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| Guide to Billing Codes for Dementia Services |

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A couple of people that are looking at the camera

Description automatically generatedLogo for the Administration for Community Living (A C L)
Logo for the National Alzheimer's and Dementia Resource Center (N A D R C)
Logo for R T I International

Guide to Billing Codes for  
Dementia Services

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Table of Contents

Section Page

[Introduction 1](#_Toc51655453)

[A Note on Methodology 1](#_Toc51655454)

[Key Components of the Billing Process 2](#_Toc51655455)

[CPT® Billing Code Tables 4](#_Toc51655456)

[Cognitive Assessment and Care Planning, and Advance Care Planning 5](#_Toc51655457)

[Counseling/Psychotherapy for Caregivers and Persons Living with Dementia 6](#_Toc51655458)

[Evaluation and Management (E&M) 8](#_Toc51655459)

[Evaluation, Services, and Cognitive Testing for Rehabilitative Medicine 12](#_Toc51655460)

[Health Behavior Assessment and Intervention (HBAI) 14](#_Toc51655461)

[Elements of Developing a Billing Infrastructure 15](#_Toc51655462)

[Third-Party Payer Enrollment 15](#_Toc51655463)

[References R-1](#_Toc51655464)

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# Introduction

Dementia services and supports play an important role in helping people who are living with dementia to remain in the community. Although providers have expanded the range of dementia services they offer, identifying means of reimbursement to sustain these services remains an ongoing challenge. Billing third-party payers, such as fee-for-service Medicare and private insurance, can provide one sustainable source of funding. Several Administration for Community Living (ACL) Alzheimer’s Disease Program grantees are successfully billing third-party payers. This guide is designed to share the knowledge they have gained.

This guide is intended primarily for organizations that have medical billing systems in place and want to understand how to bill for dementia services. It may also be useful for organizations that are considering developing a medical billing system for services. Instituting a billing process to meet the many requirements of third-party payers, which vary depending on the state and insurer, requires extensive time and resources. Carefully weigh the costs versus benefits. Typically, billing revenues do not cover the entire cost of the services provided; however, they can serve as one significant and relatively stable source of funding. Billing for services may also be attractive to other funders, who want to see that all possible sources of revenue are maximized before contributing private funds.

The guide includes codes that select ACL grantees have used successfully. It is not intended as a comprehensive review of all possible billing codes that organizations might use to bill for dementia services. Links to additional resources are provided throughout the guide.

The guide includes three sections:

1. Key Components of the Billing Process
2. Tables of Billing Codes Used by Current ACL Grantees
3. Elements of Developing a Billing Infrastructure

## A Note on Methodology

Two approaches were used to gather information for this guide. First, a group of six ACL grantees experienced in billing third-party payers for dementia services served as subject matter experts throughout the development of the guide. They generously shared their experience and recommendations through group meetings, individual interviews, and review of the draft guide. Much of the information in this guide was gleaned from these meetings and interviews. Without their collective guidance and support, this guide would not have been possible.

Second, information was gathered through online resources and references cited throughout the guide. We would like to acknowledge the Centers for Medicare & Medicaid Services (CMS) website as a primary source of information.

## Key Components of the Billing Process

#### Patients

The billing codes included in this guide relate to specific services provided to a “patient.” Most commonly, the patient is the person living with dementia, but in some cases, the patient may be the caregiver. For example, caregivers may seek psychotherapy to cope with the stress of caregiving. When the patient is the caregiver, it is their insurance that is being billed.

#### Clinicians

All billed services are either provided directly by a qualified clinician (such as a physician or nurse practitioner) or under supervision of a qualified clinician. For example, a nurse might provide case management under the supervision of a physician. The rules about who can provide a service and who can supervise the provision of service depend on the service and also vary by state and by payer. The clinician (or supervising clinician) is responsible for assigning the appropriate CPT® and ICD-10-CM code(s).

#### Third-Party Payers

Third-party payers are government agencies, private insurance companies, and employers who pay the medical expenses of the first party (the patient) to the second party (the physician or other health care provider). Medicare and private insurance companies such as Blue Cross Blue Shield are examples of third-party payers.

#### Medicare Administrative Contractor (MAC) Regions

Medicare services are billed through a MAC—a private health care insurer that has been awarded a contract to process medical claims for Medicare fee-for-service beneficiaries in a specific [multistate MAC jurisdiction](https://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/MAC-Website-List).

The roles of the MAC are the following:

1. Enroll providers in the Medicare program
2. Process Medicare claims
3. Respond to provider inquiries
4. Educate providers about Medicare billing requirements

CMS establishes national policies regarding services that must be covered, but most decisions about coverage are determined by the regional MAC. The criteria for what is considered medically necessary and covered (known as [Local Coverage Determinations](https://www.cms.gov/medicare-coverage-database/indexes/lcd-state-index.aspx)) vary by MAC (HHS, 2014). It is important to keep informed of the frequent changes in codes and new or updated Local Coverage Determinations and maintain regular communication with the MAC and other insurers.

