Center for Healthy Aging

TIP SHEET
Health and Behavior Assessment and Intervention (HBAI) Services
Coverage of Chronic Disease Self-Management Education Medicare and Medicare Advantage

Purpose:
The HBAI services are used to identify and address the psychological, behavioral, emotional, cognitive, and social factors important to the treatment and management of physical health problems. HBAI is an established intervention designed to enable individuals to overcome the perceived barriers to self-management of their chronic disease(s). HBAI is a current benefit of Original Medicare as a Part B benefit. All Medicare Advantage (MA) plans are required to cover all of the benefits of Medicare including Medicare Part A and Part B. As a result, all Medicare Advantage plans are required to cover HBAI services as a MA plan benefit.

The Chronic Disease Self-Management Education (CDSME) programs, when added to the appropriate infrastructure, appear to meet the requirements to be considered HBAI services.

Intended Audience:
The intended audience for this tip sheet is a community-based organization (CBO) that is collaborating with a physician and/or non-physician practitioners (NPP) to provide evidence-based preventive health programs licensed by the Stanford University Patient Education Research Center, based on the research of Dr. Kate Lorig. HBAI services are appropriate for individuals with one or more chronic conditions who are referred for community-based disease prevention classes, based on medical necessity and Medicare coverage requirements.

Background:
In 2002, six (6) CPT codes were added to the CPT coding system for Health and Behavior Assessment and Intervention services. HBAI services are provided to address the behavioral, social, and psychosocial barriers to the self-management of one or more chronic diseases.

The initial HBAI codes were published in the Federal Register in 2001 and included in the Medicare Fee Schedule in 2002. The codes are not to be used for the treatment of a psychiatric condition or mental illness. They are specifically intended to address any or all of the following barriers to disease self-management of a chronic physical condition:

- Cognitive
- Emotional
- Social
- Behavioral functioning

All MA plans are required to cover all of the services that a covered by Original Medicare, Part A and Part B. As a result, all Medicare Advantage plans are mandated to cover HBAI services. Any organization that wishes to provide reimbursable services to a Medicare Advantage plan, must first obtain a direct contract with the specific Medicare Advantage plan to provide the covered service(s).

Scope of Practice:
Professional scope of practice is defined by the professional practice acts of each particular state. The services outlined as part of HBAI are within the scope of practice of the following types of providers in most states:

- Physicians
- Nurse Practitioners
- Licensed Clinical Psychologists
- Licensed Clinical Social Workers

Although within the scope of work of clinical social workers, in most states, HBAI is not a benefit that is authorized to be provided by licensed clinical social workers. The reason that a clinical social worker cannot provide HBAI services is that the authorized scope of service of clinical social workers under Medicare is defined by the Social Security Act.

Specifically, the clinical social worker scope of practice for the Medicare program is defined in *Section 1861(hh)(2) of the Act – Clinical Social Worker services are limited to services intended to diagnose and treat mental illness.* HBAI services are specifically intended to treat non-mental illness factors that impact a beneficiary's ability to self-manage chronic diseases. Therefore clinical social workers cannot provide HBAI services under Original Medicare.

Since the social work practice acts, in most states, allow HBAI services in the scope of practice of clinical social workers, many Medicare Advantage plans and commercial insurance plans provide coverage of HBAI services as a reimbursable benefit in their plan. For clinical social workers to provide HBAI services under Medicare, an amendment would be required to the Social Security Act to remove the limitation that clinical social workers services only include services to diagnose and treat mental illness. Programs that employ clinical social workers and intend to work with Medicare Advantage plans should consult the coverage requirements of those plans to determine if a social worker is an authorized provider of HBAI for each specific MA plan.

Eligibility Criteria:

- The consumer must have an underlying physical illness or injury.
- There must be indications that there are bio-psychosocial factors that may be affecting treatment or self-management of the illness.
    - Examples include: Non-psychiatric illness factors that impact a person's ability to manage their chronic disease including cognitive, emotional, social, cultural, or behavioral practices that impact the maintenance of health for the individual.
- The consumer must be alert, oriented, and have the capacity to understand and respond to information related to his/her illness.
- The consumer must have a referral from a healthcare provider, such as a physician, nurse practitioner, or physician assistant, documenting the need for a psychological evaluation to address barriers to disease self-management.
    - *If the supervising clinician is a physician and/or nurse practitioner, no additional referral is required.

