

NO. 91546

PSYCHOLOGICAL EVALUATION AND MANAGEMENT OF NON-MENTAL HEALTH DISORDERS

Effective: 06/01/2026**Committee Review:** 05/13/2026**Last Updated:** 05/13/2026

Instructions for use: This document is for informational purposes only. Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable. Eligibility and benefit coverage are determined in accordance with the terms of the member's plan in effect as of the date services are rendered. It is not an authorization, certification, explanation of benefits, or contract. Receipt of benefits is subject to satisfaction of all terms and conditions of coverage. Priority Health's medical policies are developed with the assistance of medical professionals and are based upon a review of published and unpublished information including, but not limited to, current medical literature, guidelines published by public health and health research agencies, and community medical practices in the treatment and diagnosis of disease. Because medical practice, information, and technology are constantly changing, Priority Health reserves the right to review and update its medical policies at its discretion. Priority Health's medical policies are intended to serve as a resource to the plan. They are not intended to limit the plan's ability to interpret plan language as deemed appropriate. Physicians and other providers are solely responsible for all aspects of medical care and treatment, including the type, quality, and levels of care and treatment they choose to provide.

Policy scope: This medical policy addresses health and behavioral assessment and brief intervention provided by licensed clinicians (LP, LLP, LMSW, LPC, LMFT) when provided as part of a comprehensive medical program.

Related policies: Not applicable

I. MEDICAL NECESSITY CRITERIA

- A. Priority Health covers health and behavioral assessment and brief intervention provided by licensed clinicians (LP, LLP, LMSW, LPC, LMFT) when provided as part of a comprehensive medical program approved by Priority Health. Examples include comprehensive spine, weight, feeding disorders, palliative care and advance care planning programs. Services are billed with a primary medical diagnosis in 15 minute units.
- B. Indications: CPT codes 96156, 96158-96159 are reported to describe services, performed to address difficulties associated with an acute or chronic illness, prevention of a physical illness or disability and maintain health, that do not meet criteria for a psychiatric diagnosis.

1. The Health and Behavioral Assessment or re-assessment, (CPT code 96156, and Intervention services (CPT codes 96158-96159) may be considered reasonable and necessary for the member who meets all of the following criteria:
 - a. The member has an underlying physical illness or injury, and
 - b. There is reason to believe that a biopsychosocial factor may be significantly affecting the treatment, or medical management of an illness or an injury, and
 - c. The member is alert, oriented and has the capacity to understand and to respond meaningfully during the face-to-face encounter, and
 - d. The member has a documented need for psychological support in order to successfully manage his/her physical illness, and activities of daily living, and
 - e. The assessment is not duplicative of other provider assessments
2. Health and Behavioral Re-assessment (CPT code 96156) will be considered reasonable and necessary, if documentation indicates that there has been a sufficient change in mental or medical status warranting re-evaluation of the member's capacity to understand and to respond meaningfully to the psychological intervention.
3. Health and Behavioral Intervention, individual or group (two or more members) (CPT codes 96164-96165) require that:
 - a. Specific psychological intervention(s) and member outcome goal(s) have been clearly identified, and
 - b. Psychological intervention is necessary to address:
 - i. Non-adherence with the medical treatment plan, or
 - ii. The biopsychosocial factors associated with a new diagnosed physical illness, or an exacerbation of an established physical illness, when such factors affect symptom management and expression, health-promoting behaviors, health-related risk-taking behaviors, and overall adjustment to medical illness.
4. Health and Behavioral Intervention (with the family and member present) (CPT code 96167) is considered reasonable and necessary for the member who meets all of the following criteria:
 - a. The family representative directly participates in the overall care of the member, and
 - b. The psychological intervention with the member and family is necessary to address biopsychosocial factors affecting adherence with the plan of care, symptom management, health-promoting behaviors, health-related risk-taking behaviors, and overall adjustment to medical illness.

For the purpose of this policy, "family representative" is defined as: immediate family member's husband, wife, partner, siblings, children, grandchildren, grandparents, mother, and father, any primary caregiver who provides care on a voluntary, uncompensated, regular, sustained basis, guardian or healthcare proxy.

C. Limitations

1. Health and Behavioral Assessment/Intervention is not considered reasonable and necessary for members who:
 - a. Do not have an underlying physical illness or injury, or
 - b. Who have no documented indication that a biopsychosocial factor may be significantly affecting the treatment, or medical management of an illness or injury, or
 - c. Do not have the capacity to understand and to respond meaningfully during the face-to-face encounter, because of:
 - i. Dementia that has produced severe enough cognitive defect for the psychological intervention to be ineffective.
 - ii. Delirium
 - iii. Severe and profound cognitive impairment
 - iv. Persistent vegetative state or no discernible consciousness,
 - v. Impaired mental status (orientation to all three spheres), e.g.
 - disorientation to person, time, place, purpose, or
 - inability to recall current season, location of own room, names and faces, or
 - inability to recall that he or she is in a nursing home or skilled nursing facility

Alternative codes exist for coding these conditions.