#### CPT® and HCPCS Billing Codes

CPT® codes are created by the American Medical Association (AMA) to provide health care professionals a uniform language for coding medical services and procedures. These codes are used by third-party payers to determine the amount that will be paid for each service.

The Healthcare Common Procedural Coding System (HCPCS; often pronounced by its acronym as “hicpics”) is developed by CMS and is divided into Level I (service codes, consistent with CPT®) and Level II (health care equipment and supplies codes). The tables in this guide include CPT® codes that are also HCPCS Level I codes used for billing Medicare.

Each provider should be aware of the specific elements required to choose the correct CPT® code and the documentation requirements. The components that must be addressed to define the level of the CPT® code are medical history, examination, medical decision making, counseling, coordination of care, nature of presenting problem, and time spent with the patient. Greater detail of these requirements is found in the AMA CPT® code book and in a variety of other [AMA CPT® coding resources](https://www.ama-assn.org/practice-management/cpt) Exit icon.

#### ICD-10-CM Diagnostic Codes

For each CPT® procedure code billed, one or more diagnostic codes must be provided to justify the service(s). The International Classification of Diseases (ICD)-10-CM provides a system of diagnostic codes for classifying diseases. Every claim submitted for reimbursement includes both a CPT® code and one or more associated [ICD-10-CM](https://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD-10QuickStartGuide20170324.pdf) diagnostic codes that indicate the medical necessity of the service.

Approved diagnostic codes vary by location; consult your MAC and individual insurers to determine which diagnostic codes are approved for use in your area.Some commonly used diagnostic codes are included at the end of each billing code table**.**

#### COVID-19 Telehealth

COVID-19 has necessitated that many in-person services including initial assessments, care planning, and individual education or counseling sessions be delivered remotely. During the COVID-19 pandemic, CMS made the decision to allow the use of in-person billing codes for telehealth visits and will pay the same rate. CMS has provided a list of [billing codes approved for telehealth](https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes) (CMS, March 2020a).

These changes and requirements are still evolving at the time of this guide’s publication.

# CPT® Billing Code Tables

CPT® codes are organized in sets by the types of services that can be reimbursed. The five tables in this section list billing codes that some ACL grantees use or plan to use to bill for services. Links go directly to each table in this document.

* [**Cognitive Assessment and Care Planning and Advance Care Planning**](#CognitiveAssessmentandCarePlanning)These codes are used for a comprehensive cognitive assessment, creation of a care plan, and development or update of advance directives.
* [**Counseling/Psychotherapy**](#CounselingPsychotherapy)These codes can be used by providers such as licensed clinical social workers or clinical psychologists to provide counseling to the caregiver or person living with dementia.
* [**Evaluation and Management (E&M)**](#_Evaluation_and_Management)  
  These codes are used in a clinic setting and cover initial and ongoing assessment, diagnosis, care planning, and follow-up support.
* [**Evaluation, Services and Cognitive Testing for Rehabilitative Medicine**](#EvaluationServicesandCognitiveTest)These codes are used for occupational therapy services, including initial evaluation, individual sessions, and cognitive assessment.
* [**Health Behavior Assessment and Intervention (HBAI)**](#_Health_Behavior_Assessment)  
  These codes are used for services and interventions that address the behavioral, psychosocial, and other factors that impact the management of a physical health condition. They are NOT used for providing medical treatment or providing mental health services.

## Cognitive Assessment and Care Planning, and Advance Care Planning

Clinicians’ time spent conducting cognitive assessments, including care planning services for individuals who are cognitively impaired, is reimbursable. The code 99483 is used to perform a cognitive assessment that includes a patient history, medical examination, functional assessment, medication reconciliation, evaluation for behavioral symptoms, safety evaluation, identification of caregivers, creation of a care plan, and development or update of advance directives. Physicians, nurse practitioners, and staff supervised by the eligible clinician can use these codes.

If advance care planning occurs at a separate visit solely for the purpose of discussing the individual’s health care wishes, this can be billed as a separate service using code 99497.

