

## **MHPG Demographics and Coding Survey/2020**

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### **Background**

The Mental Health Professional Group (MHPG) of the American Society for Reproductive Medicine (ASRM) completed a demographic survey of its membership in 2001. At that time, the membership stood at 146. Of that number, 25% returned questionnaires. Highlights of the report include following results:

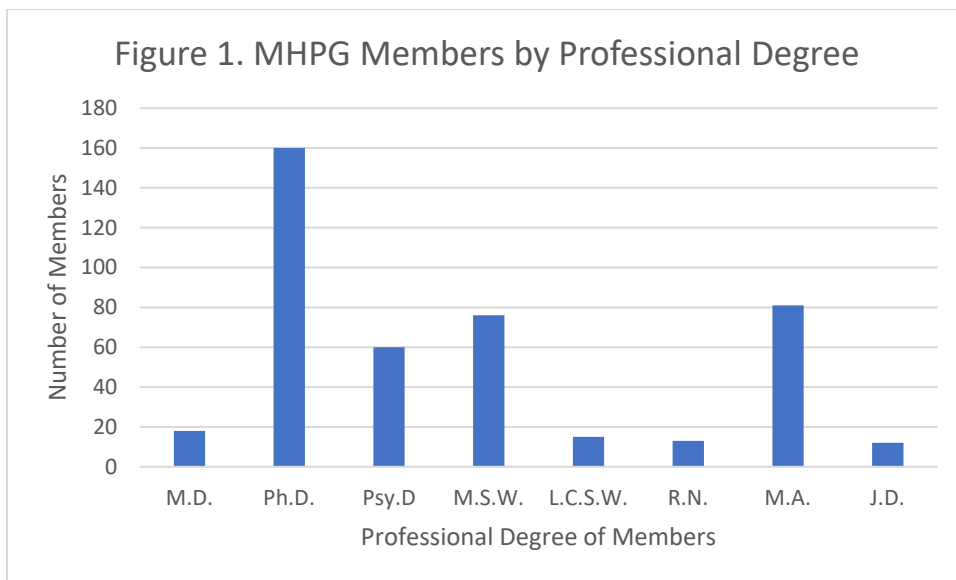
1. 69% of the respondents were between the age of 41 and 60.
2. 87.8% of the respondents were female.
3. 73% of the respondents reported they had received treatment for their own infertility.
4. 90.5% of the respondents reported their race as Caucasian.
5. 51% of the respondents reported they received their professional degrees prior to 1981.
6. 45.4% of the respondents held the doctoral degree (Ph.D. or Psy. D.) and 28% held the MSW degree.
7. There was a high percentage of experienced clinicians in the respondent pool. 50% had 19-30 years of clinical experience and 50% reported that they had worked in the infertility field between 13 and 25 years.
8. 47.5% reported that their practices were between 61 and 80% composed of infertility patients/clients.
9. 87.5% reported that they had no formal training in infertility counseling other than postgraduate courses offered by the MHPG.
10. 26% of the respondents reported work exclusively in infertility clinics. The remainder reported either a completely independent practice (53%) or some combination of clinic and private work (21%).

In 2020 a similar survey was completed by MHPG with some of the original items removed and a section on coding added. The intent of the survey was to provide leadership with a closer look at the composition of the membership and a sense of how members approached one of the more challenging tasks of practice, the procedure codes for services that members used for reimbursement purposes, either for themselves or for those clients/patients attempting to submit their bills for insurance reimbursement.

