HEALTH MANAGEMENT ASSOCIATES

Sustaining Behavioral Health Integration

LORI RANEY, MD
PRINCIPAL

LEARNING OBJECTIVES

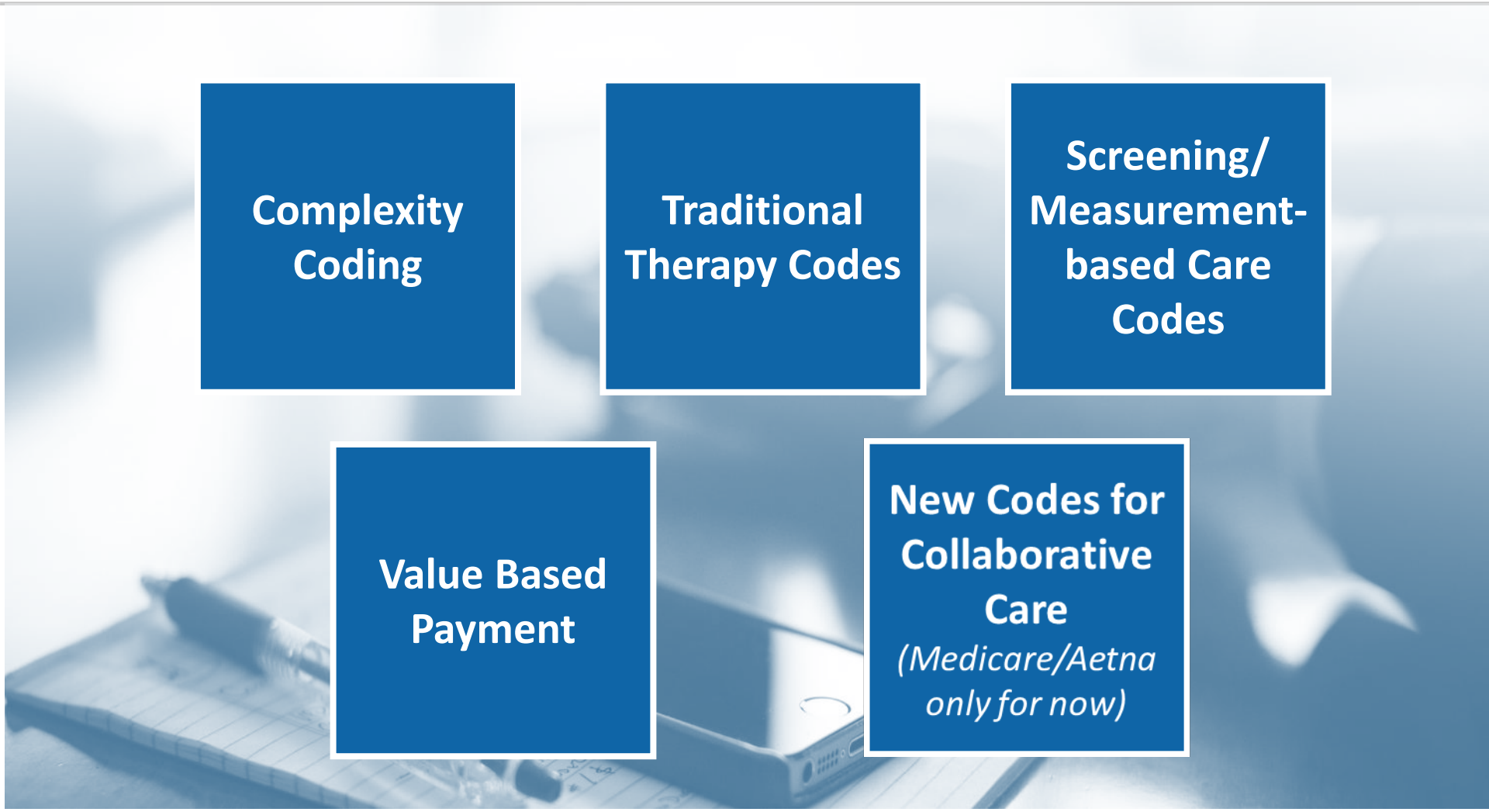
- Understand the opportunities for FFS billing in CO including 6 Medicaid BH visits annually
- List the key therapy codes suited for short term care in the primary care setting
- Recognize the key components of documentation compliance
- Comprehend the value opportunities in demonstrating outcomes based on effective care

FEE FOR SERVICE: WHAT DO WE HAVE TROUBLE BILLING FOR?

- Brief interventions
- Stress/no diagnosis
- Huddles
- Hallway conversations/consultations
- Warm hand-offs
- Curbside consultations with psychiatric consultants
- Phone calls to patients
- Repeating measurement scales
- Interdisciplinary team meetings
- Registry management

***Payment approaches are necessary for these services that do not work in a typical FFS environment. "What works can't be coded."*

BILLING OPPORTUNITIES



MEDICAL NECESSITY | DEFINITION

- ✓ Will, or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. Is provided in accordance with generally accepted professional standards for health care in the United States;
- ✓ Is clinically appropriate in terms of type, frequency, extent, site, and duration;
- ✓ Is delivered in the most appropriate setting(s) required by the client's condition

TIME

- A unit of time is attained when the mid-point if passed. For example, 30 minutes is attained when 16 minutes have elapsed
- Time Stamping:
- 90832 - **16-37** minutes
- 90834 – 38-52 minutes
- 90837 – 53+

