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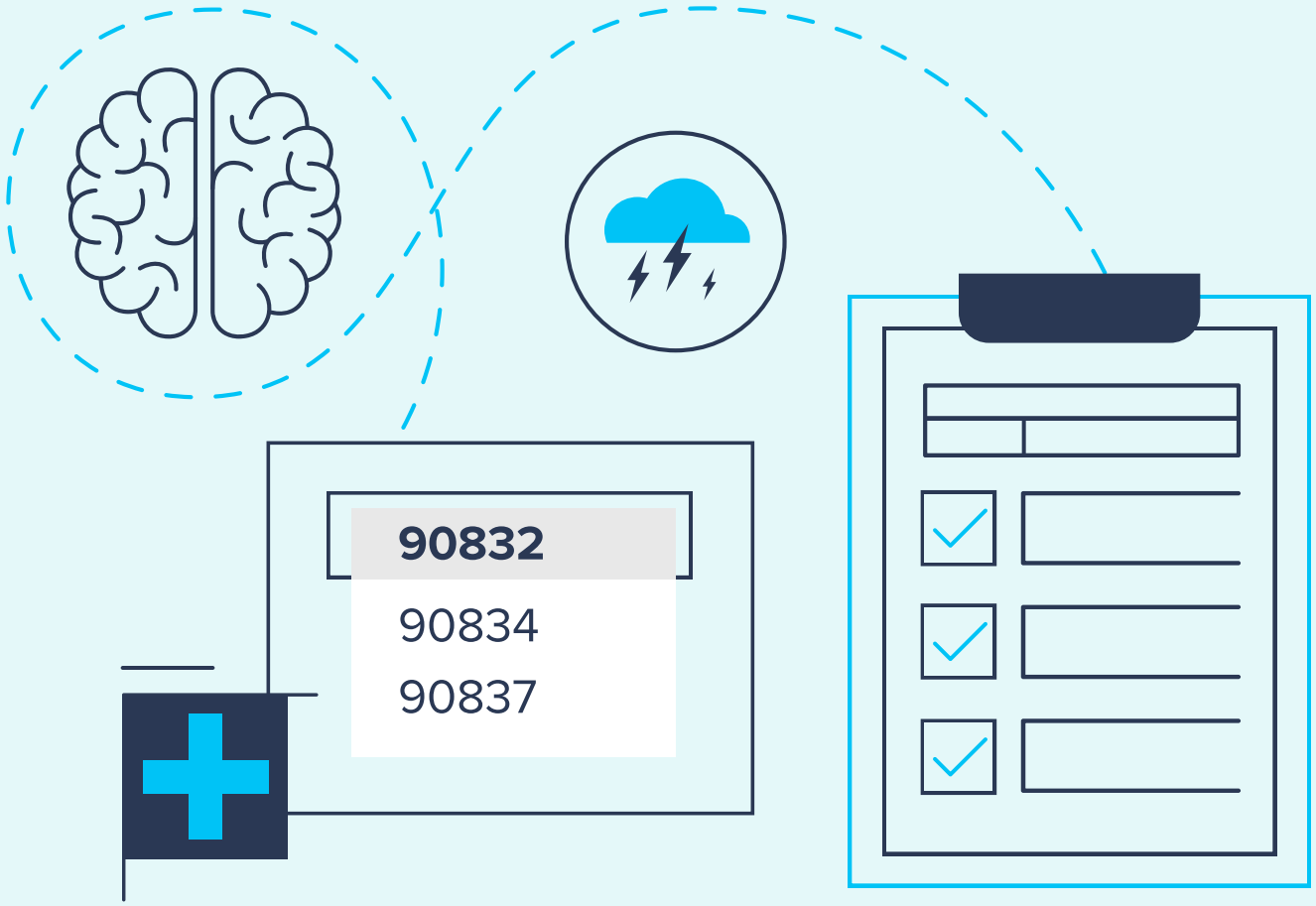
REIMBURSEMENT PROTOCOL:

# Mental Health

A comprehensive guide to essential coding for cognitive and mental health assessments and screenings using Creyos Health



## Reimbursement Strategies for Mental Health Services

Reimbursement for mental health services can be a complex process, but understanding the key elements of coding and documentation is essential for successful claims. This guide is designed to provide clarity on the essential codes used for cognitive and mental health assessments and screenings.