Examples of services and interventions that have been billed using these codes:

* Time spent with a neurologist or nurse practitioner as part of the [Care EcoSystems intervention](https://memory.ucsf.edu/research-trials/professional/care-ecosystem) Exit icon;
* Advance care planning with a physician (or under the supervision of a physician if insurer allows)

Cognitive Assessment and Care Planning, and Advance Care Planning

| Billing Code | Procedure | Time/ Complexity | Notes | Clinicians Who can Use this Code (May Vary by State and Payer) |
| --- | --- | --- | --- | --- |
| 99483 | Cognitive assessment and care planning | Untimed (flat fee for service) | Face-to-face contact with a patient.  There are many required components of the cognitive assessment and care planning process—see link below. | Physician (Phys), nurse practitioner (NP), clinical nurse specialist (CNS), physician assistant (PA) |
| 99497 | Advance care planning | First 30 minutes | Face-to-face contact with a patient, family member(s), or surrogate.  Includes the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed). | Phys, NP, CNS, PA |
| 99498 | Advance care planning | Additional 30 minutes | This code is billed along with 99497 when the advance care planning session lasts an hour | Phys, NP, CNS, PA |

**Examples of ICD-10-CM Diagnostic Codes and Modifiers**

F01.50 F02.80, F02.81, F03.90, F03.91, G11.8, G20, G23.1,G23.9, G30.0, G30.9, G31.01, G31.09, G31.83, G31.85

**Resources**

*Cognitive Assessment and Care Planning:*

[Alzheimer’s Association Expert Task Force Recommendations and Tools](https://alz.org/media/Documents/cog-impair-assess-care-plan-code.pdf) Exit icon

*Advance Care Planning:*

[Medicare Learning Network Fact Sheet](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf)

[Living with Dementia: Advance Planning Guides for Persons with Dementia and Caregivers](https://nadrc.acl.gov/node/137)

*Evidence-Based Intervention Resources:*

[Best Practice Caregiving](https://bpc.caregiver.org/#home) Exit icon

[Grantee-Implemented Evidence-Based and Evidence-Informed Interventions](https://nadrc.acl.gov/node/140)

## Counseling/Psychotherapy for Caregivers and Persons Living with Dementia

These are traditional counseling and psychotherapy codes. The patient may be the person living with dementia or the caregiver. If the caregiver is the patient, it is their insurer that is billed for the service. Psychotherapy or counseling services may only be covered for persons living with early dementia; check with the MAC or private insurer for specific limitations.

These codes can be used by a licensed clinical social worker, psychologist, or another approved clinician (as determined by insurer). The diagnostic code(s) (ICD-10-CM codes) used with these CPT® codes will relate to mental health diagnoses such as depression.

Examples of services and interventions that have been billed using these codes:

* [REACH II](https://www12.edc.gsph.pitt.edu/reach/) intervention
* Care of Persons with Dementia in Their Environments ([COPE](https://bpc.caregiver.org/#programDetails/8)) intervention
* Family counseling, with or without the person with dementia

Counseling/Psychotherapy

| Billing Code | Procedure | Time/ Complexity | Notes | Clinicians Who can Use this Code (May Vary by State and Payer) |
| --- | --- | --- | --- | --- |
| 90791 90792 | Psychotherapy diagnostic evaluation | Untimed | With patient | Licensed clinical social workers or clinical psychologist (90791); psychiatrist or other physician (90792) |
| 90832 | Psychotherapy treatment | 30 minutes | With patient | Psychiatrist (Psych MD), other physician (Phys), nurse practitioner (NP), physician assistant (PA), clinical nurse specialist (CNS), clinical psychologist (CP), licensed clinical social worker (LCSW)  *Not currently covered by Medicare but may be covered by private insurance:*  Licensed professional counselors (LPC)  Licensed mental health counselors (LMHC)  Licensed marriage family therapists (LMFT) |
| 90833 | Psychotherapy treatment | 30 minutes | With patient performed with an evaluation | Psych MD, other Phys, NP, PA, CNS, CP, LCSW  *Not currently covered by Medicare but may be covered by private insurance:*  LPC, LMHC, LMFT |
| 90834 | Psychotherapy treatment | 45 minutes | With patient | Psych MD, other Phys, NP, PA, CNS, CP, LCSW  *Not currently covered by Medicare but may be covered by private insurance:*  LPC, LMHC, LMFT |
| 90836 | Psychotherapy treatment | 45 minutes | With patient when performed with an office visit | Psych MD, other Phys, NP, PA, CNS, CP, LCSW  *Not currently covered by Medicare but may be covered by private insurance:*  LPC, LMHC, LMFT |

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Counseling/Psychotherapy (continued)

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| --- | --- | --- | --- | --- |
| Billing Code | Procedure | Time/ Complexity | Notes | Clinicians Who can Use this Code (May Vary by State and Payer) |
| 90837 | Psychotherapy treatment | 60 minutes | With patient | Psych MD, other Phys, NP, PA, CNS, CP, LCSW  *Not currently covered by Medicare but may be covered by private insurance:*  LPC, LMHC, LMFT |
| 90838 | Psychotherapy treatment | 60 minutes | With patient when performed with an office visit | Psych MD, other Phys, NP, PA, CNS, CP, LCSW  *Not currently covered by Medicare but may be covered by private insurance:*  LPC, LMHC, LMFT |
| 90846 | Family psychotherapy treatment | 50 minutes | Without patient | Psych MD, other Phys, NP, PA, CNS, CP, LCSW  *Not currently covered by Medicare but may be covered by private insurance:*  LPC, LMHC, LMFT |
| 90847 | Family psychotherapy treatment | 50 minutes | With patient | Psych MD, other Phys, NP, PA, CNS, CP, LCSW  *Not currently covered by Medicare but may be covered by private insurance:*  LPC, LMHC, LMFT |