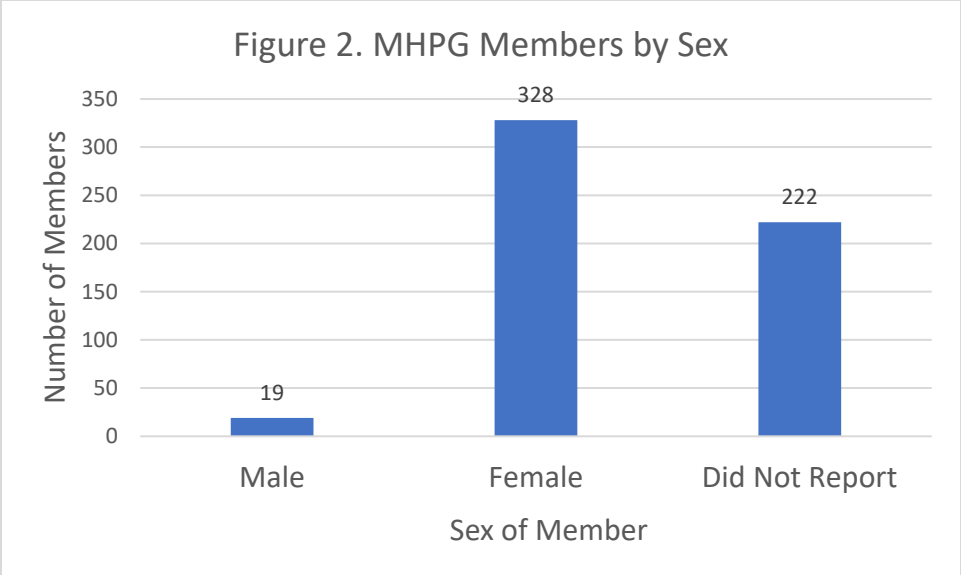
### **Current Findings**

From the ASRM Membership Database

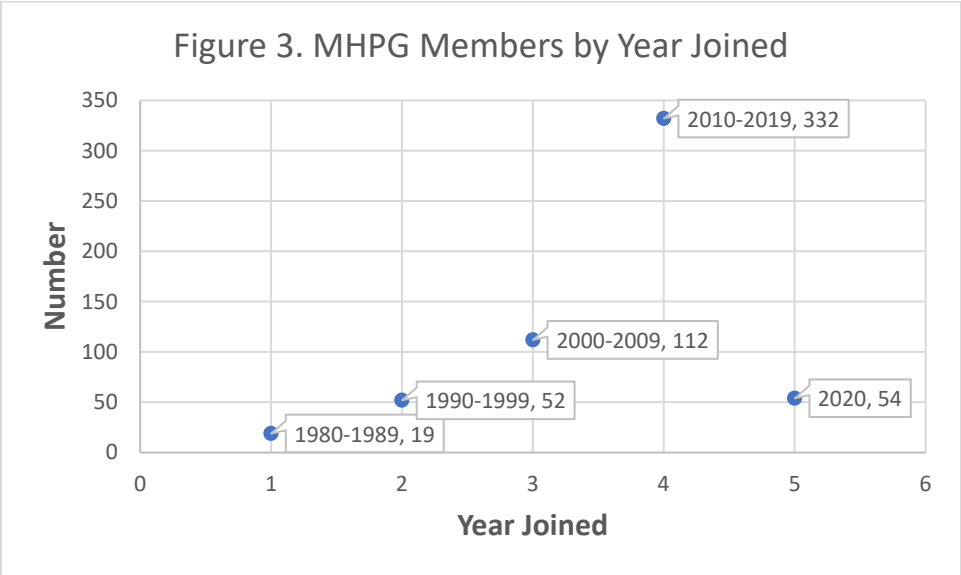
The membership has grown to 571 in the past 19 years, or almost quadrupled. The membership database for ASRM has become sophisticated and it is now possible to determine statistics for credentials, gender, years of membership within ASRM and age without asking members directly. Not every member answers every question for their membership profile so there is incomplete yet extensive data available to describe our group. ASRM data reveals that MHPG is composed of the following professions: M.D.s, PhD and PsyDs, MSW and LCSWs, R.N.s M.A. s and J.D.s. Clearly not all the membership practices mental health, although the vast majority do, suggesting the appeal of the organization transcends professional boundaries. The breakdown of professional degrees is provided in Figure 1.



