Health and Behavior Assessment and Intervention (HBAI) Services

Implementation Resource

Partnership to Align Social Care

A National Learning & Action Network

Contents

Purpose

Health Behavior and Assessment Intervention (HBAI) CPT codes are intended to be used for psychological assessment and treatment, when the primary diagnosis is a medical condition. The HBAI codes apply to services that address psychological, behavioral, emotional, cognitive, and interpersonal factors in the treatment/management of people diagnosed with physical health issues. The HBAI codes capture services related to physical health, such as adherence to medical treatment, symptom management, health-promoting behaviors, health related risky behaviors, and adjustment to physical illness.

HBAI services can be delivered concurrently with community health integration (CHI) or principal illness navigation (PIN), during the same calendar month. However, the time providing HBAI and CHI/PIN cannot be double counted. However, persons that are receiving HBAI services may be eligible for CHI or PIN. If indicated, the person could receive HBAI and CHI/PIN and the services would be complementary to address the whole-person care needs.

General HBAI Process

A health behavior assessment under these HBAI services is conducted through health-focused clinical interviews, behavioral observation and clinical decision-making and includes evaluation of the person's responses to disease, illness or injury, outlook, coping strategies, motivation, and adherence to clinical treatment. HBAI services are rendered to affected persons in individual and/or group settings. If a group HBAI is deployed, the HBAI intervention is a structured group intervention – under the direct supervision of a qualified healthcare professional. This resource was developed to increase awareness of the potential role of chronic disease self-management education (CDSME) group classes to serve as a component of a clinically-led group Health Behavior and Assessment Intervention.

HBAI Qualified Healthcare Professional (QHP)

Qualified healthcare professional for HBAI include the following:

- Clinical psychologists
- Clinical Social Workers (CSWs)
- Marriage and Family Therapists (MFTs)
- Mental Health Counselors (MHCs)

A Clinical Social Worker is defined in the following manner:

42 CFR § 410.73 - Clinical social worker services.

(a) **Definition: clinical social worker.** For purposes of this part, a clinical social worker is defined as an individual who—

(1) Possesses a master's or doctor's degree in social work; **AND**

(2) After obtaining the degree, has performed at least 2 years of supervised clinical social work; **AND**

(3) Either is licensed or certified as a clinical social worker by the State in which the services are performed and the clinical social worker is **licensed or certified at the highest level of practice** provided by the laws of the State in which the services are performed.

What Is HBAI?

HBAI is a Medicare Part B benefit established to address the behavioral, cognitive, emotional, or psychosocial factors that affect the treatment or management of one or more physical health conditions. HBAI services can be offered to address a variety of issues that affect an individual's physical health status, such as adherence to the clinical treatment regimen, symptom management, risk-taking behaviors, cultural factors, lifestyle behaviors, health-management related problem-solving techniques, and coping with a chronic illness.

HBAI Individual Assessment

HBAI is an intervention that can be provided as an individual and/or group intervention. The intervention generally begins with an individualized assessment that is conducted by a Qualified Healthcare Professional (QHP) (i.e., clinical social worker (CSW) or licensed clinical psychologist). The assessment should include an assessment of real or perceived barriers to chronic disease self-management. HBAI is not an intervention that should be provided to a person that has mental illness as the primary barrier to self-management. Management of mental health conditions should be conducted using the behavioral health interventions, covered under the Medicare behavioral health benefit.

Based on the initial assessment findings, the QHP should establish an HBAI intervention plan to address real or perceived barriers to disease self-management. The HBAI intervention plan should include support to address behavioral, cognitive, emotional, or psychosocial factors that affect the treatment or management of one or more physical health conditions. Based on the clinical judgment of the QHP, the affected person may participate in individual or group HBAI. Some persons may benefit from participation in a group intervention that provides training and assistance in developing appropriate goal setting and disease self-management skills required to properly manage their chronic disease(s).