Procedure	CPT Code	Medicaid FFS Rate	Commercial/ Medicare
Diagnostic Evaluation	90791	$106.05	*
Psychotherapy 30 min	90832	$55.13	*
Psychotherapy 45 min	90834	$88.87	*
Psychotherapy 60 min	90837	$100.80	*
Family psychotherapy w/o patient	90846	$57.00	*
Family psychotherapy with patient	90847	$59.00	*

- State fiscal year – July to June

Service Content

- The reason for the visit. Chief complaint/presenting concern(s) or problem(s)
- Referral source
- Psychiatric diagnostic interview examination elements
- HPI, past psych tx, SUD hx, medical diagnoses, family history MI
- Review of psychosocial, family, and treatment history
- Mental status exam
- Diagnostic formulation
- Plan for next contact(s) including any follow-up or coordination needed with 3rd parties and disposition

Can be brief (30 minutes) and added to over time

- Evidence-based Brief Interventions proven to work in the Primary Care Setting

- The reason for the visit. What was the intended goal or agenda? How does the service relate to the treatment/service plan?
- Description of the service
- The therapeutic intervention(s) utilized and the individual's response to the intervention(s)
- How did the service impact the individual's progress towards goals/objectives?
- Plan for next contact(s) including any follow-up or coordination needed with 3rd parties

DOCUMENTATION REQUIREMENTS | EXAMPLE

The requirements for this type of note have four parts/ requirements that we use to make documentation simple and compliant. This documentation can be short and often done concurrently with the patient and during a warm hand off. HIPAA – "psychotherapy" notes

Diagnosis: patient referred by primary care provider for depression follow-up

Assessment of symptoms: patient scored a 14 on the PHQ9, reports difficulty sleeping and concentrating as most prominent symptoms

Clinical Intervention: utilized behavioral activation to establish short term goal of XX to begin care and engage patient into treatment

Plan: patient provided with follow up phone appointment (1-2 days) on XX and follow up visit on XXX (within the week) to begin care for depression and PHQ9 reduction

- **D:** Mr. Jones reports his depression is better since his visit 2 weeks ago. His PHQ-9 score has dropped from 14 to 11 with continued endorsement of low mood, fatigue, difficulty sleeping and difficulty concentrating. He denies any suicidal ideation. Did a session of behavioral activation and set a goal to visit his daughter this weekend
- **A:** Major Depression, improving
- **P:** Follow-up on BA goal next week; Follow-up with PCP on antidepressant; FU with me in 2 weeks.

A Tipping Point for Measurement-Based Care

John C. Fortney, Ph.D., Jürgen Unützer, M.D., M.P.H., Glenda Wrenn, M.D., M.S.H.P., Jeffrey M. Pyne, M.D., G. Richard Smith, M.D., Michael Schoenbaum, Ph.D., Henry T. Harbin, M.D.

Objective: Measurement-based care involves the systematic administration of symptom rating scales and use of the results to drive clinical decision making at the level of the individual patient. This literature review examined the theoretical and empirical support for measurement-based care.

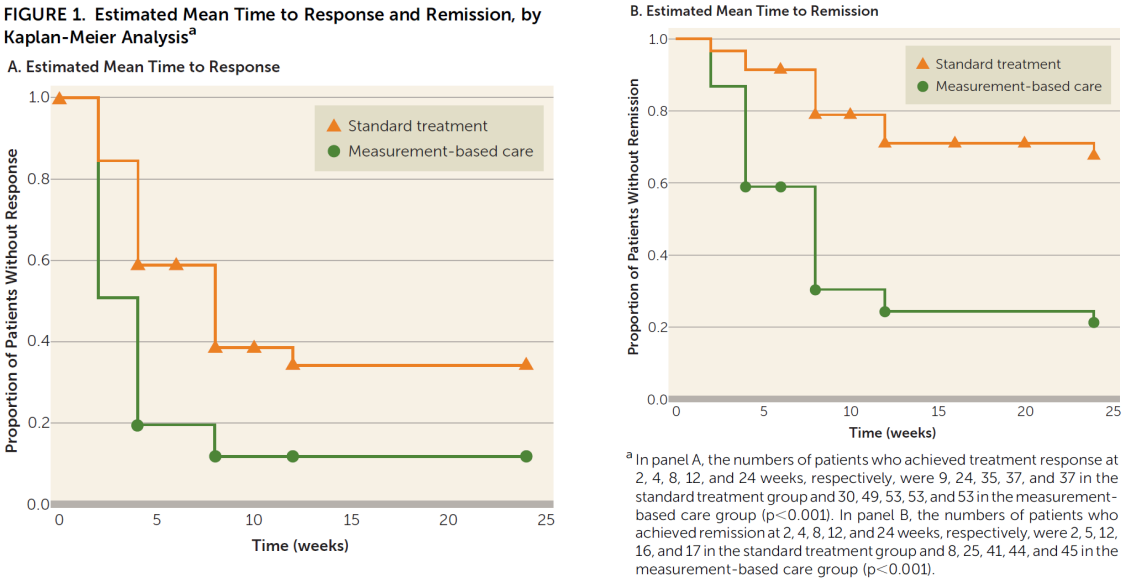
Methods: Articles were identified through search strategies in PubMed and Google Scholar. Additional citations in the references of retrieved articles were identified, and experts assembled for a focus group conducted by the Kennedy Forum were consulted.