2. Health and Behavioral Assessment/Intervention is not considered reasonable and necessary for members who do not require psychological support to successfully manage his/her physical illness through identification of the barriers to the management of physical disease and activities of daily living.
3. Health and Behavioral Assessment/Intervention is not considered reasonable and necessary for members who do not have the conditions noted in Section II, A.
4. Health and Behavioral Intervention with the family and member present is not considered reasonable and necessary for the member if:
 - a. It is not necessary to ensure member compliance with the medical treatment plan, or
 - b. The family representative does not directly participate in the plan of care, or
 - c. The family representative is not present.
 - d. There is no face-to-face encounter with the member.
5. Health and Behavioral Intervention services are not considered reasonable and necessary to:
 - a. Update or educate the family about the member's condition
 - b. Educate non-immediate family members, non-primary caregivers, non-guardians, the non-health care proxy, and other members of the treatment team, e.g., health aides, nurses, physical or occupational therapists, home health aides, personal care attendants and co-workers about the member's care plan.
 - c. Treatment-planning with staff
 - d. Mediate between family members or provide family psychotherapy

- e. Educate diabetic members and diabetic members' family members
 - f. Deliver Medical Nutrition Therapy
 - g. Maintain the member's or family's existing health and overall well-being
 - h. Provide personal, social, recreational, and general support services (these may be valuable adjuncts to care; however, they are not psychological interventions).
6. Health and Behavioral Assessment/Intervention (CPT codes 96156,96158-96159) may be performed by licensed clinicians (FLP, LLP, LMSW, LPC, LMFT). These codes are not intended for use with physician services (example: medical doctor, nurse practitioner, physician assistant, clinical nurse practitioner).
 7. Providers must be credentialed by Priority Health to provide these services. Providers credentialed to provide these services must be part of comprehensive management programs (e.g., spine, weight loss, feeding disorders, palliative care, advance care planning).
 8. Health and Behavioral Assessment/Intervention is not a covered benefit in the home setting.
 9. Examples of services that are not considered part of Health and Behavioral Intervention services are:
 - a. Stress management for support staff
 - b. Replacement for expected nursing home staff functions
 - c. Music appreciation and relaxation
 - d. Craft skill training
 - e. Cooking classes
 - f. Comfort care services
 - g. Individual social activities
 - h. Teaching social interaction skills
 - i. Socialization in a group setting
 - j. Retraining cognition due to dementia
 - k. General conversation
 - l. Services directed toward making a more dynamic personality
 - m. Consciousness raising
 - n. Vocational or religious advice
 - o. General educational activities
 - p. Tobacco or caffeine withdrawal support
 - q. Visits for loneliness relief
 - r. Sensory stimulation
 - s. Games, including bingo games
 - t. Project, including letter writing
 - u. Entertainment
 - v. Excursions, including shopping outing, even when used to reduce a dysphoric state
 - w. Teaching grooming skills
 - x. Grooming services
 - y. Monitoring activities of daily living
 - z. Teaching the member simple self-care
 - aa. Teaching the member to follow simple directives
 - bb. Wheeling the member around the facility
 - cc. Orienting the member to name, date, and place

- dd. Exercise programs, even when designed to reduce a dysphoric state
 - ee. Memory enhancement training
 - ff. Weight loss management, unless associated with comprehensive weight loss program
 - gg. Case management services including but not limited to planning activities of daily living,
 - hh. Arranging care or excursions, or resolving insurance problems
 - ii. Activities principally for diversion
 - jj. Planning for milieu modifications
 - kk. Contributions to member care plans
 - ll. Maintenance of behavioral logs
- D. Documentation requirements: Because of the impact on the medical management of the patient's disease, documentation must show evidence of coordination of care with the patient's primary medical care providers or medical provider responsible for the medical management of the physical illness that the psychological assessment/intervention addresses.