By exploring the various coding guidance—including testing evaluation, administration, screening, and diagnostic services—providers can ensure that they are maximizing reimbursement opportunities while adhering to payer-specific requirements. **Understanding the nuances of these codes and the associated reimbursement considerations is crucial** to delivering high-quality care while ensuring financial sustainability for mental health services.

# Table of Contents

# Test Evaluation Codes

Selection between **96130** (psychological evaluation) and **96132** (neuropsychological evaluation) is payer-specific and depends on factors such as the type of test performed, the primary condition being assessed, and the provider's specialization. It is essential to review individual payer policies to ensure appropriate code selection. Below are the relevant codes and reimbursement considerations.

| Psychological Evaluation | Neuropsychological Evaluation |
|---|---|
| • **96130** – Psychological testing evaluation services by provider or QHP, first hour<br>• **+96131** – Each additional hour | • **96132** – Neuropsychological testing evaluation services by provider or QHP, first hour<br>• **+96133** – Each additional hour |
| *Typically used for evaluating conditions primarily affecting emotional, behavioral, or cognitive functioning without significant neurological involvement.* | *Appropriate for assessing conditions with neurological, cognitive, or developmental complexities, including executive function, language, attention capabilities and memory, visual-spatial, and sensorimotor functioning.* |
| **Common examples include:**<br>• Anxiety disorders<br>• Depression<br>• Post-traumatic stress disorder (PTSD)<br>• ADHD (without psychological comorbidities)<br>• Thought disorders or severe emotional distress<br>• Other psychiatric conditions without significant neurocognitive impairment | **Common examples include:**<br>• Autism spectrum disorder (ASD)<br>• ADHD with comorbid psychological conditions<br>• Traumatic brain injury (TBI)<br>• Neurological psychosis<br>• Intellectual disability<br>• Other neurocognitive or neurodevelopmental disorders |

### Reimbursement Considerations:

- Base codes (96130, 96132) require 31+ minutes of service.
- Add-on codes (+96131, +96133) require 91+ minutes on the same date or 31+ minutes on a separate date (billed with the base code).
- Clear documentation of total evaluation time is critical, face-to-face services in addition to non-face-to-face activities are required to report for this service.
- Typically reimbursed when medical necessity is supported.
- Frequency limits vary by payer, generally 3-4 times per year, as medically necessary.

# Test Administration Codes

Test administration codes capture the direct application of psychological and neuropsychological testing, whether by a provider, QHP, or technician. Accurate time documentation is key for proper reimbursement. Below are the relevant codes and reimbursement considerations.

| Test Administration by Provider/QHP | Test Administration by Technician |
|---|---|
| • **96136** – Psychological/neuropsychological test administration via any method, 2+ tasks, first 30 minutes (by a provider or QHP)<br>• **+96137** – Each additional 30 minutes | • **96138** – Psychological/neuropsychological test administration via any method, 2+ tasks, first 30 minutes (by a technician)<br>• **+96139** – Each additional 30 minutes |

| Test Administration Unsupervised or Single Task |
|---|
| • **96146 –** Test administration of single task, with automated result (admin unsupervised) |

### Reimbursement Considerations:

- Base codes (96136, 96138) require 16+ minutes of service.
- Add-on codes (+96137, +96139) require 46+ minutes (billed with the base code).
- Accurate time documentation is essential for billing additional units.
- Coding should reflect whether a provider or technician supervised the administration of the test.
- Frequency limits vary by payer, typically 3-4 times per year, as medically necessary.

# Health Behavior Assessment & Intervention Services

Health Behavior Assessment and Intervention (HBAI) services evaluate psychological and behavioral factors affecting a patient's response to illness, treatment adherence, and overall health management. Using health-focused interviews, behavioral observations, and standardized assessments, providers assess coping strategies, motivation, and emotional responses to disease. These services help guide interventions aimed at improving health outcomes and treatment adherence.