Medical Necessity:
Medicare and Medicare Advantage health insurance programs each require that services rendered meet medical necessity requirements. Any credentialed provider (Physician or Non-Physician Provider (NPP) can provide services to an eligible beneficiary as long as medical necessity requirements are met. HBAI is a covered Part B benefit for all Original Medicare beneficiaries. HBAI is also a service that must be covered by ALL Medicare Advantage plans. ANY Medicare beneficiary or Medicare Advantage beneficiary that meets the medical necessity requirements for HBAI is eligible to receive the service. Prior authorizations may be required for Medicare Advantage plans, but the service has to be covered, by the MA plan, if Medical Necessity requirements are met. No special contract is required to provide HBAI for MA plan beneficiaries, if they receive services from a network physician or non-physician practitioner. Documentation of medical necessity must be in the clinical record and adhere to the eligibility requirements listed in the section above.

Intervention Procedure:
First, each consumer who is being considered for HBAI services must have an initial assessment to determine potential barriers to disease self-management ability.

NOTE: The initial face-to-face assessment must be conducted by a licensed person. If the consumer has Medicare Part B, the type of licensed person must include one of the following:

- Physician
- Nurse Practitioner
- Licensed Clinical Psychologist

If the consumer is covered by an MA plan, the organization that intends to provide the benefit must have a contract with the MA plan. The type of professional that is eligible to provide HBAI by most MA plans includes the following:

- Physician
- Nurse Practitioner
- Licensed Clinical Psychologist
- Licensed Clinical Social Worker

*A trained lay leader can assist the licensed person in obtaining the necessary information to complete the individual assessment.

Second, the licensed person must develop an individualized disease self-management education plan, based on the assessment results.

Assessment and Education Plan Documentation Requirements:
The initial assessment and individualized education plan must include the following specific documentation requirements:

- Date of initial diagnosis of physical illness
- Clear rationale for why the initial assessment was performed

- Assessment outcome and the ability of the consumer to understand and respond in a meaningful way to an individual and group intervention
- Goals and duration of the proposed intervention
- Planned frequency and duration of services
    - The plan must detail the frequency of individual and group sessions and the duration of each session.
    - Each individual session must also document the length of time that services were delivered.

Intervention Documentation Requirements:
Documentation of the proposed intervention must include the following specific requirements:

- Proposed intervention – Evidence-based disease self-management program
- The consumer's response to the intervention
- Frequency and duration of services

Billing:
Claims must state the duration of each consumer encounter.

The claim must be submitted under the National Provider Identification (NPI) number of the licensed person. Licensed professionals have the right to assign their NPIs to multiple Medicare Providers. Therefore, a licensed clinician, under contract with a Community-Based Organization provider can provide this service and assign their NPI to the Medicare number of the CBO (if that provider has its own number) or to the CBO's Medicare Provider Partner.

In order to bill Medicare, each service location for this service must be submitted for approval to Medicare as a service location prior to the billing. However, there is no fee required to add service locations.

Of note, unlike with billing codes for diabetes self-management training, there are no accreditation requirements to provide HBAI services and bill Medicare for them.

Clinical Supervision Requirements:
As noted above, all HBAI services must be performed under the supervision of the appropriate licensed clinician. However, lay leaders or community health workers can provide the actual instruction (e.g., lead the class) as long as they are under the direct supervision of a licensed clinician.

- NOTE: Supervision of lay leaders by a licensed clinician generally refers to the clinician:
    1) Performing a clinical review of the material being covered by the HBAI service.
    2) Assessing the lay leaders to ensure that they have the ability to deliver the education as defined in the materials.

3) Being physically present in the building where and when the education (e.g., CDSME class) is being provided, with intermittent direct observation.

Depending on the state and the third party insurance plan (if other than Medicare), HBAI codes may be billed by clinical psychologists, clinical social workers, or nurse practitioners. However, Original Medicare does not authorize HBAI services provided by clinical social workers. Despite this limitation, MA plans have the discretion to authorize HBAI services under the scope of covered services of clinical social workers.

Billing Requirements:
HBAI is a Medicare Part B benefit. Under Medicare Part B, HBAI CPT billing codes are only authorized for use by Licensed Clinical Psychologists. MA plans that authorize HBAI, under the scope of practice of Clinical Social Workers, allow for Clinical Social Workers to use of the same HBAI billing codes authorized for Licensed Clinical Psychologists.

