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

**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 the consumer to overcome the perceived barriers to self-management of his/her chronic disease(s). HBAI is a current benefit of original Medicare Part B. 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 MA plans are required to cover HBAI services as a 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.

**Background:**
In 2002, six CPT® codes were added to the CPT coding system for HBAI services. The services are provided to address the behavioral, social, and psychosocial barriers to the self-management of one or more chronic diseases. CPT® is the registered trademark of the American Medical Association (AMA). CPT stands for Common Procedural Therapy. The services, associated with each professional code, are defined by the AMA. Medicare and MA plans contract for professional services that are defined by the CPT code restrictions, defined by the AMA.

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

*Medicaid and Medicaid Managed Care:* Medicaid covered services are jointly defined by the Centers for Medicare & Medicaid Services (CMS) and the State Division of Medicaid. CMS provides guidance on a set of mandatory minimum coverage requirements. The State then has the option to add enhanced benefits for the Medicaid population. When a state elects to contract with a Medicaid Managed Care plan, the same requirements for mandatory services apply. In addition, the Medicaid Managed Care plan has the option of adding extra benefits.
over the minimum requirement. HBAI services are optional Medicaid benefits. This means that the State is not required to cover HBAI but does have the option to provide coverage is elected to do so. In addition, the Medicaid Managed Care plan has the option of covering HBAI, even if the State has elected not to make it a mandatory benefit. When a Medicaid Managed Care plan elects to provide coverage for a benefit that is in addition to the mandatory benefits, this is often titled an “Enhanced Benefit.” If seeking a contract with a Medicaid Managed Care plan, you should determine if it is a mandatory benefit. If not, inquire about getting the plan to provide coverage of HBAI as an “Enhanced Benefit.” The coverage requirements and process for Medicaid Managed Care plans will be similar to the requirements of MA plans.

**Type of CDSME:**
HBAI is intended to support the consumer with one or more chronic conditions with overcoming perceived social and/or emotional barriers to disease self-management. The type of curriculum or model that you choose to support the consumer in achieving this goal should be consumer driven, using a patient-centered approach. For example, if your program and the clinical staff determine that a chronic pain program is most applicable to the target population to achieve this objective, then you are justified in using the chronic pain program model as the intervention that best meets the needs of the target group. You should also consider Positive Self-Management for the HIV population in the same manner and utilize the HBAI benefit to support this population, particularly dual eligible beneficiaries with HIV.

**Clinical Oversight:**
The clinical oversight minimum requirement is dependent upon the payer in question. For Medicare, the required provider type for HBAI is a Clinical Psychologist. In addition, a Nurse Practitioner or Physician can provide HBAI services. However, when a NP or Physician provides HBAI and oversight, the service is billed under the Evaluation and Management (E&M) coding requirements.

Most MA Plans allow a Licensed Clinical Social Worker to serve as the supervising clinician providing oversight when HBAI services are rendered. However, in order to provide MA plan services, you must first become a credentialed provider with the health plan, with your licensed clinical social worker serving as the lead provider of HBAI services on behalf of your organization. This process will make your organization a network provider of these services in the MA plan network.

**Type of NP:**
If you elect to utilize a Nurse Practitioner to provide the oversight for CDSME, there is not a requirement for the NP to have a special designation or licensure as a “Psychiatric Nurse Practitioner.” The HBAI service is specifically a Non-Mental Health benefit. The services are intended to assist beneficiaries with overcoming perceived social and/or emotional barriers to disease self-management that are not related to a particular mental illness (Axis I diagnosis). Therefore, an Axis I diagnosis, for the consumer, or a special designation for the nurse practitioner, as a Psychiatric Nurse Practitioner, is not required to access the HBAI benefit, under Medicare or MA.
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, HBAI is not a benefit that is authorized to be provided by licensed clinical social workers in most states. 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 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 MA plans and commercial insurance plans provide coverage of HBAI services as a reimbursable benefit in their plan. In order for clinical social worker to provide HBAI under Medicare, it would require an amendment to the Social Security Act to remove the limitation that clinical social worker services include only services necessary to diagnose and treat mental illness. Programs that employ clinical social workers that intend to work with MA 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-psycho-social factors that may be affecting treatment or self-management of their 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 their 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.*
**Intervention Procedure:**
First, each consumer who is being considered for the HBAI service 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

An organization must have a contract with the MA plan to provide services to a consumer who is covered under that plan. The type of professionals that are eligible to provide HBAI by most MA plans include the following:

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

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

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 operate under the direct supervision of a licensed clinician.

- NOTE: Supervision of lay leaders by a licensed clinician generally refers to the clinician performing a clinical review of the material being covered in the HBAI service, he licensed clinician assessing the lay leaders to ensure that they have the ability to deliver the education as defined in the materials, and the licensed professional being physically present in the building where/when the education (e.g., CDSME class) is being held, 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, under original Medicare, 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 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 six-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 all six sessions of 2.5 hours each for the CDSME class is 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.

**E&M Coding for HBAI:**
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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 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.”

<table>
<thead>
<tr>
<th>CPT ® Code</th>
<th>Time</th>
</tr>
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<tbody>
<tr>
<td>99201 (New Pt.)</td>
<td>10 Min.</td>
</tr>
<tr>
<td>99202 (New Pt.)</td>
<td>20 Min.</td>
</tr>
<tr>
<td>99203 (New Pt.)</td>
<td>30 Min.</td>
</tr>
<tr>
<td>99204 (New Pt.)</td>
<td>45 Min.</td>
</tr>
<tr>
<td>99205 (New Pt.)</td>
<td>60 Min.</td>
</tr>
<tr>
<td>99211 (Est. Pt.)</td>
<td>5 Min.</td>
</tr>
<tr>
<td>99212 (Est. Pt.)</td>
<td>10 Min.</td>
</tr>
<tr>
<td>99213 (Est. Pt.)</td>
<td>15 Min.</td>
</tr>
<tr>
<td>99214 (Est. Pt.)</td>
<td>25 Min.</td>
</tr>
<tr>
<td>99215 (Est. Pt.)</td>
<td>40 Min.</td>
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</tbody>
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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 sample below provides 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 15 consumers for participation in a scheduled CDSMP class. Of the 15 participants, there were 12 that were enrolled to participate. The 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 12 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 include participating in a community-based program 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.
Fidelity Requirements:
The Stanford University CDSME programs are evidence-based interventions. 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 CDSME class sessions and are designed to be supplemental in nature to the evidence-based Stanford CDSME model. Holding the face-to-face encounters, with the licensed clinician during CDSME class sessions or interrupting a session, in order to accommodate the face-to-face encounter, would be a violation of CDSME fidelity standards. Each face-to-face encounter in the proposed model occur before, after, and outside of the structured six-session CDSME workshop.

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

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 the 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 eligibles 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.

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