**Examples of ICD-10-CM Diagnostic Codes and Modifiers**

F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.9, F33, F33.0,F33.1, F33.2, F33.3, F33.41, F33.42, F33.9, F41.1, F41.9, F43.20, F43.21, F43.22, F43.23, F43.24, F43.25, F43.20

**Resources**

*Evidence-Based Intervention Resources:*

[Best Practice Caregiving](https://bpc.caregiver.org/#home) Exit icon

[Grantee-Implemented Evidence-Based and Evidence-Informed Interventions](https://nadrc.acl.gov/node/140)

## Evaluation and Management (E&M)

E&M codes are used by primary care and memory clinics to bill for assessment, diagnosis, care planning, and follow-up. An advantage of these billing codes is that services can be billed by time, which often increases overall reimbursement. Examples of services and interventions that have been billed using these codes:

* Memory clinic cognitive assessment, diagnosis, care planning, and follow-up
* Care EcoSystems intervention initial cognitive assessment, diagnosis, care planning, and follow-up

Evaluation and Management (E&M)

| Billing Code | Procedure | Time/ Complexity | Notes | Clinicians Who can Use this Code (May Vary by State and Payer) |
| --- | --- | --- | --- | --- |
| 99201–99205 | Office/outpatient visit, new patient | 99201–10 min  99202–20 min  99203–30 min  99204–45 min  99205–60 min  Complexity increases with code number | Standard codes used by clinics to bill for **new** patient clinic visits.  Billing by time for complex patients may result in greater reimbursement—see codes 99354–99358. | Physicians (Phys), nurse practitioners (NP), clinical nurse specialists (CNS), physician assistants (PA) |
| 99211–99215 | Office/outpatient visit, established patient | 99211–5 min  99212–10 min  99213–15 min  99214–25 min  99215–40 min  Complexity increases with code number | Standard codes used by clinics to bill for established patient clinic visits.  Billing by time for complex patients may result in greater reimbursement—see codes 99354–99358. | Phys, NP, CNS, PA |
| 99341–99345 | Home visit | 99341–20 min  99342–30 min  99343–45 min  99344–60 min  99345–75 min  Problem severity increases with code number | New patient | Phys, NP, CNS, PA |
| 99347–99350 | Home visit | 99347–15 min  99348–25 min  99349–40 min  99350–60 min  Problem severity increases with code number | Established patient  Self-limited or minor problem | Phys, NP, CNS, PA |
| 99348 | Home visit | 25 minutes  Low to moderate problem | Established patient | Phys, NP, CNS, PA |
| 99349 | Home visit | 40 minutes  Moderate to high problem | Established patient | Phys, NP, CNS, PA |
| 99350 | Home visit | 60 minutes | Established patient  Patient unstable or significant new problem requiring immediate attention  Place of Service (POS) Code 12—Home | Phys, NP, CNS, PA |

(continued)

Evaluation and Management (E&M) (continued)

| Billing Code | Procedure | Time/ Complexity | Notes | Clinicians Who can Use this Code (May Vary by State and Payer) |
| --- | --- | --- | --- | --- |
| 99354 | Prolonged face-to-face contact with the patient visit | Minimum 30–74 minutes beyond the office visit | Grantees use these codes to bill for new patient visits, follow-up, home visits, cognitive evaluation, and care planning.  99354 can only be billed when there is face-to-face contact with a patient, including a psychotherapy visit. These codes are billed in addition to an office visit code. | Phys, NP, CNS, PA |
| 99355 | Prolonged in-person visit | Each additional 30 minutes | Grantees use these codes to bill for new patient visits, follow-up, home visits, cognitive evaluation, and care planning.  99355 can only be billed when there is face-to-face contact with a patient, including a psychotherapy visit. These codes are billed in addition to an office visit code. | Phys, NP, CNS, PA |
| 99358 | Prolonged service without direct patient contact | Minimum 30–74 minutes | Grantees use these codes to bill for new patient visits, follow-up, home visits, cognitive evaluation, and care planning.  99358 can be billed for a different date of service from the face-to-face contact with a patient. These codes can be billed when doing research, making phone calls to other providers, or phone calls to family members to gather information. | Phys, NP, CNS, PA |
| 99359 | Prolonged service without direct patient contact | Each additional 30 minutes | Grantees use these codes to bill for new patient visits, follow-up, home visits, cognitive evaluation, and care planning.  99359 can be billed for a different date of service from the face-to-face contact with a patient. These codes can be billed when doing research, making phone calls to other providers, or phone calls to family members to gather information. | Phys, NP, CNS, PA |
| 99421 | Online digital evaluation and management service | 5–10 minutes cumulatively, over a period of up to 7 days | Patient-initiated follow-up or check-in contacts with an established patient. | Phys, NP, CNS, PA |