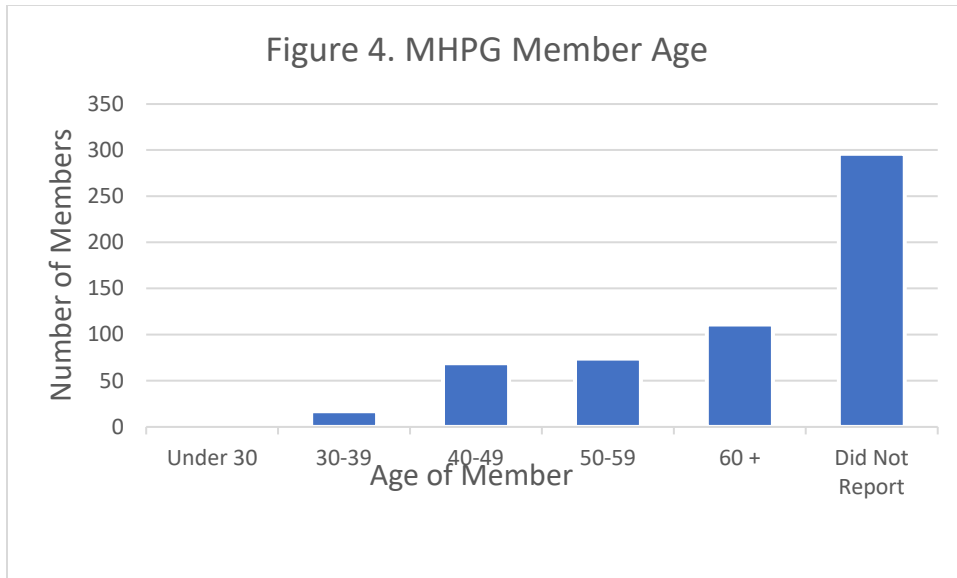
Of 569 membership records included in the data for sex of member, 347 reported sex and 222 chose not to report. The membership continues to be overwhelmingly female with 94.6% of those reporting designating themselves as female, suggesting that male membership in the organization is declining. Figure 2 shows this data.



The majority of members of MHPG have been with the organization for 10 years or less. Fully 67% have been with the organization less than 10 years and 2020 has seen 54 new members or just less than 10% of the membership. Figure 3 shows this data.



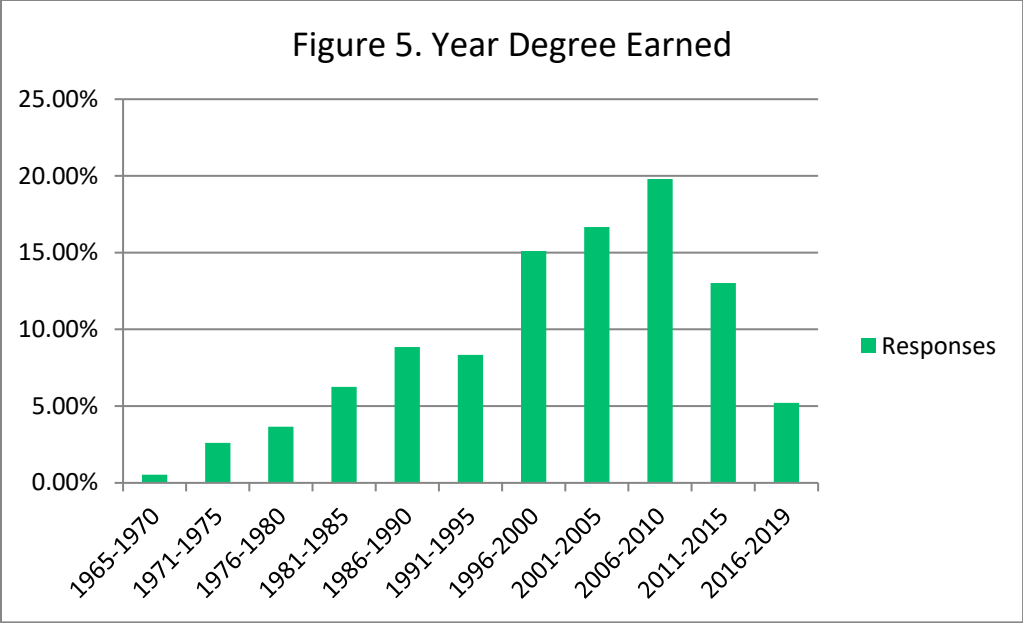
MHPG members are age conscious. More than half did not report their age to ASRM. Of the 273 that did report their age, almost 41% are 60+ years of age, the largest group that did report age on their membership profiles for ASRM. That data is displayed in in Figure 4.