Documentation in the medical record by a licensed clinician (LP, LLP, LMSW, LPC, LMFT) must include:

1. Evidence of a referral, for the initial assessment and for each reassessment, to the licensed clinician (LP, LLP, LMSW, LPC, LMFT) by the medical provider responsible for the medical management of the member's physical illness.
2. Evidence of coordination of care with the member's primary medical care providers or medical provider responsible for the medical management of the physical illness that the psychological assessment/intervention was meant to address.
3. The diagnosis (ICD-10 CM code) that reflect the condition of the member, and indicate the reason(s) for which the service was performed
4. Initial assessment (CPT code 96156) documentation in the medical record by the licensed clinician (LP, LLP, LMSW, LPC, LMFT) must include evidence to support that the assessment is medically and clinically reasonable and necessary, and must include, at a minimum, the following elements:
 - a. Date of initial diagnosis of physical illness, and
 - b. Clear rationale for why assessment is required, and
 - c. Assessment outcome including mental status and ability to understand and to respond meaningfully, and
 - d. Goals, objectives, and expected duration of specific psychological intervention(s), if recommended
5. Reassessment (CPT code 96156) documented must include the following elements:
 - a. Date of change in mental or physical status, and
 - b. Clear rationale for why re-assessment is required, and
 - c. Clear indication of the precipitating event that necessitates re-assessment.
6. Intervention service, (CPT code 96158 – 96159) documentation to support that the intervention is reasonable and necessary must include, at a minimum, the following elements:

- a. Evidence that the member has the capacity to understand and to respond meaningfully, and
 - b. Clearly defined psychological intervention plan and goals, and
 - c. The goals of the psychological intervention should clearly state how the psychological intervention is expected to improve compliance with the medical treatment plan, and
 - d. The response and progress to the intervention must be indicated, and
 - e. Rationale for frequency and duration of services as evidenced by progress toward goals or lack thereof, and/or new and continued stressors and precipitants.
7. The time duration (stated in minutes) for each visit spent in the health and behavioral assessment or intervention encounter.

Medical records need not be submitted with the claim; however, the medical record, e.g., complete nursing home record, doctor’s orders, progress notes, office records, and nursing notes, must be available to the carrier upon request.

II. CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) COVERAGE DETERMINATION

Any applicable federal or state mandates will take precedence over this medical coverage policy.

Medicare: Refer to the [CMS Online Manual System \(IOMs\)](#) and Transmittals. For the most current applicable CMS National Coverage Determination (NCD)/Local Coverage Determination (LCD)/Local Coverage Article (LCA) refer to [CMS Medicare Coverage Database](#).

The information below is current as of the review date for this policy. However, the coverage issues and policies maintained by CMS are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. MAC jurisdiction for purposes of local coverage determinations is governed by the geographic service area where the Medicare Advantage plan is contracted to provide the service. Please refer to the Medicare [Coverage Database website](#) for the most current applicable NCD, LCD, LCA, and CMS Online Manual System/Transmittals.

National Coverage Determinations (NCDs)	
None identified	
Local Coverage Determinations (LCDs)	
CGS Administrators, LLC	None identified
First Coast Service Options, Inc.	None identified
National Government Services, Inc.	Health and Behavior Assessment/Intervention A52434*
Noridian Healthcare Solutions	None identified
Novitas Solutions, Inc.	None identified
Palmetto GBA	Health and Behavior Assessment/Intervention L37638 A56526
WPS Insurance Corporation	None identified

*Not an LCD Reference Article

III. BACKGROUND

Health and Behavior Assessment procedures identify the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment or management of physical health problems. The focus of the assessment is not on mental health but on the biopsychosocial factors important to physical health problems and treatments.

Health and Behavior Intervention procedures modify the psychological, behavioral, emotional, cognitive, and social factors important to or directly affecting the member's physiological functioning, health and well-being, or specific disease-related problems.

IV. GUIDELINES / POSITION STATEMENTS

Medical/Professional Society	Guideline
American Psychological Association (APA)	APA Guidelines on Evidence-Based Psychological Practice in Health Care (APA, 2021)
American Medical Association (AMA)	Behavioral Health Integration Compendium (AMA, 2024)

V. REGULATORY (US FOOD AND DRUG ADMINISTRATION)

See [U.S. Food & Drug Administration \(FDA\) Medical Device Databases](#) for the most current information.

VI. CODING

See also [Priority Health Billing Policy No. 054 Behavioral Health](#)

See also *Priority Health Medical Policy No. 91636 - Category III Current Procedural Terminology (CPT®) Codes ("T" codes)*

See also the following resources:

[American Medical Association \(AMA\) Behavioral health coding guide
Health Behavior Assessment and Intervention Services](#)

ICD-10 Codes that **DO NOT** support medical necessity

F01-F99 Mental, Behavioral and Neurodevelopmental disorders
R45.0-R4589 Symptoms and signs involving emotional state
R46.0 – R46.89 Symptoms and signs involving appearance and behavior

CPT/HCPCS Codes

Not medically necessary for social worker (MSW) for Priority Health Medicare.