(continued)

Evaluation and Management (E&M) (continued)

| Billing Code | Procedure | Time/ Complexity | Notes | Clinicians Who can Use this Code (May Vary by State and Payer) |
| --- | --- | --- | --- | --- |
| 99422 | Online digital evaluation and management service | 11–20 minutes cumulatively, over a period of up to 7 days | Patient-initiated follow-up or check-in contacts with an established patient | Phys, NP, CNS, PA |
| 99423 | Online digital evaluation and management service | 21 or more minutes cumulatively, over a period of up to 7 days | Patient-initiated follow-up or check-in contacts with an established patient | Phys, NP, CNS, PA |
| 99487 | Non–face-to-face contact with a patient chronic care management | 60 minutes | Revise or establish a comprehensive care plan with moderate- to high-complexity medical decision making | Phys, NP, CNS, PA |
| 99489 | Non–face-to-face chronic contact with a patient care management | Additional 30 minutes |  | Phys, NP, CNS, PA |
| 99490 | Non–face-to-face contact with a patient chronic care management | 20 minutes over the period of a month | Coordination of care across providers  Monthly follow-up  Around-the-clock access to a qualified health care professional who has access to necessary health information to address any urgent needs after hours | Registered nurses, social workers, non-credentialed community health workers (e.g., Care Ecosystems intervention) |

**Examples of ICD-10-CM Diagnostic Codes and Modifiers**

99205, 99212, and 99215: G31.84, F41.1, F43.23, F43.22, F41.9

**Resources**

*Prolonged Service Resources:*

[Prolonged Services](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm5972.pdf)

[Specific criteria must be met to use prolonged services codes](https://www.aappublications.org/news/2018/01/10/Coding010518) Exit icon

*Chronic Care Management Resources:*

CMS Chronic Care Management Toolkit (

<https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/CCM-Toolkit-Updated-Combined-508.pdf )>

[American Academy of Family Physicians Chronic Care Management](https://www.aafp.org/practice-management/payment/coding/medicare-coordination-services/chronic-care.html#:~:text=The%20four%20CPT%20codes%20used,providers%20and%20support%20patient%20accountability) Exit icon

[Medicare Learning Network Chronic Care Management](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf)

[Frequently Asked Questions](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Payment_for_CCM_Services_FAQ.pdf)

*Evidence-Based Intervention Resources:*

[Best Practice Caregiving](https://bpc.caregiver.org/#home) Exit icon

[Grantee-Implemented Evidence-Based and Evidence-Informed Interventions](https://nadrc.acl.gov/node/140)

## Evaluation, Services, and Cognitive Testing for Rehabilitative Medicine

ACL grantees have used the billing codes for Occupational Therapy (OT) Evaluation, Services, and Cognitive testing to bill for services delivered by OTs. ACL grantees that provide OT services often do so in the home rather than in a clinic setting. However, the reimbursed rate often does not cover the full cost of services in the home.

Dementia services are billed for the patient, who is the person living with dementia. Caregiver education is an integral part of providing OT services to people with cognitive impairment and may be billed using these service codes, even though the patient is the person living with dementia.

Examples of services and interventions that have been billed using these codes:

* Care of Persons with Dementia in Their Environments (COPE) intervention
* [Skills2Care®](https://www.jefferson.edu/university/rehabilitation-sciences/jefferson-elder-care/professional-training.html) intervention
* Medication management

Evaluation, Services, and Cognitive Testing for Rehabilitative Medicine

| Billing Code | Procedure | Time/ Complexity | Notes | Clinicians Who can Use this Code (May Vary by State and Payer) |
| --- | --- | --- | --- | --- |
| 97110 | Therapeutic procedure/ Therapeutic exercise | 15-minute units |  | Occupational therapist (OT), physical therapist (PT), speech language pathologist (SLP) |
| 97112 | Neuromuscular reeducation | 15-minute units |  | OT, PT, SLP |
| 96125 | Cognitive performance testing | Untimed | Requires interpretation of results and written report  Check with the insurer to confirm it will cover this service | OT, PT, SLP, |
| 97129 | Cognitive function intervention | Initial 15 minutes | Multiple units of 97130 can follow the initial use of 97129 | Physicians (Phys), nurse practitioners (NP) psychologists (CP), physician assistants (PA), clinical nurse specialists (CNS), OT, SLP, PT |

(continued)