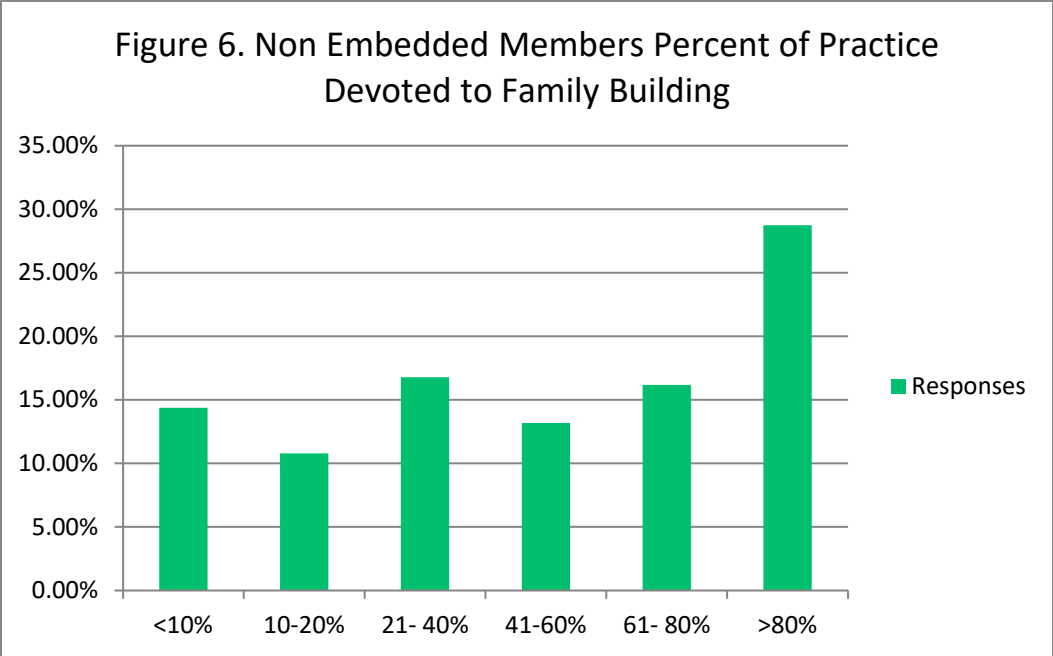
From the Current Survey Data

A Survey Monkey survey was created with the approval of the MHPG leadership. Notice of the survey was delivered to all MHPG members via an email “blast” from ASRM and a follow up email to all who had not responded 6-8 weeks later. 193 members responded to the survey. The vast majority answered every demographic question. The findings are as follows:

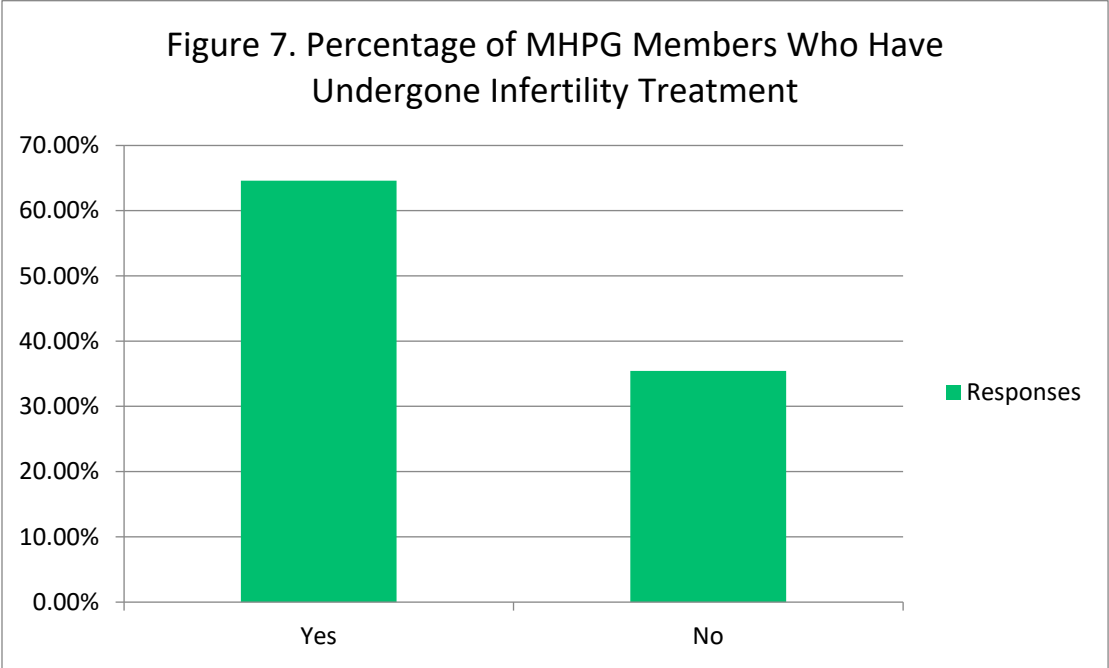
Over 54% of MHPG’s members earned their professional degree since 2001. Almost 19% have joined since 2011. We could speculate that members are joining after they have been in practice for some time, suggesting that this specialty is not something professionals contemplate while in graduate school. The data for year members earned their degrees in provided in Figure 5.



