Commentary: Medicaid Reimbursement and Utilization of Health and Behavior Codes: Year One in Oklahoma

Kristine Woods, PsyD, and Stephen R. Gillaspy, PhD
Department of Pediatrics, University of Oklahoma Health Sciences Center

All correspondence concerning this article should be addressed to Stephen R. Gillaspy, PhD, University of Oklahoma Health Sciences Center, 1200 N. Children’s Drive, Suite 12400, Oklahoma City, OK, 73104, USA. E-mail: stephen-gillaspy@ouhsc.edu

Received December 15, 2011; revisions received January 23, 2012; accepted January 24, 2012

Introduction

In 2002, the Centers for Medicaid and Medicare Services (CMS) approved and activated the health and behavior Current Procedural Terminology (CPT) codes (H&B codes) with the purpose of improving services delivered to patients within the medical system (Foxhall, 2000). The implementation of H&B codes for use by licensed clinical psychologists was the culmination of efforts by the American Psychological Association (APA) Practice Directorate and the Interdivisional Healthcare Committee starting in 1997.

The APA has been continually working with Medicare and private insurance companies to improve access and reimbursement of the codes, but Mullins, Ambrosino, Duncan, Smith, and Phelps (2010) noted that adoption and reimbursement from Medicaid continues to lag behind. These authors reported on results of a survey of success with Medicaid reimbursement for pediatric psychologists and the typical process for psychologists pursuing reimbursement for the codes. Unfortunately, the majority of respondents either did not have Medicaid reimbursement or were unaware of the source of the funds (e.g., State Medicaid office, Health Care Authority, the Behavioral Health Division). Currently, no data have been published on the number of states that provide Medicaid reimbursement for H&B codes. Since Medicaid is administered at the state level, monitoring of successful Medicaid reimbursement remains a challenge.

Few articles have been published since Noll and Fischer’s (2004) commentary on the H&B codes, and it remains unclear how accessible the codes are across the country, in part because of the variability in reimbursement across states, and the lack of a systematic way to track this information. The purpose of this commentary is to provide an overview of the process of obtaining Medicaid reimbursement for the H&B codes in Oklahoma and to report on the data compiled by the state’s Medicaid program on the utilization and reimbursement of the codes during their first year of implementation. Additionally, in Oklahoma postdoctoral fellows and predoctoral interns enrolled in accredited training programs are permitted to bill Medicaid for services while under the supervision of a licensed psychologist; therefore, the process of opening up the codes for use by psychology trainee as well as utilization of H&B codes are reported in addition to services provided by licensed psychologists.

Why is Medicaid Reimbursement for the H&B Codes Critical?

It is estimated that approximately 60 million people are currently enrolled in the national Medicaid program (Kaiser Family Foundation, 2011a), which equates to roughly one in five Americans. Furthermore, in June 2010, over 26 million children were enrolled in the Medicaid program (Kaiser Family Foundation, 2011b). In order to qualify for Medicaid, the family income is compared to the federal poverty level (Centers for Medicare and Medicaid Services, 2011b); thus, the majority of children with Medicaid coverage come from families of lower socioeconomic status (SES). Research has indicated a positive association between SES and health outcome, and access to optimal health care is limited with lower SES (Fuemmeler, Moriarty, & Brown, 2009).

Examination of 2010 census data revealed that over 3,751,000 people resided in the state of Oklahoma, with roughly 25% being under the age of 18 years. For the fiscal year of July 2010 to June 2011, the Oklahoma Health Care Authority (OHCA; Russel, 2011) reported an
average enrollment of 487,396 children in the state Medicaid program, which translates into 59% of all Oklahoma children receiving insurance coverage from the state Medicaid program. Therefore, Medicaid is the predominant insurance provider for the vast majority of children in Oklahoma.

The passage of the Affordable Care Act in 2010 has the potential to greatly influence the role that psychologists play and the types of services patients and families will receive. Specifically, health care reform brings a new focus to the integration of mental and physical health care services, an investment in prevention, the expectation of collaboration between behavioral health providers and primary care and other medical providers, and the establishment of patient-centered health homes and accountable care organizations. Psychologists have the unique biopsychosocial skill set necessary to provide integrated care and the H&B codes provide a reimbursable mechanism to provide such care. Moreover, it is expected that health care reform will expand Medicaid eligibility, underscoring the importance of Medicaid reimbursement of H&B codes.