Evaluation, Services, and Cognitive Testing for Rehabilitative Medicine (continued)

| Billing Code | Procedure | Time/ Complexity | Notes | Clinicians Who can Use this Code (May Vary by State and Payer) |
| --- | --- | --- | --- | --- |
| 97130 | Cognitive function intervention | Additional 15 minutes | Multiple units of 97130 can follow the initial use of 97129 | OT, Phys, NP, CP, SLP, PT, PA, CNS |
| 97165 | OT evaluation | Untimed (typically 30 minutes)  Low complexity | The OT evaluation level of complexity is determined by the occupational therapist | OT |
| 97166 | OT evaluation | Untimed (typically 45 minutes)  Moderate complexity | The OT evaluation level of complexity is determined by the occupational therapist | OT |
| 97167 | OT Evaluation | Untimed (typically 60 minutes)  High complexity | The occupational therapist must determine if the complexity of the evaluation warrants this code. The CPT Code Book provides guidance on each complexity level. Also refer to the [American Occupational Therapy Association](https://www.aota.org/) Exit icon. | OT |
| 97168 | OT reevaluation | Untimed |  | OT |
| 97530 | Therapeutic activities | 15-minute units |  | OT, PT, SLP |
| 97533 | Sensory integration | 15-minute units | When completing interventions for persons living with moderate cognitive impairment who are supported by their caregiver, sensory diets may become part of a care approach to mitigate behaviors. | OT, PT, SLP |
| 97535 | Self-care/Home management training | 15-minute units |  | OT, PT, SLP |
| 97755 | Assistive technology assessment | 15-minute units | Requires interpretation of results and written report. | OT, PT, SLP |

**Examples of ICD-10-CM Diagnostic Codes and Modifiers**

Medical diagnoses: G31.83, G30.8, G30.9, F03.9, G30.1, F03.91, F01.5, F01.51, G21.4

Treatment diagnoses: Z74.1, Z74.8, Z74.3

**Resources**

*Evidence-Based Intervention Resources:*

[Best Practice Caregiving](https://bpc.caregiver.org/#home) Exit icon

[Grantee-Implemented Evidence-Based and Evidence-Informed Interventions](https://nadrc.acl.gov/node/140)

## Health Behavior Assessment and Intervention (HBAI)

HBAI codes are used to bill for services provided by or under the supervision of a clinical psychologist that address symptom management, unsafe behaviors, or other “cognitive, emotional, or psychosocial factors that affect the treatment or management of one or more physical health conditions” (National Council on Aging, 2018). For example, a chronic disease self-management education program could be billed using these codes. Dementia services may be provided to a person living with dementia, their family, or a group. If these same services are provided by a physician, nurse practitioner, or physician assistant, they are billed using E&M codes rather than HBAI codes.

Note: These are medical codes, not mental health codes; there must be a medical diagnosis, not a psychiatric/mental health diagnosis. Some insurers classify Alzheimer’s disease and other dementias as a psychiatric or mental health condition (American Psychological Association, 2018).

One ACL grantee will begin using these codes shortly and several others are exploring their use for services such as [REACH Community](https://bpc.caregiver.org/#programDetails/24) Exit icon and [Savvy Caregiver Program™](https://bpc.caregiver.org/#programDetails/5) Exit icon interventions.

Health Behavior Assessment and Intervention (HBAI)

| Billing Code | Procedure | Time/ Complexity | Notes | Clinicians Who can Use this Code (May Vary by State and Payer) |
| --- | --- | --- | --- | --- |
| 96156 | Health behavior assessment or reassessment (i.e., health-focused clinical interview, observations, clinical decision making) | Untimed | Dementia must not be severe enough for the intervention to be ineffective (as defined by the insurer) | Clinical psychologist or auxiliary staff directly supervised by a clinical psychologist, such as licensed clinical social worker.  Verify approved auxiliary staff providers with the MAC and insurers. |
| 96158 | Health behavior intervention, individual | Initial 30 minutes | Individual, face-to-face contact with a patient | See explanation in 96156 above |
| 96159 | Health behavior intervention, individual | Each additional 15 minutes | Individual, face-to-face contact with a patient | See explanation in 96156 above |
| 96164 | Health behavior intervention, group | Initial 30 minutes | Group of two or more patients, face-to-face contact with a patient | See explanation in 96156 above |
| 96165 | Health behavior intervention, group | Each additional 15 minutes | Group of two or more patients, face-to-face contact with a patient | See explanation in 96156 above |

(continued)

Health Behavior Assessment and Intervention (HBAI) (continued)

| Billing Code | Procedure | Time/ Complexity | Notes | Clinicians Who can Use this Code (May Vary by State and Payer) |
| --- | --- | --- | --- | --- |
| 96167 | Health behavior intervention, family with patient | Initial 30 minutes | Family (with the patient present), face-to-face contact with a patient | See explanation in 96156 above |
| 96168 | Health behavior intervention, family with patient | Each additional 15 minutes | Family (with the patient present), face-to-face contact with a patient | See explanation in 96156 above |
| 96170 | Health behavior intervention, family without patient | Initial 30 minutes | Family (without the patient present), face-to-face contact with patient | See explanation in 96156 above |
| 96171 | Health behavior intervention, family without patient | Each additional 15 minutes, up to 1 hour | Family (without the patient present), face-to-face contact with patient | See explanation in 96156 above |

**Examples of ICD-10-CM Diagnostic Codes and Modifiers**

None at this time, several grantees will begin billing to these codes soon.