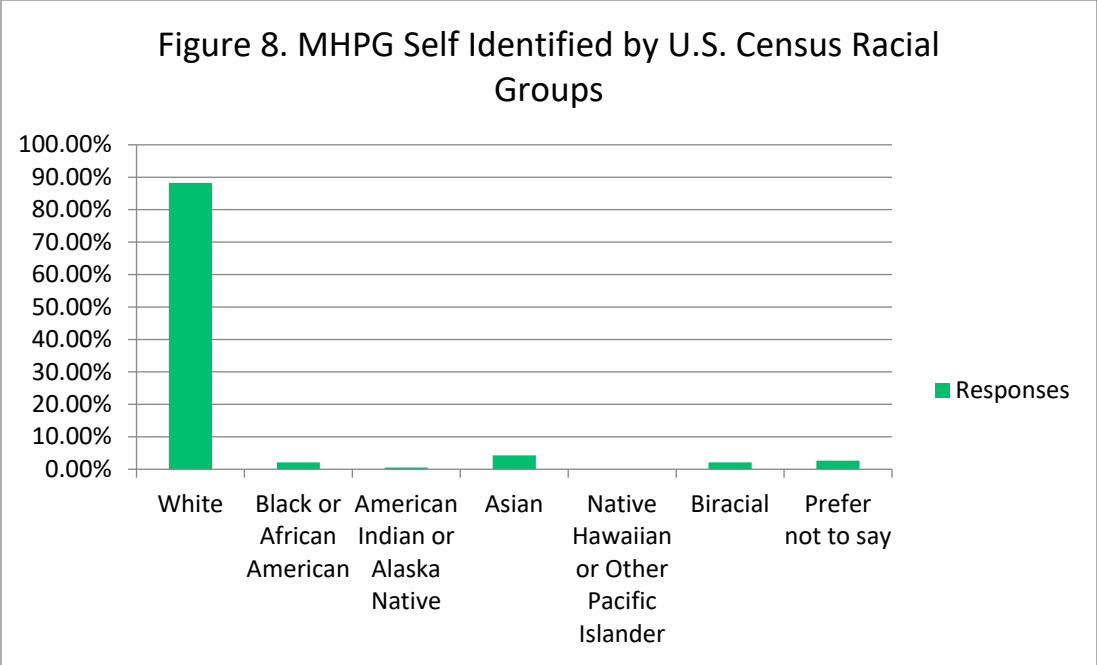
Less than 20% of the respondents indicated they were embedded in a clinic (18.75%). Of those not embedded, 58% said that 41% or more of their practice was devoted to family building. Of that group, the single largest segment reported devoting more than 80% of their practice to family building. This data suggests that it is possible for a mental health professional to devote a significant amount of clinical time to work in reproductive medicine without being a fertility clinic employee. The data for this question are displayed in Figure 6.



MHPG continues to attract members who have undergone treatment for infertility at a high rate. Almost 65% of the respondents indicated they had experienced their own challenges with family building. Interestingly, this is down from the original survey by 8% suggesting that our membership is attracting those who find the specialization compelling for other than personal reasons. Figure 7 shows this data.



In order to determine the racial or ethnic diversity of our group we utilized United States Census descriptors. We continue to be an overwhelmingly White group. People of color comprise slightly over 2% of the membership. An additional 2.14% identify as Biracial and 4.28% identify as Asian. American Indian or Alaska Native membership is the lowest of groups, identifying themselves at less than 1%. Slightly over 2.5% declined to identify themselves on this question. This data are presented in Figure 8.