Process for Obtaining Medicaid Reimbursement for H&B Codes in Oklahoma

In 2005, the secondary author made contact with the Behavioral Health Unit at the OHCA regarding reimbursement for the H&B codes. At that time, the OHCA was unaware of the codes and had no plans to open the codes for use. This initial contact was followed by subsequent emails and face to face meetings with the Director of the Behavioral Health Unit. The secondary author and three other psychologists in the state (two pediatric psychologists and one health psychologist) began informal and formal discussions with the Behavioral Health Unit regarding the codes and their positive impact on health conditions. During these discussions, the Behavioral Health Unit was provided with literature on the intent of the codes, and they were informed of Medicare reimbursement and a movement for the majority of private insurance companies to reimburse the codes. The state association was also educated about the H&B codes and was asked to support the need for Medicaid reimbursement.

The OHCA staff was receptive to the concept of the codes, but reported a budget request would have to be approved in order to open the codes for use. In 2007, the Behavioral Health Unit of the OHCA proposed reimbursement for the H&B codes and submitted a budget request for the state fiscal year of 2009 (July 1, 2008–June 30, 2009). Although funding for the H&B codes was added to the annual budget request, it was not a priority, and was typically included with other behavioral health initiatives. Each year the H&B codes fell below the funding priority. During that time, the OHCA Behavioral Health Director participated in a presentation on the H&B codes at the 2008 Oklahoma Psychological Association annual meeting (Mullins et al., 2008) and encouraged psychologists to lobby the state legislature for increased behavioral health funding and reimbursement of H&B codes. In 2010, the H&B codes were included with several other behavioral health initiatives focused on increased access to care and the codes were approved through the OHCA emergency rules. From 2005 to 2010, the OHCA initiated a medical home model for primary care, emphasizing integration of behavioral health and a biopsychosocial perspective to primary care. It is believed that the OHCA focus on integration of care and increased access for behavioral health services influenced the decision to provide reimbursement for the H&B codes.

Oklahoma Medicaid began reimbursing for the H&B codes in July of 2010, and reimbursement for the H&B codes was and continues to be paid from the behavioral health budget rather than the medical budget as proposed. Despite this discrepancy from the intended funding source for the codes, it does not appear to have had an impact on reimbursement rates or success. Medicaid reimbursement for H&B codes was restricted to only those services provided by licensed clinical psychologists, and currently, Oklahoma Medicaid only provides reimbursement to psychologists for services provided to children under 21 years of age, restricting reimbursement for the codes to children and adolescents. Additionally, the OHCA specified that the codes are to be used for children with chronic and terminal illnesses, which is inconsistent with the current CPT manual which states “Codes 96150-96155 describe services offered to patients who present with primary physical illnesses, diagnoses, or symptoms and may benefit from assessments and interventions that focus on the biopsychosocial factors related to the patient’s health status,” (American Medical Association, 2011, p. 517).

In 2008, the secondary author worked with the OHCA and the state licensing board to develop a formal process to allow psychology interns and fellows to bill Medicaid for trainee-provided services using the traditional CPT codes. This agreement stipulates that only psychology interns and fellows participating in formal training programs are permitted to bill Medicaid and receive reimbursement under their clinical supervisor for clinical services provided to patients and families. The reimbursement schedule for
trainee-provided services was negotiated at the same rate as services provided by licensed psychologists. When the H&B codes were approved for use for licensed psychologists, psychology interns and fellows in formal training programs were also approved to bill for the codes while under supervision.

Oklahoma Medicaid Reimbursement Statistics

The data included in this report were extracted by the OHCA and includes all H&B codes reimbursable by psychologists (96150–91655). Medicaid claims were extracted from July 1, 2010 to September 30, 2011 in order to capture all claims submitted during the state’s fiscal year.

Number of Encounters and Units of Service

Data provided by the OHCA indicates that a total of 448 encounters were submitted to Medicaid using H&B codes between July 2010 and June 2011 (T. Russell, OHCA, personal communications, November–December 2011). Of these 448 encounters, only 44 encounters were denied reimbursement (9.8%). Of note, however, is the fact that substantially more claims were initially denied reimbursement, but were later reimbursed after being resubmitted. Licensed psychologists utilized the H&B codes for a total of 197 encounters, comprised of 355 units of service, at both the inpatient and outpatient levels. Of these 197 encounters, 108 were billed under the assessment codes (96150-initial assessment and 96151-reassessment) and 89 encounters were billed under the intervention codes (96152-individual, 96154-family with patient present, and 96155-family without patient present). Psychology interns and fellows billed for a total of 243 encounters, which was comprised of 526 units. Of these 243 encounters, 127 were billed under the assessment codes whereas 11 were billed under the intervention codes.

Children between the ages of 5 and 12 received the majority of services billed through the H&B codes (188 total encounters) followed by 174 total encounters for adolescents 13 to 18 years old. The most commonly used primary medical diagnoses included sickle cell disease (76 encounters), cancer (62 encounters), weight-related diagnoses (49 encounters), pain conditions (31 encounters), hemophilia (22 encounters), and cystic fibrosis (12 encounters).