## Health Behavior Assessment & Intervention

- **96156** – Health behavior assessment, or re-assessment
- **96158** — Health behavior intervention, individual, face-to-face; initial 30 minutes
- **+96159** — Each additional 15 minutes

Typically used to identify biopsychosocial factors that may impact a physical health problem and its management or treatment in patients that have acute or chronic illnesses or disabilities.

**Common examples include:**

- Chronic Pain
- Cardiovascular Disease
- Diabetes
- Obesity
- Chronic Digestive/Gastrointestinal Disorder
- Epilepsy
- Cystic Fibrosis
- Eating Disorders

### Reimbursement Considerations:

- HBAI codes cannot be reported with E/M services (99202-99215), psychiatric diagnostic evaluations (90791-90792), or psychotherapy services (90832-90838).
- When performed alongside health behavior assessment/reassessment or testing services (96130-96146) on the same date, use modifier 59 to indicate distinct services. Documentation must support medical necessity and differentiate between test administration, scoring, and evaluation.
- Frequency limits vary by payer, typically reassessment is allowed every 180 days when deemed medically necessary.

# Screening Codes

Screening assessments are essential for evaluating a patient's emotional, behavioral, or developmental health. These codes are used to capture brief assessments, which can guide further evaluation and treatment planning.

| Screening for Emotional/Behavioral Assessment | Screening for Developmental Delay Assessment |
|---|---|
| • **96127** – Brief emotional/behavioral assessment (e.g., depression, anxiety, or ADHD screening) | • **96110** – Developmental screening (e.g., autism screening) |

| Commercial Payer - Screening and Intervention for Alcohol and/or Substance Abuse | Medicare Payer - Screening and Intervention for Alcohol and/or Substance Abuse |
|---|---|
| • **96160** – Administration of patient-focused health risk assessment instrument<br>• **99408** – Alcohol and/or substance abuse structured screening, and brief intervention (SBI) services (eg, AUDIT, DAST); 15-30 minutes<br>• **99409** – Alcohol and/or substance abuse structured screening, and brief intervention (SBI) services (eg, AUDIT, DAST); 30+ minutes | • **G2011** – Alcohol and/or substance abuse structured screening, and brief intervention (SBI) services (eg, AUDIT, DAST); 5-14 minutes<br>• **G0396** – Alcohol and/or substance abuse structured screening, and brief intervention (SBI) services (eg, AUDIT, DAST); 15-30 minutes<br>• **G0397** – Alcohol and/or substance abuse structured screening, and brief intervention (SBI) services (eg, AUDIT, DAST); 30+ minutes |

### Reimbursement Considerations:

- Can be billed separately from an E/M visit if MDM and time are separate, with appropriate documentation support.
- When billed with an E/M service, must be separately identifiable. Requires modifier 25 appended to the E/M code (e.g., 99202-99215).
- Cannot be reported alongside psychiatric diagnostic evaluation (e.g., 90791-90792) or psychotherapy services (e.g., 90832-90838).
- Should not be reported on the same date as testing services codes (e.g., 96130-96146).
- Frequency limits vary by payer, typically allowed as medically necessary.

# Psychiatric Diagnostic Procedures

Psychiatric diagnostic procedures are fundamental to evaluating a patient's mental health and determining appropriate treatment plans. The diagnostic interview exam is typically conducted when the provider first sees the patient but may also be repeated for new episodes of illness or readmission due to underlying complications. This evaluation helps establish a comprehensive understanding of the patient's condition and informs further care decisions.

| Psychiatric Diagnostic Evaluation |
| --- |
| • **90791** – Psychiatric diagnostic evaluation<br>• **90792** – Psychiatric diagnostic evaluation with medical services |

### Reimbursement Considerations:

- Used for initial psychiatric intake, although may also be used if there has been a long gap in treatment or if the patient is not taking his medications regularly, resulting in changes to the initial recorded mental status.
- Can be performed in combination as testing services (e.g., 96130-96146) and reported on the same date; although, cannot be reported alongside psychotherapy services (e.g., 90832-90838) or another E/M service code (e.g., 99202-99215).
- In certain circumstances, one or more other informants (family members, guardians, or significant others) may be seen in lieu of the patient.
- Codes 90791 and 90792 may be reported more than once for the patient when separate diagnostic evaluations are conducted with the patient and other informants.