Results: Fifty-one relevant articles were reviewed. There are numerous brief structured symptom rating scales that have strong psychometric properties. Virtually all randomized controlled trials with frequent and timely feedback of patient-reported symptoms to the provider during the medication management and psychotherapy encounters significantly improved outcomes. Ineffective approaches included one-time screening, assessing symptoms infrequently, and feeding back outcomes to providers outside the context of the clinical encounter. In addition to the empirical evidence about efficacy, there is mounting evidence from large-scale pragmatic trials and clinical demonstration projects that measurement-based care is feasible to implement on a large scale and is highly acceptable to patients and providers.

Conclusions: In addition to the primary gains of measurement-based care for individual patients, there are also potential secondary and tertiary gains to be made when individual patient data are aggregated. Specifically, aggregated symptom rating scale data can be used for professional development at the provider level and for quality improvement at the clinic level and to inform payers about the value of mental health services delivered at the health care system level.

Psychiatric Services 2016; 00:1–10; doi: 10.1176/appi.ps.201500439

Care That Is Measured Gets Better



- HAM-D 50% or <8
- Paroxetine and mirtazapine
- Greater response
- Shorter time to response
- More treatment adjustments (44 vs 23)
- Higher doses antidepressants
- Similar drop out, side effects

Quo T, Correll, et al. American Journal of Psychiatry, 172 (10), Oct, 2015

Screening and Measurement of Symptoms

96127
Brief emotional/ behavioral health risk assessment

- PHQ9, GAD7, Vanderbilt, SCARED, etc.
- Commercial, sometimes limited dude to "bundling" criteria by payer
- Bill code up to 4x/year for up to 4 screening tools per visit
- Recommended Depression every annual visit age 11+

96160
Patient focused health risk assessment

- PHQ9, etc. except Medicaid (see below). Interchangeable with 96127, basically the same rate.

96161
Care-giver focused health risk assessment

- For example: post partum depression
- Unless Medicaid (see next)

96110
Screenings

- Can bill 96127 in addition if both performed at same visit.
- Developmental – 1 unit billed on a single visit, 1 per year, $17.67
- Autism – 2 screens total between 18 and 24 months, $17.67

ONGOING MEASUREMENT OF PROGRESS: MEASUREMENT BASED CARE (MBC)

- 96127 – approximately $10
  - Repeat measurement up to 4x/year typically, although, may be some variation between payers, can do use any of the following:
    - PHQ9
    - GAD7
    - SCARED
    - Vanderbilt
    - AUDIT-C
- Scenario: the PHQ9 is administered during screening for depression and then monthly for up to 3 months to track progress and adjust treatment for patients not improving.

Medicaid: G Codes

- For teen depression screening and PPD, screen and bill for mom up to three times, once a year only for teen depression screening up to age 21 (although recommended every visit) and adults, includes counseling, referral and follow-up
  - G8431: positive screen for depression - $29.68
  - G8510: negative screen for depression - $10.70

Alcohol Treatment

- Screening:
  - Medicaid: H0049
    - Negative screen for substance use, 1 per day, 2 per state fiscal year (July 1-June 30) - $10.70
  - Other Payers: 96127 or 96160; can use psychotherapy code like 90832 for counseling
- Treatment: SBIRT
  - 99408 – positive substance use screen with intervention, 15-30 minutes - $31.39
  - 99409 – positive substance use screen with intervention, 30+ minutes - $64.26

HIGHER COMPLEXITY BILLING FOR THE PCP DUE TO BH INTERVENTION

Higher Complexity or time based:

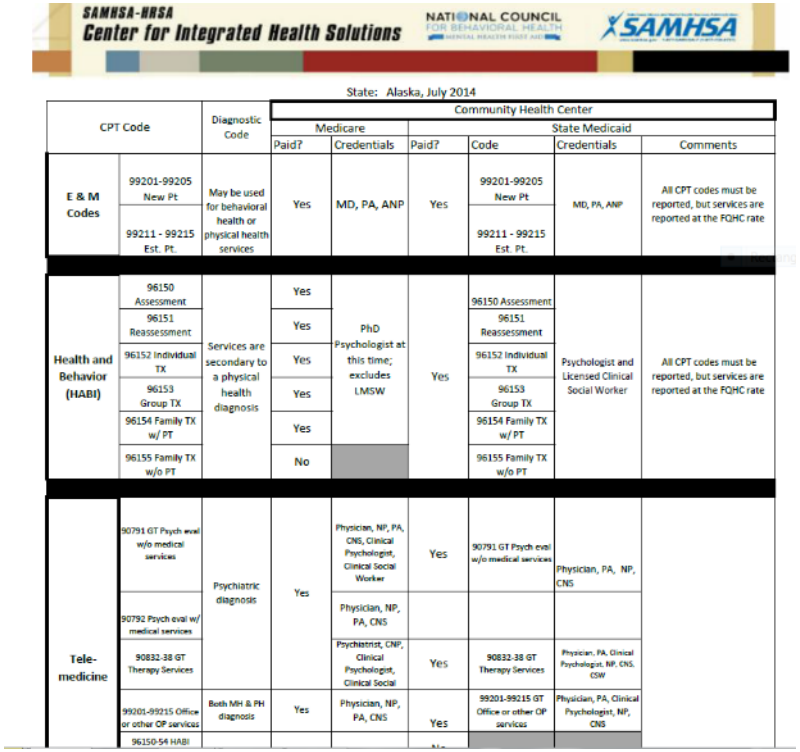
- 99213 – 15 minutes
- 99214 – 30 minutes
- 99215 – 45 minutes

SCENARIO

Dr. Begay sees a patient for a 15 minute routine blood pressure check and depression follow-up (typically billed as 99213 if all is stable) She notices a repeat of the PHQ9 score is now elevated at 14. She calls the BHP to the exam room, steps out and the BHP completes a brief assessment. Dr. Begay returns to the exam room and they discuss depression treatment. There are now 2 problems being addressed - 1 old and one new, 30 minutes was spent with the patient and a 99214 was billed.