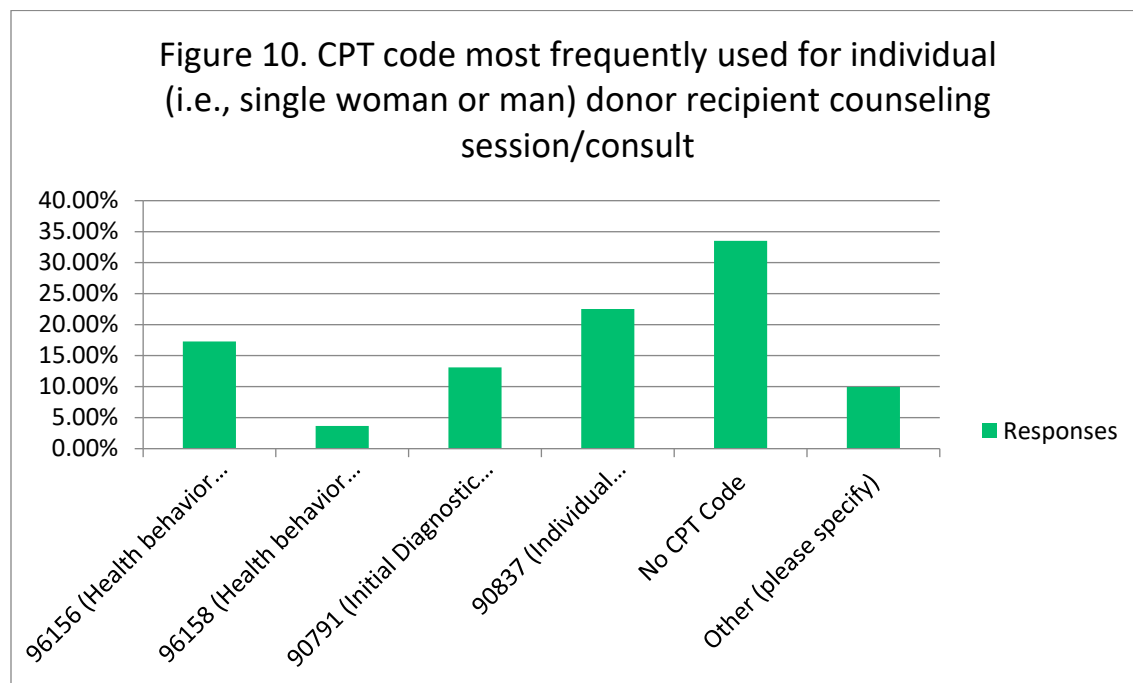
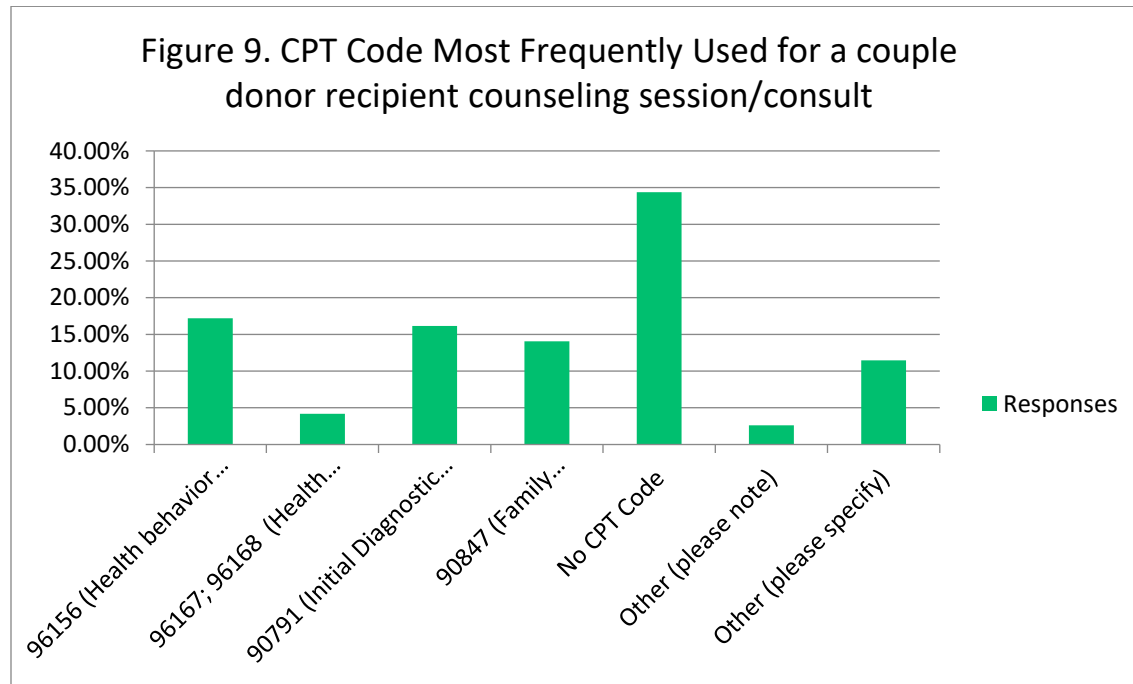
Coding Questions

A secondary purpose of this survey was to begin to understand how our members approach coding of third-party mental health services. This is an area of practice that continues to be a source of questions, discussion, and some confusion among our membership, especially for those in private practice. Questions in this survey focused on CPT and ICD-10 codes utilized for donor (i.e., egg, sperm, embryo) recipient consults. Survey responses suggest there is a significant amount of variation in how our members code donor recipient consults.

