

Health Workforce Policy Brief

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Understanding Billing Restrictions for Behavioral Health Providers

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BACKGROUND

In 2012, the Substance Abuse and Mental Health Services Administration (SAMHSA) reported that nearly 1 in 5 Americans live with a mental health or substance use disorder (SUD).¹ Meanwhile, the Health Resources and Services Administration (HRSA) reports that more than 7,800 mental health professionals are needed to address the lack of behavioral health services in the nearly 3,700 workforce shortage areas throughout the country.² Inadequate access to behavioral health services has the potential to cause great personal and economic challenges:

- The National Alliance on Mental Illness (NAMI) noted that untreated mental illnesses costs the American economy more than \$100 billion in lost productivity.³
- SAMHSA estimates that untreated drug and alcohol dependencies result in 500 million lost work-days annually.²
- More than 90% of the 42,000 people who commit suicide each year lived with a mental illness or SUD.⁴

Balancing the disequilibrium between the demand for mental health and SUD services and the supply of qualified behavioral health professionals compels an examination of the billing and reimbursement practices and payer policies impacting behavioral health service access. One strategy to enhance access is to ensure that behavioral health professionals can receive reimbursement for common procedures in behavioral health, especially when those services fall well within their expertise. This brief examines the extent to which behavioral health professionals are recognized as reimbursable providers for common billing codes that fall within their scope of practice.

METHODS

The National Council for Behavioral Health (National Council) identified several Common Procedural Terminology (CPT) codes that are the frequently used by behavioral health organizations and are representative of the broadest scopes of practice for mental health and SUD professionals:

| | | | |
|---------|--|-------|---------------------------|
| 90791 | Psychiatric Diagnosis Evaluation | 90839 | Psychotherapy for Crisis |
| 90792 | Psychiatric Diagnosis Evaluation with Medical Services | 90853 | Group Psychotherapy |
| 90846/7 | Family or Couples Psychotherapy with/without Patient | 90832 | Psychotherapy, 30 minutes |
| 90863 | Pharmacological Management | | |

¹ National Alliance on Mental Illness. (2016, August 15). *NAMI*. Retrieved from Living with a Mental Health Condition: <http://www.nami.org/Find-Support/Living-with-a-Mental-Health-Condition>

² Substance Abuse and Mental Health Services Administration. (2013). *Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues*. Washington, DC: United States Department of Health and Human Services.

³ National Alliance on Mental Illness. (2016, August 15). *NAMI*. Retrieved from Living with a Mental Health Condition: <http://www.nami.org/Find-Support/Living-with-a-Mental-Health-Condition>

⁴ Substance Abuse and Mental Health Services Administration. (2016, August 23). *Substance Abuse and Mental Health Services Administration*. Retrieved from Suicide Prevention: <http://www.samhsa.gov/suicide-prevention>

CONCLUSIONS AND POLICY IMPLICATIONS

The findings of this study show:

- Across Medicaid and Medicare, almost all codes were able to be used by almost all providers to bill for the services proscribed by these specific codes.
- Lack of reimbursement to a provider does not necessarily indicate a barrier to entry for a particular professional.
- Exceptions often exist when the service expected under the code is outside the scope of work for the provider (i.e. medication prescription by physicians).
- In cases where codes are disallowed by provider type, other codes may be used to provide similar or more targeted services.

Although this research suggests that the behavioral health professionals highlighted here are generally recognized as approved providers, opportunities for further research include:

- The misalignment of reimbursement with value of care as a disincentive toward high-quality, coordinated care
- The reimbursement of non-licensed professionals, team-based care, and other approaches that drive down healthcare costs
- Variation in Medicaid billing practices within states can hinder full expression of scopes of practice, and thus, access to quality services

To investigate both the impact of behavioral health organizations' billing and reimbursement practices, and restrictions enforced by various payers, the National Council conducted a state-by-state analysis of regulations for each identified CPT code for Medicare and Medicaid. Sources included the official Medicare website, internet-based Medicaid billing manuals, and outreach to state Medicaid offices. Regulations were investigated for the following five types of behavioral health care providers: psychiatrists, psychologists, licensed clinical social workers (LCSWs), licensed professional counselors (LPCs), and marriage and family therapists (MFTs). Restrictions were noted as they related to setting, required supervision, and allowable number of encounters/services, among others.

Ten states (Arizona, Georgia, Indiana, Kansas, Louisiana, New Hampshire, Ohio, Oregon, Washington, Wisconsin) were selected for more in-depth research. The selection process intentionally identified a diverse geographic and political sample, which was representative of the broad diversity of America's payer landscape. This process included ensuring that both Medicaid expansion and non-expansion states were represented. Commercial insurance provider coverages were surveyed in selected states through online research and phone outreach. To corroborate and illuminate these findings further, the National Council conducted key informant interviews with 12 leaders from as many organizations across six of the ten chosen states as possible, regarding their utilization of the common behavioral health focused billing codes. Key informant interviewees were based in Georgia (2), Louisiana (1), Washington (3), Indiana (3), Arizona (1), and New Hampshire (2), and were recruited from the National Council's network of more than 2,800 community behavioral health organizations. Interview protocols were developed in collaboration with the research team at the Behavioral Health Workforce Research Center.

KEY FINDINGS

Currently, the five disciplines listed above are recognized as core behavioral health professionals by the federal government. In the majority of states, most of the five practitioner types were recognized for Medicaid reimbursement by the codes under consideration. Per Medicare policies, psychiatrists, psychologists, and social workers could be reimbursed for all eight of the CPT codes of interest. However, unlike the majority of Medicaid plans, MFTs and LPCs cannot be reimbursed by Medicare. Research into billing code use by commercial insurance payers was unsuccessful for major companies, due to corporate data restrictions. Across all 50 states, behavioral health services were covered under benchmark plans. More research would be needed to identify specifically which services are covered for specific populations.

The following major billing exceptions and variability was found:

- CPT codes 90791 and 90792 – psychiatric diagnostic evaluation, the latter of which requires prescribing authority and was often limited to physicians and advanced practice nurses
- 90863 is only used in Louisiana and New Mexico by psychologists who have prescribing rights when done in conjunction with psychotherapy
- Pennsylvania, South Carolina, South Dakota, West Virginia, and Wyoming all excluded LCSWs, LPCs, and/or MFTs from most or all of the listed billing codes
- Social workers and counselors in Missouri were restricted to serving clients under the age of 21 for all but one code combination (90846 for social workers)
- The most variability among eligible provider types occurred with codes 90846 and 90847
 - Three states did not reimburse for these codes at all
 - South Carolina, Wyoming, and Oklahoma allowed only psychologists or psychiatrists to be reimbursed
- Florida and Mississippi used H-2011 instead of 90839 to reimburse of psychotherapy for crisis
 - The use of this “H code” could be due to better reimbursement rate or the avoidance of pre-authorizations for providing crisis services
- For all codes selected, states typically required that practitioners be licensed through the state in order to practice without supervision
 - In other cases, such as Tennessee, non-licensed master's level providers could provide the services if under the direct supervision of a licensed provider