HEALTH BEHAVIORAL ASSESSMENT AND INTERVENTION (HBAI)

- Not Paid in Colorado
- Includes 96150-155
- Psychologists (some now allow LCSW)
- Developed by CMS in 2002 to support determining the biological, psychological, and social factors affecting the patient's physical health and any treatment problems, and related interventions by psychologists.



SAMHSA-HRSA Center for Integrated Health Solutions — NATIONAL COUNCIL FOR BEHAVIORAL HEALTH — SAMHSA

State: Alaska, July 2014

CPT Code		Diagnostic Code	Community Health Center: Medicare Paid?	Medicare Credentials	State Medicaid Paid?	State Medicaid Code	State Medicaid Credentials	Comments
E & M Codes	99201-99205 New Pt 99211 - 99215 Est. Pt.	May be used for behavioral health or physical health services	Yes	MD, PA, ANP	Yes	99201-99205 New Pt 99211 - 99215 Est. Pt.	MD, PA, ANP	All CPT codes must be reported, but services are reported at the FQHC rate
Health and Behavior (HABI)	96150 Assessment	Services are secondary to a physical health diagnosis	Yes	PhD Psychologist at this time; excludes LMSW	Yes	96150 Assessment	Psychologist and Licensed Clinical Social Worker	All CPT codes must be reported, but services are reported at the FQHC rate
	96151 Reassessment		Yes			96151 Reassessment		
	96152 Individual TX		Yes			96152 Individual TX		
	96153 Group TX		Yes			96153 Group TX		
	96154 Family TX w/ PT		Yes			96154 Family TX w/ PT		
	96155 Family TX w/o PT		No			96155 Family TX w/o PT		
Tele-medicine	90791 GT Psych eval w/o medical services	Psychiatric diagnosis	Yes	Physician, NP, PA, CNS, Clinical Psychologist, Clinical Social Worker	Yes	90791 GT Psych eval w/o medical services	Physician, PA, NP, CNS	
	90792 Psych eval w/ medical services			Physician, NP, PA, CNS				
	90832-38 GT Therapy Services			Psychiatrist, CNP, Clinical Psychologist, Clinical Social	Yes	90832-38 GT Therapy Services	Physician, PA, Clinical Psychologist, NP, CNS, CSW	
	99201-99215 Office or other OP services	Both MH & PH diagnosis	Yes	Physician, NP, PA, CNS	Yes	99201-99215 GT Office or other OP services	Physician, PA, Clinical Psychologist, NP, CNS	
	96150-54 HABI							

Common H Codes in PC; reimbursed by the RAE, not state MCD- Negotiate!

- H0023: outreach and engagement, can be in person or by phone, peer and up, can be used to prevent or address a BH problem
- H0025: psychoeducation for prevention/reduce risk, delivered prior to onset of BH problem
- H0031: brief assessment, no MSE, bachelors degree, intern and up
- H2011: crisis per 15 minutes
- H0002: alcohol and drug screen
- T1017: targeted case management