**Resources**

[National Council on Aging: Health and Behavior Assessment / Intervention (HBAI)](https://www.ncoa.org/wp-content/uploads/HBAI-Information-Resource_CMS-Reviewed_FINAL.pdf) Exit icon

*Evidence-Based Intervention Resources:*

[Best Practice Caregiving](https://bpc.caregiver.org/#home) Exit icon

[Grantee-Implemented Evidence-Based and Evidence-Informed Interventions](https://nadrc.acl.gov/node/140)

# Elements of Developing a Billing Infrastructure

Successful billing requires a robust operational structure. The process to institute billing is complex and requires substantial time. It is important to understand that some services and service components cannot be billed, and that reimbursement typically does not cover the full cost of services.

This section outlines key elements for organizations to understand and establish. The items are not listed in a chronological order; your organization will need to consider many of these elements simultaneously.

## Third-Party Payer Enrollment

Individual clinicians or providers must be enrolled with each payer. Once credentialing is approved, payment can be made retroactively within time limits.

* **Medicare provider enrollment**—To bill services to Medicare, the organization must enroll as a Medicare provider:
  + Providers must obtain a National Provider Identifier (NPI) before enrolling in Medicare. Providers obtain an NPI online via the [National Plan & Provider Enumeration System](https://nppes.cms.hhs.gov/#/).
  + Enroll as a Medicare **fee-for-service** provider:
    - Medicare provider enrollment is managed in the [PECOS system](https://pecos.cms.hhs.gov/pecos/-). There is an annual cost to enroll as a Medicare provider both for your agency and each of your individual providers.

Payment for billed services will be assigned to your agency.

This [CMS PowerPoint](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/2019_National_Provider_Enrollment_Conference_Provider_Enrollment_101.pdf) provides a tutorial covering all the steps to provider enrollment.

* + - CMS hosts a [National Provider Enrollment Conference](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Provider-Enrollment-Events).
  + Connect to Your Regional MAC:
    - When you enroll as a Medicare provider in PECOS, your MAC will be identified, and an analyst at your MAC will be assigned to assist in the completion of the enrollment process.
    - You may also enroll as a Medicare provider through [your MAC](https://www.cms.gov/Medicare/Provider-Enrollment-and%20Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf), but the process generally takes longer.
* **Medicaid Provider Enrollment** 
  + Medicaid reimbursement rates vary by state but are [typically much less](https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D) Exit icon than those of Medicare and private insurers (Kaiser Family Foundation, 2016).
  + Learn about Medicaid provider enrollment through the [Medicaid Provider Enrollment Compendium](https://www.medicaid.gov/sites/default/files/2019-12/mpec-7242018.pdf).
  + Enroll as a Medicaid provider through your State Department of Health. Specific instructions can be found by conducting a web search using the terms “state” + “Medicaid provider enrollment” (replace “state” with the name of the state where you seek to enroll).
  + Additional information on Medicaid provider enrollment is available in this [CMS presentation](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/2019_National_Provider_Enrollment_Conference_Medicaid_Provider_Enrollment.pdf).
  + CMS hosts a [National Provider Enrollment Conference](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Provider-Enrollment-Events).
* **Private Insurance Provider Enrollment** 
  + Identify private insurers that you will bill, including Medicare Advantage and Medicaid managed care plans.
  + Each insurer’s website will provide directions on their provider enrollment process. Here is a link to [Anthem’s](https://www.anthem.com/provider/credentialing/?cnslocale=en_US_mo) enrollment webpage as an example.
  + Many insurers use a national credentialing database such as the [Council for Affordable Quality Healthcare (CAQH) ProView](https://proview.caqh.org/) Exit icon to enroll their providers. This allows the provider to enroll with a number of private insurers at the same time.
  + Payment processes, coverage, and speed of claims processing vary by insurer. It is important to understand the billing practices of each insurer that you will bill.
  + Determine which clinicians will be enrolled with each insurer and if separate credentialing contracts are necessary (as in private/group practices).
* **Contracting Enrollment Services**
  + Each provider should consider its capacity to effectively execute the enrollment process.
  + Another option is to use the services of a private agency to enroll providers in Medicare, credential clinicians, and update CAQH databases. If you are considering using a third-party agency for billing, it may also assist you with the enrollment process.