*Payment to facility providers is limited to Behavioral Health service providers.
Not medically necessary in the home setting.*

- 96156 Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)
- 96158 Health behavior intervention, individual, face-to-face; initial 30 minutes
- 96159 Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
- 96164 Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes
- 96165 Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
- 96167 Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes
- 96168 Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service (*not medically necessary*))
- 96170 Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes (*not medically necessary*)
- 96171 Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)

DOCUMENTATION REQUIREMENTS

Because of the impact on the medical management of the patient's disease, documentation must show evidence of coordination of care with the patient's primary medical care providers or medical provider responsible for the medical management of the physical illness that the psychological assessment/intervention addresses.

Documentation in the medical record by a licensed clinician (LP, LLP, LMSW, LPC, LMFT) must include:

1. Evidence of a referral, for the initial assessment and for each reassessment, to the licensed clinician (LP, LLP, LMSW, LPC, LMFT) by the medical provider responsible for the medical management of the member's physical illness.
2. Evidence of coordination of care with the member's primary medical care providers or medical provider responsible for the medical management of the physical illness that the psychological assessment/intervention was meant to address.
3. The diagnosis (ICD-10 CM code) that reflect the condition of the member, and indicate the reason(s) for which the service was performed
4. Initial assessment (**CPT code 96156**) documentation in the medical record by the licensed clinician (LP, LLP, LMSW, LPC, LMFT) must include evidence to support that the assessment is medically and clinically reasonable and necessary, and must include, at a minimum, the following elements:
 - a. Date of initial diagnosis of physical illness, and
 - b. Clear rationale for why assessment is required, and
 - c. Assessment outcome including mental status and ability to understand and to respond meaningfully, and

- d. Goals, objectives, and expected duration of specific psychological intervention(s), if recommended
5. Reassessment (**CPT code 96156**) documented must include the following elements:
 - a. Date of change in mental or physical status, and
 - b. Clear rationale for why re-assessment is required, and
 - c. Clear indication of the precipitating event that necessitates reassessment.
 6. Intervention service, (**CPT code 96158 – 96159**) documentation to support that the intervention is reasonable and necessary must include, at a minimum, the following elements:
 - a. Evidence that the member has the capacity to understand and to respond meaningfully, and
 - b. Clearly defined psychological intervention plan and goals, and
 - c. The goals of the psychological intervention should clearly state how the psychological intervention is expected to improve compliance with the medical treatment plan, and
 - d. The response and progress to the intervention must be indicated, and
 - e. Rationale for frequency and duration of services as evidenced by progress toward goals or lack thereof, and/or new and continued stressors and precipitants.
 7. The time duration (stated in minutes) for each visit spent in the health and behavioral assessment or intervention encounter.

Medical records need not be submitted with the claim; however, the medical record, e.g., complete nursing home record, doctor's orders, progress notes, office records, and nursing notes, must be available to the carrier upon request.

VII. **MEDICAL NECESSITY REVIEW**

Prior authorization for certain drugs, devices, services and procedures may or may not be required. In cases where prior authorization is required, providers will submit a request demonstrating that a drug, service or procedure is medically necessary. For more information, refer to the [Priority Health Provider Manual](#), specifically the following pages:

[Behavioral health services](#)

[Behavioral health services in the primary care / medical setting](#)

Individual case review may allow coverage for care or treatment that is investigational yet promising for the conditions described. Requests for individual consideration require prior plan approval. All determinations of coverage for experimental, investigational, or unproven treatment will be made by a Priority Health medical director or clinical pharmacist. The exclusion of coverage for experimental, investigational, or unproven treatment may be reviewed for exception if the condition is either a terminal illness, or a chronic, life threatening, severely disabling disease that is causing serious clinical deterioration.

VIII. APPLICATION TO PRODUCTS

Coverage is subject to the member's specific benefits. Group-specific policy will supersede this policy when applicable.

- **HMO/EPO:** This policy applies to insured HMO/EPO plans.
- **POS:** This policy applies to insured POS plans.
- **PPO:** This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.
- **ASO:** For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.
- **INDIVIDUAL:** For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.
- **MEDICARE:** Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, this policy applies.
- **MEDICAID/HEALTHY MICHIGAN PLAN:** For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the [Michigan Medicaid Fee Schedule](#). If there is a discrepancy between this policy and the [Michigan Medicaid Provider Manual](#), the Michigan Medicaid Provider Manual will govern. If there is a discrepancy or lack of guidance in the Michigan Medicaid Provider Manual, the Priority Health contract with Michigan Medicaid will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.

IX. REFERENCES

SUMMARY OF CHANGES

No changes to medical necessity criteria.

Past committee review dates: 10/2007, 10/2008, 10/2009, 06/2010, 06/2011, 06/2012, 06/2013, 08/2014, 08/2015, 08/2016, 08/2017, 08/2018, 08/2019, 08/2020, 08.2021, 08/2022, 08/2023, 05/2024, 05/2025

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