*CPT Codes*

We asked about the CPT codes members use when conducting donor recipient consults with couples and individuals (i.e., single woman or single man), respectively. Survey responses suggested minimal differences in CPT codes used for sessions with couples, versus individuals. Interestingly, over one-third of all respondents revealed they do not utilize any CPT code for purposes of billing/recording a donor recipient consult with either couples or individuals. When a CPT code is applied, respondents indicated they were more likely to use a psychotherapy code than a Health Behavior Assessment and Intervention (HBAI) code. However, there was not consistency in the psychotherapy code used for either couple or individual sessions. When working with a couple, about 16% of all respondents noted they assign the CPT 90791 (initial diagnostic interview), while 14% utilize 90847 (family psychotherapy with patient present). When seeing a single individual for donor recipient consult, 13% of survey respondents use

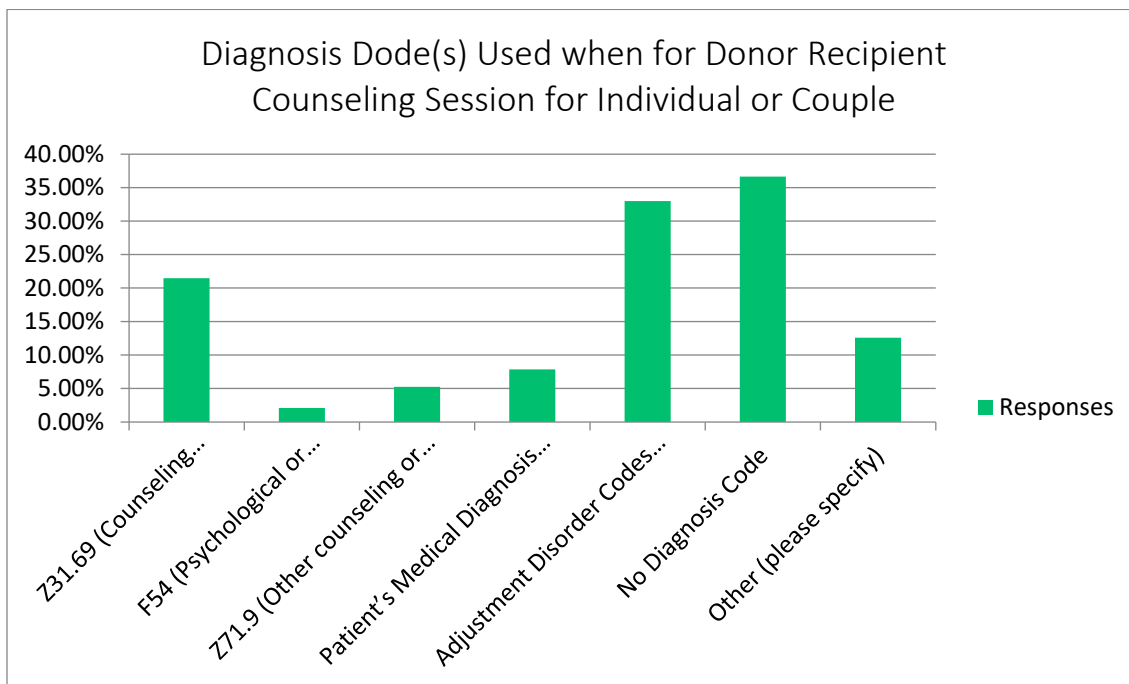
90791 (initial diagnostic interview) and over 22% use 90837 (individual psychotherapy, 60 minutes). Approximately 21% of respondents reported they utilize an HBAI code for donor recipient consults with couples and individuals: about 17% apply 96156 (health behavior assessment or re-assessment) and 4% use 96167/96168 (health behavior intervention). Finally, the majority of respondents who checked “Other” wrote in that they do not conduct recipient consults. This data are displayed in Figures 9 and 10.