H0004	$22.77
H2011	$11.88
T1017	$16.25
H0031	$112.68
H0002	$27.36
H0023	$3.60
H0025	$23.04

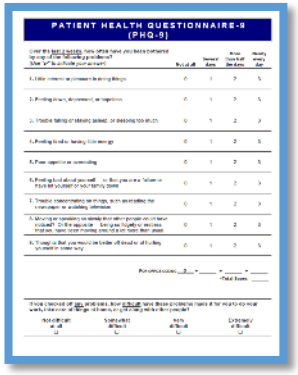
THE COLLABORATIVE CARE MODEL

Informed,
Activated Patient

Effective Collaboration

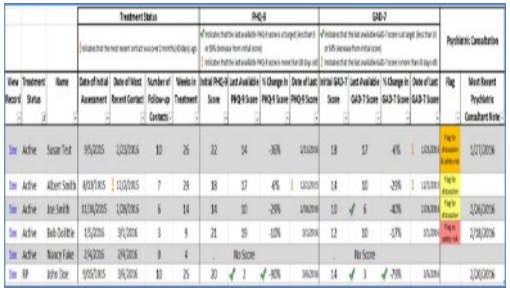
PRACTICE SUPPORT

PCP supported by Behavioral Health Care Manager



Measurement-based
Treat to Target

Psychiatric
Consultation



Caseload-focused
Registry review

Training

Codes and Reimbursement for CoCM

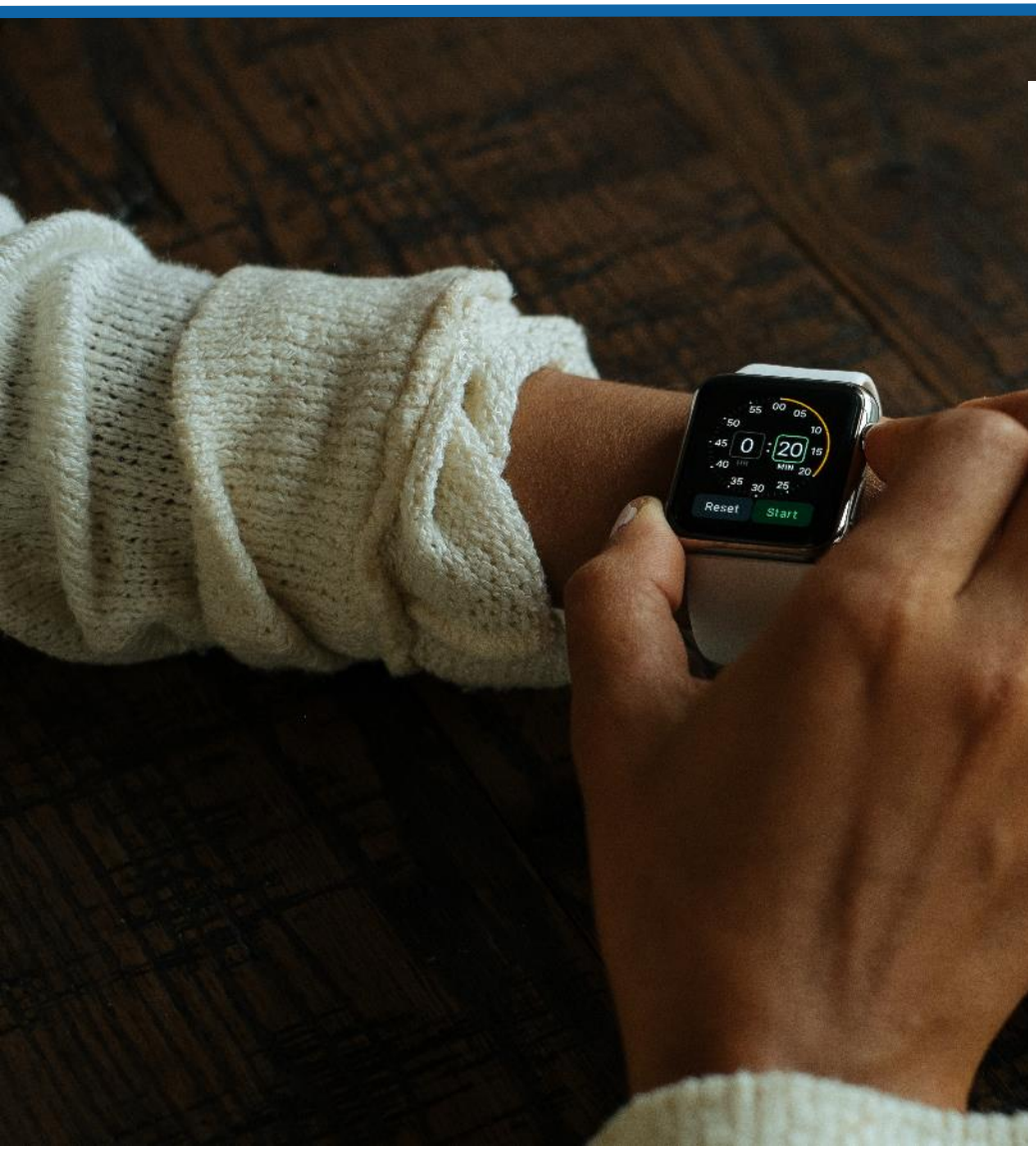
- 99492 (Initial month, CoCM) - $161
- 99493 (Subsequent month, CoCM) - $129
- 99494 (Add'l 30 mins, CoCM) - $69
- 99484 – other models of BHI - $48
- G0512 – FQHCs $135/month

Billed once a month under the PCP's NPI

CODES COVER:

- Outreach and engagement by BH Provider or Care Manager
- Initial assessment of the patient, including administration of validated rating scales
- Entering patient data in a registry and tracking patient follow-up and progress
- Participation in weekly caseload review with the psychiatric consultant
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.

TIME STAMPING – PER MONTH



- Minutes spent talking to patient (in person or phone)
- Minutes spent talking to the PCP
- Minutes spent talking to the psychiatric consultant
- Minutes spent coordinating care
- Minutes spent documenting anything or scoring
- Minutes spent reviewing charts/documentation
- Minutes spent talking to referral source
- ETC! Get it all