One of the most researched disease self-management evidence-based interventions is the Chronic disease self-management education (CDSME) program. If the QHP determines that the CDSME program is the appropriate HBAI group intervention for the beneficiary, the beneficiary should attend a clinically-led group CDSME class. The role of the QHP in the delivery of a group HBAI is to provide direct supervision of the group intervention and monitor each participant's progress towards meeting the goals in their intervention plan.

HBAI Group Intervention

Persons with two or more chronic conditions can be easily overwhelmed by the enormity of disease self-management. When it is determined that the beneficiary would benefit from obtaining support with developing skills to self-manage their disease, then individual and group interventions to support the beneficiary with learning skills related to appropriate goal setting, disease monitoring, and encouragement to increase communication about their disease, are essential to the disease management plan. Goal setting and disease self-management skill building are hallmarks of the evidence-based suite of programs including the following:

- Chronic Disease Self-Management Program (CDSMP)
- Chronic Pain Self-Management (CPSMP)
- Cancer: Thriving and Surviving (CTSP)
- Positive Self-Management (CPSMP)

If the QHP determines that one of the chronic disease self-management group interventions is appropriate, the beneficiary could be referred to a clinically-led group chronic disease self-management education program. The QHP should be on-site and directly supervising each of the group CDSME sessions and documenting each participants' progression in learning appropriate goal setting and disease self-management skills. This documentation should include, but not limited to, individual weekly goal setting and monitoring of the attainment of weekly disease self-management goals.

Eligibility Requirements

- To receive the Medicare HBAI benefit, an individual must have an underlying physical illness or injury.
- Because HBAI is a Part B Medicare benefit, the person receiving the service must have Part B coverage.
- There must be one or more behavioral, cognitive, emotional, or psychosocial barriers that are interfering with the treatment or management of the physical health condition(s).
- The person receiving HBAI services must be alert, oriented, and have the capacity to understand and respond to the interventions that are provided.
- There must be a signed referral (the signature may be electronic) from a physician or non-physician practitioner (nurse practitioner or physician assistant) which includes the date of the referral, the physical diagnosis, and the rationale for providing the HBAI intervention. The referral should be filed in the clinical record.

CPT Codes and Billing Requirements

The Common Procedural Terminology (CPT) codes are a set of medical billing codes developed and owned by the American medical Association. CPT® is a registered trademark of the American Medical Association. All Rights are reserved.

Background

The HBAI codes were published in the Federal Register in 2001 and included in the Medicare Fee Schedule and the Current Procedural Terminology (CPT) Manual in 2002. The CY2024 Physician Fee Schedule final rule expanded the types of clinical staff that can perform HBAI services. The CY2024 Physician Fee schedule added the following clinicians to the list of eligible professionals of HBAI: 1) clinical psychologists, 2) clinical social workers, 3) marriage and family therapists, and 4) mental health counselors.

Six CPT codes were added to the CPT coding system for HBAI services. HBAI is NOT a psychiatric benefit, and the codes are not to be used for the treatment of a psychiatric condition or mental illness. In January 2010, the list of Medicare telehealth services was expanded to include HBAI. Persons that receive telehealth services, under the Medicare Part B program, must adhere to the applicable Medicare and state regulatory requirements for conducting telehealth services.

HBAI Codes

The HBAI CPT codes describe both individual and group services. It is the responsibility of the QHP that is overseeing the intervention to define the appropriate codes describing the services rendered during both individual and group services. The table below outlines the CPT Codes, code description and the National rate, per code.

CMS uses a method to determine the reimbursement rates for services that is based on Relative Value Units (RVUs). RVUs provide a objective method of determining cost components that are used to determine the allowable reimbursement rate. RVU calculations include provider labor, practice costs, and professional/general liability costs. Some organizations tie clinical reimbursement to RVUs and provider performance assessments. The RVUs are assessed annually. Therefore, the allowable reimbursement rates may change on an annual basis based on the RVU calculation at the time of review.