### ICD-10 Codes

We also asked about diagnosis or ICD-10 codes members typically assign when conducting a donor recipient consult; more than one response could be checked for this question. The most frequent responses were: “No Diagnosis” (37%); “Adjustment Disorder Codes” (33%); and Z31.69 (counseling involving current fertility therapy; 21%). In addition, approximately 8% of respondents indicated they use the patient’s medical diagnosis, 5% use Z71.9 (other counseling or consult), and 2% use F54 (psychological or behavioral factors associated with disorders or diseases). Finally, approximately 13% of respondents checked “Other” and wrote in that that they either do not include an ICD-10 code or do not conduct recipient consults.



### **DISCUSSION/RECOMMENDATIONS:**

#### *Demographic Diversity*

MHPG membership continues to be a seriously skewed to white females and is not representative of either the national census data or the distribution of infertility between the sexes. We suggest that leadership make efforts to recruit new members with greater diversity on both dimensions.

Several avenues for recruiting a more racially diverse group seem relevant and worth exploring. Historically Black Colleges and Universities (HBCU) offer graduate programs that lead to licensure in mental health fields. For example, Howard University offers a PhD in Counseling Psychology, Xavier University of Louisiana (New Orleans) offers a Master's degree in Mental Health Counseling, North Carolina Central University (Durham) offers a Master's degree in Mental Health Counseling, Morgan State University (Baltimore) offers a Master's and Doctorate in Social Work, Prairie View A&M University (Prairie View, TX) offers a Master's degree in Counseling Psychology, and Savannah State University offers a Master's degree in Social Work. MHPG can offer speakers to these graduate programs for a 1 time talk on the field either via webinar or by a nearby member of our organization. This type of outreach seems worthwhile given that few if any graduate programs in mental health fields offer more than a passing notice of the issues raised for couples and individuals dealing with family building challenges.

Another recruiting tool to improve diversity would be to speak at organizations that are devoted to professionals such as the National Association of Black Counselors (NABC) the Association of Black Psychologists, the Black Mental Health Alliance and the National Latina/o Psychological Association (NLPA).

Recruiting men to MHPG could take a similar approach with speakers presenting at the American Psychological Association's annual conference for the Association's Society for the Psychological Study of Men and Masculinity or similar divisions within other national organizations such as the National Association for Social Work or the American Counseling Association. Many organizations also have newsletters that will target specific groups, men being one of them. We recommend active efforts to place articles about the emotional impact of male factor infertility in them, working closely with ASRM's office of public affairs to do so.

Finally, recruiting can take place by with working with members who have social media presence to market our organization to these diverse groups.

### *Improving Awareness*

MHPG can improve awareness of the field to mental health professionals in training and those newly licensed by actively reaching out to training programs. We suggest the development of webinars, a group of MHPG members willing to give one off talks at local training programs and within local and state professional organizations to increase awareness of the field and our "brand."

### *Coding*

Data from this survey indicate a lack of consistency across our membership in the coding of donor recipient consults. In July 2018 ASRM posted a "Coding Corner" document that provided some direction on coding for mental health services during assisted reproduction (see <https://www.asrm.org/resources/coding/coding-qa/coding-corner/summary-of-coding-for-mental-health-services-during-assisted-reproduction/>). This document recommends the use of Evaluation and Management (E & M) CPT codes, and Z31.69 or Z31.62 ICD-10 codes for routine counseling prior to

pursuing treatment. E & M codes are utilized by medical personnel but not mental health professionals (MHPs). As revealed by responses to this survey, the majority of MHPG members are MHPs.

While most respondents applied psychotherapy codes for donor recipient consults, the appropriate use of psychotherapy codes would require that the majority of the session be spent conducting psychotherapy. Thus, HBAI codes (e.g., 96156 or 96167/16168) may be most appropriate for MHPs to use for the routine counseling session that occurs for patients pursuing treatment with donor gametes. The proper use of HBAI codes requires a physical health diagnosis as the primary diagnosis (see <https://www.apaservices.org/practice/reimbursement/health-codes/health-behavior>). A patient's fertility diagnosis is likely accessible to MHPs embedded in a reproductive endocrinology clinic and who have ready access to a patient's electronic medical record. However, the current survey indicated that over 80% of MHPG members are not embedded in a clinic and thus, do not have access to this information.

Appropriate coding is an issue of ethical practice, as well as providing the best opportunity for insurance coverage/reimbursement for fertility patients. The survey data suggests that MHPG members require guidance on coding donor recipient consults. It is recommended that ASRM/MHPG provides such guidance to our members.