Physicians and Nurse Practitioners can also file claims for HBAI services under Original Medicare. However, when a physician or NP provides HBAI services, the services are coded under the standard Evaluation & Management (E&M) coding requirements.

The list of HBAI codes includes the following:

- 96150: Initial Health and Behavior assessment
- 96152: Individual intervention
- 96153: Health and Behavior intervention service provided in a group setting

Each of the HBAI codes is billed in fifteen (15) minute increments.

The Initial Health and Behavior assessment (code 96150) is expected to not exceed one hour (4 units of 15-minutes each). The CDSME program itself would be billed using code 96153. The individual intervention provided after (and perhaps concurrent with) the 6 week CDSME class would be billed using code 96152.

Time billed using procedure codes 96152 and 96153 accumulate toward a 15-hour calendar year threshold limit per Medicare beneficiary. So, if each two and a half hour period of all six sessions for the CDSME class are fully billed (code 96153), there would not be any remaining billable time for the individual intervention (code 96152) during that calendar year for that individual.

<u>E&M Coding for HBAI</u>

If a Nurse Practitioner or Physician provides supervision for a CDSMP class, then the services are billed according to the Evaluation & Management (E&M) code requirements.

The Common Procedural Terminology (CPT) codes are a set of medical billing codes that are developed and owned by the American medical Association. An important factor to consider is that CPT allows for coding for services based on time. CPT states the following regarding coding based on time, "When counseling and/or coordination of are dominates (more than 50%) of the Physician or qualified provider encounter (face-to-face time), then time may be considered the key controlling factor to qualify for a particular level of evaluation and management services.

CPT ® Code	Time
99201 (New Pt.)	10 Min.
99202 (New Pt.)	20 Min.
99203 (New Pt.)	30 Min.
99204 (New Pt.)	45 Min.
99205 (New Pt.)	60 Min.
99211 (Est. Pt.)	5 Min.
99212 (Est. Pt.)	10 Min.
99213 (Est. Pt.)	15 Min.
99214 (Est. Pt.)	25 Min.
99215 (Est. Pt.)	40 Min.

Sample Reimbursement Model – CDSMP under clinical supervision of a Nurse Practitioner

(*Disclaimer: The sample below is based on the 2015 Physician Fee Schedule Rates. Average rates for each reimbursable intervention are listed based on the 2015 fee schedule. Programs should contact their Medicare Administrative Contractor (MAC) to determine the actual rates for your specific geographic region. The two samples below provide an example of a nurse practitioner working with a CBO to implement a sustainable model. Nurse practitioners are reimbursed at 85% of the published fee schedule rates. The rates listed reflect the 85% collection adjustment applied to nurse practitioners in the Medicare program. The 85% nurse practitioner reimbursement requirements are separate and distinct from applicable deductible and co-insurance requirements. Questions regarding the specific payment rate for services in your program should be directed to your Medicare Administrative Contractor (MAC).)

A CBO partnering with a Medicare provider screens fifteen (15) consumers for participation in a scheduled CDSMP class. Of the fifteen participants, there were twelve (12) that were enrolled to participate. The twelve (12) final participants attended all of the CDSMP sessions and consented to participate in ongoing chronic care management provided by trained health coaches.

The CBO uses two trained lay leaders to deliver the CDSMP class, under the clinical supervision of a partnering nurse practitioner. Each participant has two or more chronic

conditions and the Nurse Practitioner conducts an individualized assessment on Day 0 of the class.

The twelve consumers participate in the CDSMP intervention and then enroll in a health coaching program, supported by a CBO health coach over the course of a 12-month period, in support of a chronic care management care plan with general supervision of a nurse practitioner. The goals set forth in the chronic care management plan includes participating in a community-based programs provided by an Area Agency on Aging or YMCA.

The initial Day 0 assessment will require a face-to-face encounter to complete the consumer-directed self-management plan. The plan is completed in a consumer-directed manner incorporating the principles of self-management. The plan will incorporate consumer-identified goals and milestones. The clinical supervising clinician, in this proposed model, is a nurse practitioner. The subsequent billable encounters in the reimbursement chart also require a face-to-face encounter with the nurse practitioner to provide the completion of a preventive health care plan, provide additional health education, and assess the consumer's progression towards attaining the preventive health goals in their care plan.