CONSIDERATIONS FOR SUSTAINABILITY

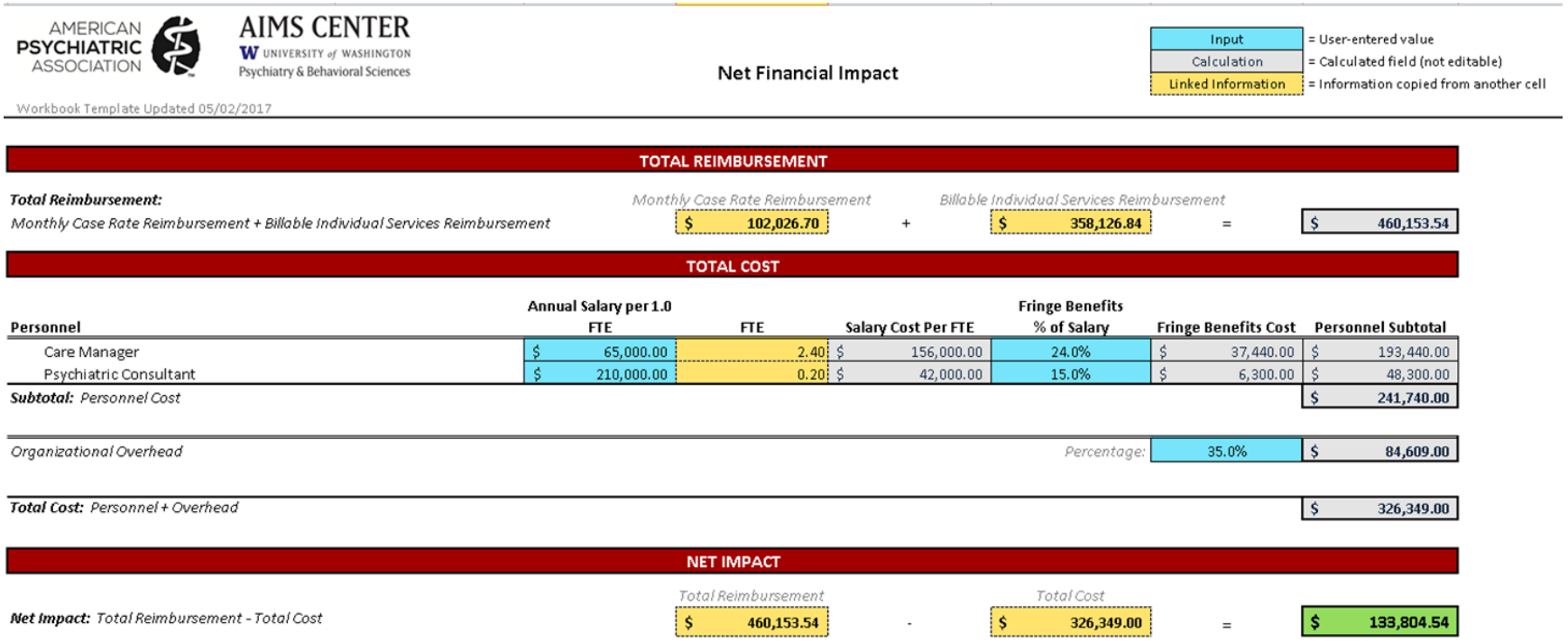
- Staffing
- Productivity/Volume
- Payer mix
- Direct Revenue
- Indirect Revenue
- Coding
- Contracting
- Optimization (concurrent doc)
- Back end-denials,
- Dashboard development
- Even if you have a grant

BILLING GRID BY PAYER

Licensed Clinical Social Worker *(continued)*												
Payers	**90791**	**90832**	**90834**	**90837**	**90853**	**96150**	**96151**	**99366**	**99367**	**99368**	**98967**	**98968**
Cigna												
Elderplan												
Empire BCBS/HealthPlus												
Empire BCBS (HMP/PPO)												
Fidelis												
GHI												
HealthFirst												
HIP												
MagnaCare												
MetroPlus												
MVP												
MultiPlan												
Pomco												
NHA												
United Healthcare												
WellCare												
Carve-Outs												
Beacon Health Options												
Value Options												
Optum/UBH												

Raney L, Lasky G: Chapter 8, Financing Integrated Care, in Integrated Care: A Guide to Effective Implementation, APPI 2017, courtesy Virna Little

FINANCIAL MODELING WORKBOOK



AMERICAN PSYCHIATRIC ASSOCIATION

AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

Net Financial Impact

Input	= User-entered value
Calculation	= Calculated field (not editable)
Linked Information	= Information copied from another cell

Workbook Template Updated 05/02/2017

TOTAL REIMBURSEMENT

	Monthly Case Rate Reimbursement		Billable Individual Services Reimbursement		
Total Reimbursement: *Monthly Case Rate Reimbursement + Billable Individual Services Reimbursement*	$ 102,026.70	+	$ 358,126.84	=	$ 460,153.54

TOTAL COST

Personnel	Annual Salary per 1.0 FTE	FTE	Salary Cost Per FTE	Fringe Benefits % of Salary	Fringe Benefits Cost	Personnel Subtotal
Care Manager	$ 65,000.00	2.40	$ 156,000.00	24.0%	$ 37,440.00	$ 193,440.00
Psychiatric Consultant	$ 210,000.00	0.20	$ 42,000.00	15.0%	$ 6,300.00	$ 48,300.00
Subtotal: *Personnel Cost*						$ 241,740.00
Organizational Overhead				*Percentage:*	35.0%	$ 84,609.00
Total Cost: *Personnel + Overhead*						$ 326,349.00

NET IMPACT

	Total Reimbursement		Total Cost		
Net Impact: *Total Reimbursement - Total Cost*	$ 460,153.54	-	$ 326,349.00	=	$ 133,804.54

https://aims.uw.edu/collaborative-care/financing-strategies/financial-modeling-workbook

TELEHEALTH REIMBURSEMENT

- Constantly moving target between insurers and medical boards and state and federal government
- No two states are alike – Medicaid pays in CO
- Rural vs not –Medicare
- Home as originating site
- Equal pay issue for the Tele vs in person
- Commercial can do or not unless forced through legislation
- Parity – Colorado OK
- Consent and co-pays apply
- FQHC and Medicare distant provider billing limitations
- Instate or across state lines
- Special modifiers you add to CPT codes

- 50 state report – American Telemedicine report
- Resources – Colorado Medicaid Telemedicine Reimbursement Manual