Table 1

List of HBAI Codes, Definition, Description, and Rates Per Unit

HBAI Code	Definition	Description	Rate
96156	Initial Health and Behavior Assessment/reassessment	Conducted to assess behavioral, cognitive, emotional, or psychosocial factors that may affect the individual's treatment, recovery, or management of the physical health condition. Includes an individualized person-centered plan, based on the assessment findings.	$98.98
96158	HBAI Individual Intervention, initial 30 minutes	One-on-one time spent with an individual after the initial assessment. May be provided during the course of the CDSME workshop and once the workshop ends to assess progress, reinforce goals, and provide recommendations for follow-up care.	$67.93
96159	HBAI Individual Intervention, ea. additional 30 min	Each additional 30 minutes, per encounter, beyond the initial 30 minutes for one-on-one time spent with an individual after the initial assessment.	$23.29
96164	HBAI group, initial 30 minutes	HBAI group intervention provided in a group setting with two (2) or more persons. First 30 minutes, per encounter.	$10.35
96165	HBAI group, each additional 30 minutes	Each additional 30 minutes, per encounter, beyond the initial 30 minutes for a group HBAI intervention. HBAI group intervention provided in a group setting with two (2) or more persons.	$4.85
96167	HBAI family intervention, initial 30 minutes	One-to-one intervention with a beneficiary and the family that is focused on strategies to change family dynamics and behaviors that adversely affect the patient's physical health and coping behaviors. First 30 minutes, per encounter.	$72.13
96168	HBAI family intervention, each additional 30 minutes beyond the initial 30 minutes	Each additional 30 minutes, per encounter, beyond the initial 30 minutes for a one-to-one intervention with a beneficiary, and family members, that is focused on strategies to change family dynamics and behaviors that adversely affect the patient's physical health and coping behaviors.	$25.88

* Rates shown are the National Rate for CY2025.

Billing Requirements for HBAI Codes

- Only face-to-face time is billable.
- Each of the HBAI codes is billed in thirty (30) minute increments.
- The Initial Health and Behavior Assessment (code 96156) does not have a time limit or time threshold for this code.
- Time billed using procedure codes 96158, 96159, 96164, 96165, 96167, and 96168 accumulate toward a 15-hour calendar year threshold limit per Medicare beneficiary.

Clinical Supervision Requirements

Qualified Healthcare Professional (QHP)

Medicare requires HBAI services to be provided directly by one of the following licensed clinicians:

- Clinical psychologist (CP)
- Clinical Social Worker (CSW)
- Marriage and Family Therapist (MFT)
- Mental Health Counselor (MHC)

Physicians and Non-physician providers (NPPs) may provide HBAI services. However, physicians and NPPs must use evaluation and management (E&M) codes when providing the service. The HBAI CPT codes are designated only for CPs, CSWs, MFTs, and MHCs.

QHP Responsibilities

All HBAI services are rendered by a QHP. The QHP is responsible for completing the initial assessment, developing the intervention plan, implementing the individual and/or group intervention(s), and monitoring the progress toward attainment of treatment goals. The HBAI services are billed under the National Provider Identifier (NPI) of the QHP.

Auxiliary Personnel or Lay Leaders

The QHP may use auxiliary personnel to assist in the delivery of a group HBAI intervention, such as CDSME, when the QHP is present. CSWs, MFTs, MHCs and clinical psychologists are able to provide incident to services only under certain circumstances to include the delivery of psychological services. HBAI is not a psychological service. Therefore, CSWs, MFTs, MHCs, and clinical psychologists cannot provide HBAI services under the incident to provision. If auxiliary personnel are used to assist the qualified practitioner in the delivery of HBAI, the personnel are providing services to directly assist the practitioner in the service delivery – however – the auxiliary personnel are not operating under incident to supervision. A QHP can use auxiliary personnel provided by a Community-Based Organization (CBO) or network of CBOs organized into a Community Care Hub (CCH). If the QHP is using auxiliary personnel from a CBO or CCH, there should be a contract in place with the CBO/CCH, prior to the implementation of any HBAI interventions that involve auxiliary personnel from a CBO/CCH.