# Psychotherapy Services

Psychotherapy services focus on helping patients address mental health challenges through techniques like support, insight discussions, and behavior modification. These services aim to enhance self-understanding, improve relationships, and foster emotional healing by providing tailored interventions for the patient's unique needs.

## Individual Psychotherapy

- **90832** – Psychotherapy, 30 minutes with patient
- **+90833** – Psychotherapy, 30 minutes with patient, performed with E/M service (add-on)
- **90834** – Psychotherapy, 45 minutes with patient
- **+90836** – Psychotherapy, 45 minutes with patient, performed with E/M service (add-on)
- **90837** – Psychotherapy, 60 minutes with patient
- **+90838** – Psychotherapy, 60 minutes with patient, performed with E/M service (add-on)

**Reimbursement Considerations:**

- The psychotherapy service codes 90832-90838 include ongoing assessment and adjustment of psychotherapeutic interventions and may include involvement of informants in the treatment process.
- Total times are for face-to-face services with patients and may include informant(s). The patient must be present for all or a majority of the service.
- In reporting, choose the code closest to the actual time (ie, 16-37 minutes for 90832 and 90833, 38-52 minutes for 90834 and 90836, and 53 or more minutes for 90837 and 90838). Do not report psychotherapy of less than 16 minutes duration.
- To report both an E/M service and psychotherapy, the two services must be significant and separately identifiable.
- See codes 90846-90847 when utilizing family psychotherapy techniques, such as focusing on family dynamics.

# Diagnosis Considerations

Diagnosis categories within mental health care encompass a broad range of conditions, from mood and anxiety disorders to neurodevelopmental and behavioral syndromes. These categories help guide the clinical evaluation and treatment process, ensuring that the most relevant diagnoses are considered based on the patient's specific symptoms and history.

### Mental, Behavioral, and Neurodevelopmental Disorders (F01-F99)

- **F01-F09:** Mental disorders due to known physiological conditions
- **F10-F19**: Mental and behavioral disorders due to psychoactive substance use
- **F20-F29:** Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders
- **F30-F39:** Mood [affective] disorders
- **F40-F48:** Anxiety, dissociative, stress-related, somatoform, and other nonpsychotic mental disorders
- **F50-F59:** Behavioral syndromes associated with physiological disturbances and physical factors
- **F60-F69:** Disorders of adult personality and behavior
- **F70-F79:** Intellectual disabilities
- **F80-F89:** Pervasive and specific developmental disorders
- **F90-F98:** Behavioral and emotional disorders with onset usually occurring in childhood and adolescence
- **F99:** Unspecified mental disorder

*While additional diagnoses may apply, these represent the most commonly encountered categories in mental health care settings.*

# Key Takeaways for Reimbursement Success

A comprehensive approach that includes accurate coding, strategic scheduling, and thorough documentation is essential to ensure optimal reimbursement outcomes.

Consider the following:

- **Verify payer-specific policies** – Coverage, frequency limits, and medical necessity criteria may differ.
- **Ensure clear documentation** – Differentiate between test administration, evaluation, and screening to support medical necessity.
- **Plan service scheduling strategically** – Separating testing from E/M visits can help prevent denials due to bundled payments.
- **Use modifiers appropriately** – Apply modifier 25 for separately identifiable E/M services and modifier 59 for procedural services when required, but always check NCCI edits for restrictions.
- **Maintain thorough records** – Even with correct coding and modifier use, reimbursement is subject to payer review. Detailed documentation is key.

By adhering to payer-specific guidelines and maintaining clear distinctions between services, providers can help mitigate the risk of denials and maximize reimbursement success.