessment. The next step would be to examine rates of collection at the individual insurance carrier level to determine if rates of collection differ by carrier and are thus driving this result. With respect to treatment, it is disappointing that we received relatively low rates of collection for groups and provision of individual intervention with parents alone. These treatment approaches are included in the 2007 Expert Committee recommendations for the prevention, assessment, and treatment of childhood obesity (Barlow & The Expert Committee, 2007). Insurers should be encouraged to cover these recommended services. As pediatric psychologists we need to promote these specific mechanisms through which to deliver evidenced-based treatment. This may include educating insurance carriers about different models of treatment delivery and presenting data to support delivering obesity treatment via groups and sessions with parents alone. Education may occur via letters to insurance companies and/or scheduling meetings where data can be presented. If these attempts are unsuccessful, administrators within large institutions where pediatric psychologists are working, such as medical centers, may be able to facilitate efforts to connect with insurance companies. In fact, when our PCWMC was first being developed, the administration at our institution was involved with presentations made to insurers in an effort to increase coverage. Although rates of collection were higher for individual interventions involving patients, rates could clearly improve and thus may benefit from similar advocacy efforts.

---

**Figure 2.** Average percent collection from private insurance for each Health and Behavior CBT code collapsed across financial year (2008–2011).
Pediatric Obesity Multidisciplinary Treatment

As part of FOCUS on a Fitter Future, convened by the National Association of Children’s Hospitals and Related Institutions (NACHRI), senior administrators of member hospitals were surveyed about their pediatric obesity programs. The most frequently cited challenge was lack of reimbursement (Eneli et al., 2011). This challenge is echoed by many others involved in the treatment of obese youth (Edwards & Schwarzenberg, 2009; Griffith, Gantz, Lowry, Dai, & Bada, 2007; Simpson & Cooper, 2009; Tershakovec, Watson, Wenner, & Marx, 1999), although most research is aimed at examining reimbursement for medical services rather than psychological services. Limited data is available about reimbursement for behavioral health services provided by psychologists in weight management. Pediatric psychologists, as experts in health behavior change, play an important role in the assessment and treatment of obese youth, and are an integral part of clinical multidisciplinary obesity treatment teams. In order for pediatric psychologists to continue their presence in multidisciplinary treatment, collection for services provided needs to be demonstrated. Using health and behavior codes to bill for weight management services provided by a pediatric psychologist appears to be a viable option. As psychologists we need to get involved in advocacy efforts with insurance companies in order to increase acceptance and reimbursement for health and behavior codes. This will ultimately provide more children with access to behavioral health services that have been demonstrated to have a significant positive impact on their health and quality of life.

Acknowledgments

The author expresses appreciation to Pam Egbert for providing data about the use and reimbursement of health and behavior codes by third-party payors in the Pediatric Comprehensive Weight Management Center, and to Ilene Phillips for her thoughts regarding the interpretation of the data.

Conflicts of interest: None declared.

References