The QHP is responsible for the service delivery and is expected to:

1. Assess the auxiliary personnel to ensure that they have the ability to deliver the education as defined in the materials;
2. Perform a clinical review of the interventions being provided via the HBAI benefit; and
3. Be physically present and available to intervene if necessary when auxiliary personnel deliver HBAI services, i.e., during each workshop session.

Documentation Requirements

There must be appropriate documentation in the clinical record to support claims that are submitted for HBAI services, including a referral from the physician or non-physician practitioner (i.e., nurse practitioner or physician assistant). The referral must include the physical diagnosis and the rationale for providing the HBAI service (i.e., how psychosocial factors are affecting the individual's ability to manage their physical health condition). Documentation requirements for each specific service are listed below.

Initial Assessment and Person-Centered Plan (HBAI Code 96156):

- Diagnosis and initial date of the diagnosis (physical condition or injury) for which HBAI services are indicated (the date of referral must precede the date services start)
- Clear rationale for why the initial assessment was provided
- Assessment outcome and ability of the consumer to understand and respond in a meaningful way to the interventions that will be provided
- Goals and time frame to achieve the goals (by what date or how many weeks)
- Consumer's agreement with the goals and plan
- Planned frequency and duration of each session:
  - The plan must include the frequency of individual and group sessions and the duration of each session.

Individual HBAI Interventions (HBAI codes 96158 or 96159):

- A brief description of each individual intervention that is provided:
  - For individual services, the specific counseling or instruction that is provided to reinforce the person-centered plan goals.
- The consumer's response each time the intervention is offered and progress toward attainment of person-centered plan goals.
- Any change in the frequency or duration of services should be documented.

Group HBAI Interventions (HBAI codes 96164 and 96165):

- A brief description of each individual intervention that is provided:
  - For group services, the evidence-based disease self-management education program content, weekly goal setting , and the ongoing monitoring of the consumer is meeting their weekly self-defined goals.
    - This provides insight into the efficacy of the intervention to assist the beneficiary in learning how to establish realistic health maintenance goals and tracking their ability to accomplish stated goals.
- The consumer's response each time the intervention is offered and progress toward attainment of person-centered plan goals.
- Any change in the frequency or duration of services should be documented.

Family HBAI Interventions (HBAI codes 96167 and 96168):

- A brief description of each individual and family intervention that is provided:
  - For individual and family HBAI services, the specific counseling or instruction that is provided to reinforce the person-centered plan goals.
- The consumer and family member's response each time the intervention is offered and progress toward attainment of person-centered plan goals.
- Any change in the frequency or duration of services should be documented.

The QHP should complete a follow-up plan at the completion of HBAI services. The follow-up plan should be submitted to the referring physician/provider and contain the following information:

- A summary of the services that were provided
- Reassessment of how the individual is self-managing as a result of the CDSME workshop, including outcomes, i.e., what progress was made and to whether or not or to what extent was the behavior-change goal met
- How the disease will be managed after the conclusion of the individual, group, or family HBAI interventions, including recommendations and/or referrals for follow-up care and ongoing self-management support

Coinsurance

Medicare Part B requires a co-insurance payment of 20% of the coverage limit. The consumer is responsible for the coinsurance payment amount. Consumers are educated about the Medicare Part B coinsurance requirement when they sign up to participate in Original Medicare.