COST SAVINGS WITH INTEGRATED CARE

MILLIMAN RESEARCH REPORT

Potential economic impact of integrated medical-behavioral healthcare

Updated projections for 2017

January 2018

Stephen P. Melek, FSA MAAA
Douglas T. Norris, FSA, MAAA, PhD
Jordan Paulus, FSA, MAAA
Katherine Matthews, ASA, MAAA
Alexandra Weaver, ASA, MAAA
Stoddard Davenport

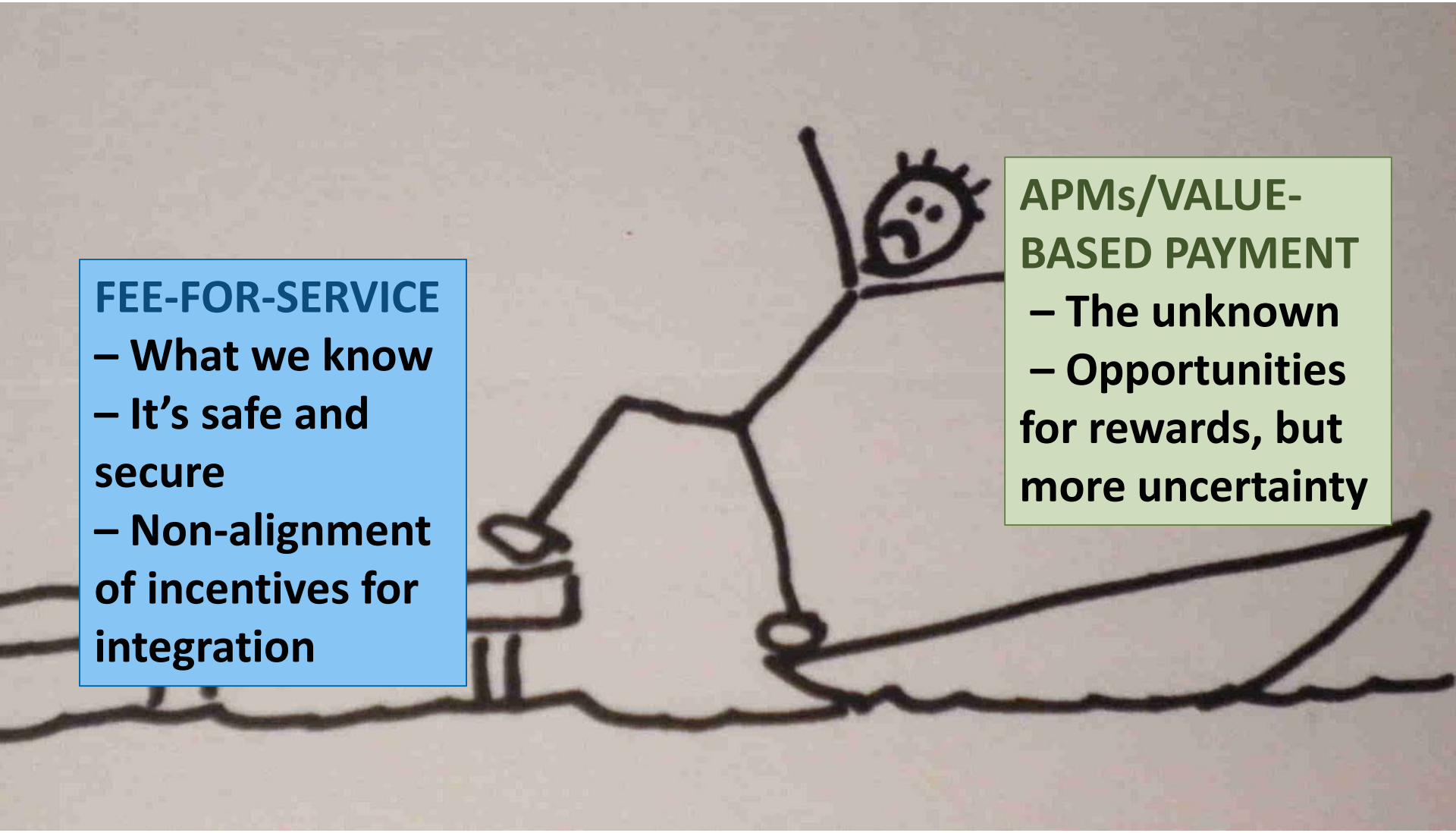
VALUE OPPORTUNITY

FIGURE 14: IMPACT OF BEHAVIORAL COMORBIDITIES, MEDICAID POPULATION, 2017 TOTAL PMPM COSTS

BODY SYSTEM (CONDITION)	NO MH/SUD	MH/SUD
BENIGN/IN SITU/UNCERTAIN NEOPLASM	$922	$2,123
CARDIORESPIRATORY ARREST	$6,445	$6,896
CEREBROVASCULAR	$2,756	$4,432
COGNITIVE DISORDERS	$3,115	$4,772
DIABETES	$1,432	$3,181
EARS, NOSE, AND THROAT	$656	$1,954
EYES	$789	$2,182
GASTROINTESTINAL	$1,132	$2,595
GENITAL SYSTEM	$889	$2,066
HEART	$1,375	$2,867
HEMATOLOGICAL	$1,906	$4,034
LIVER	$1,784	$3,444
LUNG	$990	$2,568
MALIGNANT NEOPLASM	$2,569	$4,278
MUSCULOSKELETAL AND CONNECTIVE TISSUE	$931	$2,181
NEUROLOGICAL	$1,982	$3,177
NUTRITIONAL AND METABOLIC	$1,095	$2,583
PREGNANCY-RELATED	$1,540	$2,242
SKIN AND SUBCUTANEOUS	$804	$2,379
URINARY SYSTEM	$1,449	$3,217
VASCULAR	$2,428	$4,533
TOTAL (INCLUDING THOSE WITHOUT ANY MEDICAL CONDITIONS)	$494	$1,708