#### Determining Who Will Do the Billing

* **Hire staff with medical billing experience**—Hiring the right staff is critical. Experienced billers will understand the procedure and diagnostic codes and modifiers. They will also be familiar with the reimbursement rates for various insurers and the state Local Coverage Determinations that define what will be covered and how it will be covered in the state(s) that you bill.

OR

* **Hire a third-party billing agency**—This is strongly suggested by grantees if an agency is new to the billing process. Third-party billers have the expertise to identify and resolve many common billing issues and help you to identify the practices that will ensure the highest return for services provided. As an example, they will know diagnostic code modifiers that enhance your level of reimbursement with the insurers that you bill. To find a quality third-party billing agency in your region, you may want to solicit recommendations from other providers in your area.

#### Other Billing Structure Components

* **Health Insurance Portability and Accountability Act (HIPAA) Compliance—**There is no certification process for HIPAA compliance. Agencies are required to demonstrate HIPAA compliance by having written policies and procedures in place that protect the privacy of patients and their health care records. CMS provides guidance to achieving and maintaining [HIPAA](https://www.hhs.gov/hipaa/for-professionals/index.html) compliance. Check website for updates regularly.
* **Process for Determination of Services to be Billed**
  + Finalize the services you will bill for, and to what payers.
  + Identify CPT® codes for each billable component of care.
  + Identify corresponding diagnostic code(s) and modifiers. Examples are provided at the bottom of each table.
  + Electronic Medical Records (EMR) and Electronic Billing Software may have the billing and diagnostic codes preprogrammed (provided via drop-down list for selection).
* **Proper documentation of care**—Necessary care must be provided and documented in compliance with payer requirements. This includes:
  + Obtaining/documenting prior approval from payer if required.
  + Obtaining a physician’s orders for the service, if required.
  + Developing a required care plan or partnering with a physician or qualified health care provider who develops and signs the care plan.
  + Documenting specific elements of care as required, such as medical history, exam, and complexity of provider decision making.
* **Electronic Medical Records—**Maintaining electronic (or handwritten) documentation/patient records:
  + Streamlines patient records and maintains timely documentation, which can reduce delays in treatment and increase accuracy and clarity of records.
  + Maintains documentation needed to justify billing.
  + Provides diagnostic codes and modifiers to optimize billing and CPT® codes for billing.
  + The newest EMR software includes built-in electronic billing software.
  + EMR software varies greatly and is dependent on the type of patients you will be seeing and the services that you will deliver. One grantee tested 20 EMR systems before selecting one based on its flexibility and the ability to support the types of services it was delivering.
* **Electronic Billing Software** 
  + Optimally, it may be a built-in component of your EMR software so that the processes operate seamlessly.
  + If not integrated, it is important that the electronic billing software interfaces seamlessly with the EMR software.
  + Provides the billing codes and diagnostic codes and modifiers that generate invoices to optimize payment for services.
  + The billing software connects to one of the approved billing clearinghouses that initiates the payment process with the appropriate third party payer (CMS, 2019).

#### Denials, Appeals, and Audits

* **Denials** 
  + Once a claim is processed, it may be denied for a variety of reasons, including missing information, submission past the required time limit, a service that is not covered, or services that have been billed incorrectly (Marting, 2015).
  + It takes time to determine and understand the billing requirements of different payers. Clinicians may need education on the appropriate CPT® and ICD-10-CM codes and modifiers to use for different types of services to avoid denials.
* **Appeals**
  + Be prepared for many claim denials, especially when instituting a new billing system or billing for a new service.
  + Claims denied by private insurance companies can be appealed, and each insurer will provide information on its appeals process. Visit the Anthem website to view an [example of one insurer’s appeals process](https://www.anthem.com/docs/public/inline/CLAIMS_CE_00001.pdf) Exit icon.
  + Medicare claims (CMS, 2005)
    - Minor claim errors or omissions may be corrected without going through the appeals process.
    - The [Medicare appeals process](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM4019.pdf) has five levels, each with its own adjudicating body. The first level of appeal is to the MAC and may be submitted by the patient or the provider.
    - File appeals promptly and in writing.
    - Consolidate similar claims into one appeal.
    - Include copies of all required documentation (decision letter, request for repayment, etc.).
* **Medicare Compliance and Audits**
  + Consider instituting an internal compliance and ethics committee. Such a group can oversee an internal controls process to ensure that new policies and regulations are adhered to.
  + CMS employs [multiple programs](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Overview) to educate providers on billing policies and to reduce instances of Medicare overpayment (CMS, 2020c).
  + The federal government contracts with [Recovery Audit Contractors](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program) that review past claims for evidence of over- or underpayment (CMS, 2020d).
  + Automated reviews are completed using electronic claims data; the provider is notified of an overpayment through a Demand letter (CMS, 2013, 2020b).
  + Complex reviews include a review of medical records, requested from the provider. Most of these audits look at whether the service was medically necessary (CMS, 2013).

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