Services must meet medical necessity requirements and be documented in a HIPAA-compliant electronic health record (E.H.R.). The final post-CDSMP assessment is an opportunity for the Nurse Practitioner to assess the progress made towards meeting the preventive health goals set at Day 0 and to refer the consumer for ongoing disease self-management and disease support programs in a community-based program at a local Area Agency on Aging or YMCA, supported by a chronic care management health coach.

*Chronic Care Management
Beginning January 2015, Medicare and Medicare Advantage plans began providing reimbursement for a chronic care management service. Chronic Care Management (CCM) is meant to provide reimbursement for non-face-to-face care management services provided to a Medicare beneficiary with two or more chronic conditions. An eligible beneficiary can receive both services, if required. The combination of the benefit provides more financial resources to support a comprehensive care management intervention.

<u>*Fidelity Requirements:</u>
The Stanford University CDSMP class is an evidence-based intervention. As such, all fidelity standards and requirements apply. The face-to-face encounters, with a licensed clinician in the proposed model, all occur outside of the structured CDSMP class sessions and are designed to be supplemental in nature to the evidence-based Stanford CDSMP model. Holding the face-to-face encounters, with the licensed clinician, during CDSMP class sessions or interrupting a session, in order to accommodate the face-to-face encounter, would be a violation of CDSMP fidelity standards. Each face-to-face encounter in the proposed model occur before or after and outside of the structured six-sessions of CDSMP.

Service	CPT® Code	Rate
Day 0 – Initial Assessment	99214 (25 Min.)	$92.09
Day 1 – CDSMP	99212 (15 Min.)	$62.00
Day 3 – CDSMP	99211 (5 Min.)	$17.02
Day 6 – CDSMP	99211 (15 Min.)	$62.00
Day 7 – CDSMP post intervention reassessment and development of CCM plan	99212 (25 Min.)	$92.09
CDSMP Reimbursement Subtotal Per Person		$325.20
CDMSP Reimbursement Subtotal for 12 Participants		$3,902.40
Chronic Care Management (12 Months)	99490	$36.47 x 12 = $437.64
Post CCM Eval. Face-to-face encounter with Nurse Practitioner	99214 (25 Min.)	$92.09
Grand Total Per Person/12 Mo		$854.93
Grand Total for 12 Participants/12 Mo (CDSMP+CCM)		$10,259.16

(Each of the interventions listed in the reimbursement model require a face-to-face encounter with the participating nurse practitioner, with the exception of chronic care management. Chronic care management can be provided under general supervision guidelines with no face-to-face encounter required with the nurse practitioner for coverage.)

Co-Insurance Requirements:
Medicare Part B covers outpatient services provided by a physician or non-physician practitioner. Medicare Part B requires a co-insurance payment of 20% of the coverage limit. The consumer is responsible for the co-insurance payment amount. Consumers are educated about the Medicare Part B co-insurance requirement when they sign up to participate in Original Medicare. Consumers are also educated about their right to select a Medigap policy. Medigap policies cover the portion of Medicare that is not reimbursed directly from Medicare. The provider is required to bill the Medigap policy for the required co-insurance payment along with submitting he claim to Medicare for the 80% coverage amount. The provider is required to collect the necessary Medicare coverage information and applicable Medigap policy information, prior to delivering services to the beneficiary.

Low-income Medicare beneficiaries may be eligible for Medicaid and Medicare. Medicaid is a means-tested health coverage program that is administered by a participating State Medicaid agency. A Medicare beneficiary that is eligible for both Medicaid and Medicare is commonly referred to as a Dual Eligible or a Medi-Medi. If a person meets the means test requirement to participate in both Medicare and Medicaid, then Medicaid is required to cover the portion that Medicare does not cover. As a result, Dual Eligible beneficiaries have full coverage because Medicare covers the primary 80%, and Medicaid is mandated to cover the remaining 20%.

If a Dual Eligible beneficiary is enrolled in a Medicaid managed care program or managed long-term services and supports managed care program, then the co-insurance coverage is the responsibility of the applicable Medicaid Managed Care Organization (MCO). The provider is required to register with the Medicaid MCO as a provider, bill Medicare for the primary 80% payment and the MCO for the 20% coinsurance payment.

This project was supported in part by grant number 90CR2001-01-00 from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201. Grantees undertaking projects under government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official Administration for Community Living policy.