Medigap Policies

Medigap policies, which are sold by private insurance companies, pay some of the health care costs not covered by Original Medicare, e.g., copayments, coinsurance, and deductibles. Consumers are educated about their right to select a Medigap policy, and many people elect to have a Medigap policy. For Part B services, such as HBAI, Original Medicare pays 80% of the fee schedule rate, and the coinsurance (20%) is the responsibility of the beneficiary. QHPs are expected to collect the coinsurance either from the beneficiary or by billing the consumer's Medigap policy. If the beneficiary has a Medigap policy, the QHP should collect the necessary Medicare coverage information and applicable Medigap policy information, prior to delivering services to the Medicare beneficiary. Applicable co-insurance coverage can be billed to the Medigap policy, once the service requirements have been met as a Part B benefit of Original Medicare.

Dual Eligibles

Depending on the State requirements, some low-income Medicare beneficiaries may be eligible for Medicaid. Medicaid is a means-tested health coverage program administered by the participating State Medicaid agency and jointly funded by the Centers for Medicare & Medicaid Services. A Medicare beneficiary that is eligible for both Medicare and Medicaid is commonly referred to as a "dual eligible beneficiary." If a person meets the means test requirement to participate in both Medicare and Medicaid, and the person has current Medicaid coverage, then they are a dual eligible beneficiary. Dual eligible beneficiaries have Medicaid as their Medigap policy. As a result, dual eligible beneficiaries have full coverage because Medicare covers the primary 80%, and Medicaid is mandated to cover the remaining Part B coinsurance – 20% of the current coverage.

If a dual eligible beneficiary is enrolled in a Medicaid managed care program or long-term services and supports managed care program, then the coinsurance coverage may be the responsibility of the applicable Medicaid Managed Care Organization (MCO), depending on the requirements administered by the State Medicaid agency.

Dual eligible beneficiaries often have complex medical conditions and are likely to encounter a variety of barriers that affect the treatment and management of their health. As a result, many dual eligible beneficiaries, that suffer from multiple chronic conditions, may be candidates for HBAI services.

Coverage of HBAI Services by Other Health Plans

In addition to Original Medicare, a number of other health plans also cover HBAI services. All Medicare Advantage Plans and Special Needs Plans have a statutory requirement to cover all Medicare Part A and Part B services. As a Medicare Part B service, all Medicare Advantage and Special Needs Plans have a statutory requirement to cover HBAI services, if the clinical eligibility criteria is met. Prior to offering HBAI services to a plan's members, it is important to notify the plan of your intention to provide HBAI services, register as a QHP, and inquire about whether there are prior-authorization requirements. At this time, rates for HBAI services can be negotiated with each plan.

Medicaid

State Medicaid Agencies and Medicaid managed care organizations (MCOs) have the option of providing HBAI as part of an enhanced benefit package.

Commercial Insurance Plans

A number of commercial insurance plans also cover HBAI services. However, their policies may be more or less restrictive than Medicare. Therefore, it is important to check with each plan about their requirements.

Partnership to Align Social Care

A National Learning & Action Network

The Partnership to Align Social Care ("Partnership") is a national learning and action network whose purpose is to enable cross-sector collaboration focused on co-designing and sharing solutions that advance sustainable and aligned health and community care delivery systems leveraging community care hubs (CCHs) to promote whole-person health. The Partnership consists of leaders from across the healthcare and social care sectors, including health plans, health systems, providers, community-based organizations, national associations, and government. Partnership stakeholders collectively advance initiatives that build awareness about opportunities to promote whole-person health through coordination across health care providers and CCHs, expand CCH and CBO adoption of opportunities to bill for labor and services that improve whole-person health, and elevate innovative practices among health care sector stakeholders, CCHs, and CBOs pursuing cost-effective partnerships to drive high-quality care.

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- **Timothy McNeill,** Chief Executive & Founding Member, Freedmen's Health Consulting
- **Bonnie Ewald,** Managing Director, Center for Health and Social Care Integration, Department of Social Work and Community Health, Rush University Medical Center

For more information about the Partnership to Align Social Care, visit **www.partnership2asc.org**.