Reimbursement Rates

Currently, Medicaid reimbursement rates in Oklahoma are approximately equal to the reported reimbursement rates for Medicare across all codes. Importantly, the average reimbursement rate for the five largest private insurance companies in Oklahoma remains substantially above the national Medicare rates (J. Hayes, personal communication, November–December 2011). See Table I for more information. Noll and Fischer (2004) cautioned that underuse of the codes by psychologists could potentially result in loss of control over the codes as well as decreased reimbursement values for the codes. Compared to national Medicare rates published by Noll and Fischer (2004), the national average for Medicare reimbursement of H&B codes has declined over the years (Centers for Medicare and Medicaid Services, 2011a). See Table II for more information. Information generated from the CMS indicates that Medicare reimbursement of H&B codes has decreased in Oklahoma from 2004 to 2011, and this overall decrease has been gradual over the years (Table III). What is unclear, however, is whether the rates have decreased due to lack of use, economic decline across the country, or some other factor.

Conclusions

Implementation of the H&B codes for pediatric psychologists has allowed for greater integration of psychosocial functioning within the medical system, thus allowing for utilization of the biopsychosocial model of care. Despite the presence of psychosocial stressors, many of the children receiving services under these codes would not have a diagnosable mental health disorder. Thus, the H&B codes allow psychologists to assist the medical team in providing comprehensive care within the context of the child’s medical condition (Kessler, 2008).

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Oklahoma Medicare</th>
<th>Oklahoma Medicaid</th>
<th>Average Private</th>
<th>Estimated Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>96150-Initial assessment</td>
<td>$20.68</td>
<td>$20.01</td>
<td>$30.66</td>
<td>$62.04</td>
</tr>
<tr>
<td>96151-Reassessment</td>
<td>$20.00</td>
<td>$19.35</td>
<td>$29.66</td>
<td>$60.00</td>
</tr>
<tr>
<td>96152-Individual</td>
<td>$19.01</td>
<td>$18.39</td>
<td>$28.29</td>
<td>$57.03</td>
</tr>
<tr>
<td>96153-Group</td>
<td>$4.57</td>
<td>$4.42</td>
<td>$6.66</td>
<td>$13.71</td>
</tr>
<tr>
<td>96154-Family w/patient</td>
<td>$18.67</td>
<td>$18.06</td>
<td>$27.79</td>
<td>$56.01</td>
</tr>
<tr>
<td>96155-Family w/o patient</td>
<td>–</td>
<td>$21.22</td>
<td>$29.22</td>
<td>$58.00</td>
</tr>
</tbody>
</table>

Note. Amounts are for one unit of service
Rates were included from the five largest private insurance carriers in the state, and reimbursement rates were specific to the rate for the authors’ institution
Estimated charge is based on 200% of Medicare. Specific charge data not publicly available, but typical methodology for determining charges is initially based on setting the charge floor at 200% of Medicare.
A review of the process for obtaining Medicaid reimbursement for H&B codes in Oklahoma and examination of the first year of utilization data revealed several important findings. First, it is commendable that Oklahoma has one of only a few state Medicaid programs to reimburse for the H&B codes. The reimbursement data reveal that previously cited issues with denials for H&B codes (e.g., noncovered service, no prior authorization, ineligible provider; Brosig & Zahrt, 2006) has not been a significant problem during this first year. Additionally, the fact that a significant portion of the reimbursed encounters were provided by psychology interns and fellows demonstrates that our trainees are actively engaged in using the H&B codes. This active engagement should help to promote the use of the H&B codes and suggests that we are slowly making improvements in the area of workforce development for integrated healthcare.

Although the Oklahoma Medicaid agency is supportive of the H&B codes, the fact that reimbursement is from the behavioral health budget versus the medical budget evidences the addition of language assigned to the codes referring to the provision of services for chronically and terminally ill patients. As healthcare reform calls for increased integration of services and removal of the medical versus behavioral health approach (Clay, 2011), it is hoped that the H&B codes will be better appreciated and seen as applicable to all patients where psychological, behavioral, emotional, cognitive, and social factors impact the management of physical health problems. Lastly, although Oklahoma Medicaid reimburses for H&B codes at approximately the same rate as Medicare, the current reimbursement is significantly less than private insurance companies. This parity with Medicare reimbursement should be concerning given that Medicare reimbursement for H&B codes has declined since 2004 (Centers for Medicare and Medicaid Services, 2011a).

**Future Directions**

It will continue to be important for psychologists to advocate for proper use and reimbursement of the H&B codes by their state Medicaid programs (Clay, 2011). Recommendations drawn by Mullins et al. (2010) on ways to further the successful reimbursement of H&B codes included having the background and education about the codes to properly bill for services, using the codes when appropriate to do so and appealing claims that are denied, working with the financial department of one’s institution, enlisting support from state psychological associations, and seeking support from the children and families being served under the codes. Families can directly lobby state Medicaid agencies and their state legislators to emphasize the importance of the H&B codes and the need for increased reimbursement. This can take the form of emails, letters, phone calls, or face to face interactions. Families may also request to have their medical provider lobby on behalf of the H&B codes. Many pediatricians appreciate the value of pediatric psychology and because of the medical hierarchy and perceived leadership, can often provide more influence than psychologists or individual families. Additionally, support at the state level from physician organizations can have a substantial impact on insurance companies’ willingness to reimburse the codes, particularly as physicians are able to attest to the value of psychological services in the management of chronic illnesses.

Regarding seeking Medicaid reimbursement, we would add that it is essential to determine the rule-making process within the state Medicaid agency and what Medicaid

---

**Table II. 2011 National Average Reimbursement Rates for Medicare**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>96150-Initial assessment</td>
<td>$21.07</td>
<td>$26</td>
</tr>
<tr>
<td>96151-Reassessment</td>
<td>$20.39</td>
<td>$26</td>
</tr>
<tr>
<td>96152-Individual</td>
<td>$19.37</td>
<td>$25</td>
</tr>
<tr>
<td>96153-Group</td>
<td>$4.76</td>
<td>$5</td>
</tr>
<tr>
<td>96154-Family w/patient</td>
<td>$19.03</td>
<td>$24</td>
</tr>
<tr>
<td>96155-Family w/o patient</td>
<td>–</td>
<td>$23</td>
</tr>
</tbody>
</table>

**Table III. Medicaid Reimbursement Rates for Oklahoma 2004–2011**

<table>
<thead>
<tr>
<th>Year</th>
<th>96150</th>
<th>96151</th>
<th>96152</th>
<th>95153</th>
<th>96154</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>25.19</td>
<td>24.12</td>
<td>23.04</td>
<td>5.20</td>
<td>22.67</td>
</tr>
<tr>
<td>2005</td>
<td>24.99</td>
<td>24.24</td>
<td>23.15</td>
<td>5.25</td>
<td>22.77</td>
</tr>
<tr>
<td>2006</td>
<td>24.92</td>
<td>24.16</td>
<td>23.08</td>
<td>5.23</td>
<td>22.70</td>
</tr>
<tr>
<td>2008</td>
<td>21.50</td>
<td>20.74</td>
<td>20.03</td>
<td>4.59</td>
<td>19.65</td>
</tr>
<tr>
<td>2010a</td>
<td>21.94</td>
<td>21.22</td>
<td>20.16</td>
<td>4.84</td>
<td>19.47</td>
</tr>
<tr>
<td>2010b</td>
<td>22.42</td>
<td>21.68</td>
<td>20.60</td>
<td>4.94</td>
<td>20.23</td>
</tr>
<tr>
<td>2011</td>
<td>20.68</td>
<td>20.00</td>
<td>19.01</td>
<td>4.37</td>
<td>18.69</td>
</tr>
</tbody>
</table>

*Note. Amounts are for 1 unit of service. Retrieved from www.cms.hhs.gov/apps/pfslookup/*
personnel psychologists should work with to advocate for H&B codes. Furthermore, as each state Medicaid program is either in the planning stages or already making preparations for healthcare reform, psychologists are urged to advocate for the H&B codes in the context healthcare reform (Nordal, 2011). Psychologists also play an important role in educating Medicaid personnel on how utilization of the H&B codes is congruent with integrated care and allows for a truly biopsychosocial approach to healthcare. As each state modifies its Medicaid program to comply with the Affordable Care Act of 2010, it will be important to monitor Medicaid reimbursement for H&B codes across all states as currently there is no way to track this information in one uniform manner.

In Oklahoma, we will continue to promote the H&B codes and the role psychologists can play in the new healthcare system. We will lobby for increased reimbursement for H&B codes and provide feedback on utilization to date. Although, reimbursement has not been denied for clinical services provided to patients outside the definition of chronically and terminally ill, we will lobby for removal of this language. This change in the language will be increasingly important with health care reform’s focus on early intervention and prevention services.

Acknowledgments

The authors would like to acknowledge the Oklahoma Health Care Authority Reporting and Statistics Unit for providing descriptive statistics on Medicaid utilization and reimbursement of the Health and Behavior CPT codes. The authors would like to specifically thank Tony Russell for his assistance. The authors would also like to thank Drs Larry Mullins, Rhonda Johnson, and Teri Bourdeau for their efforts in lobbying the OHCA for reimbursement of the H&B codes.

Conflicts of interest: None declared.

References