Potential calculated savings with IC $175 billion

NAVIGATING TWO WORLDS – THE CHALLENGING FINANCES OF BEHAVIORAL HEALTH INTEGRATION AND VALUE BASED PAYMENT



CASH FLOW IN FFS VS. A VALUE-BASED ENVIRONMENT

Fee-for-Service World

- Provider performs a service and receives payment for it in a quantifiable period of time (30 – 90 days)
- Reimbursement is certain if billing requirements are met
- Steady cash flow throughout the year
- Traditionally no payment for care coordination, integration, quality

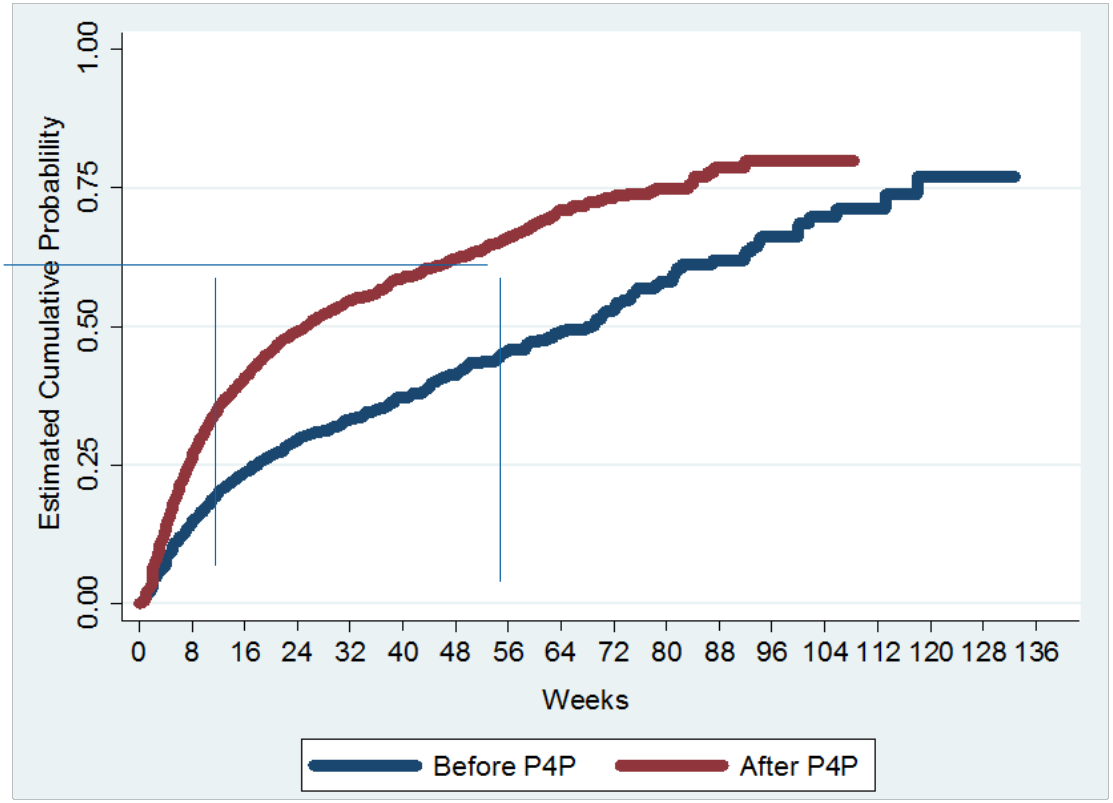
Value-Based Payment World

- Provider performs a service and may receive a FFS payment for some portion of the service
- Payments based on contract performance (managing total cost of care and quality measures) are received after the measurement period, and cannot be quantified at the time service is rendered
  - Some payments may be PMPM
- Uncertain cash flow with delays from time service delivered
- Providers/systems rewarded for quality and metrics that integrated care addresses
  - Alignment of incentives around achieving better outcomes

EXAMPLE VBP METRICS - WASHINGTON

Task	VBP Target	Fidelity Measure	% Payment Returned
Systematic Follow-up	1. Maintain minimum monthly caseload 2. > 50% of caseload receives >2 visits with BHP per month	At least one follow-up with the BHP in each 4 week period Same as above	5% 5%
Measurement-based Care	Not incentivized	At least on PHQ9 in each 4 week period	0
Stepped Care	3. BHP reviewed >50% of their caseloads with psychiatrist 4. Registry documents current psychiatric medication for >75% of the caseload	At least one psychiatric consultation of the care in each 4 week period NA	5% 5%

American Psychiatric Association found that when P4P arrangements were in place, median time to depression treatment response was reduced by half.



- Cut median time to depression response in half

Unützer et al., 2012

COMMON PERFORMANCE MEASURES FOR ACOs, VALUE-BASED PAYMENT

Process Metrics • Percent of patients screened for depression • Percent with follow-up with therapist within 2 weeks • Percent not improving that received case review • Percent not improving referred to specialty BH	**NQF 712**
Outcome Metrics • Percent with 50% reduction PHQ-9 – Clinical Response at 6 and 12 months • Percent reaching remission (PHQ-9 < 5) at 6 and 12 month	**NQF 1884 and 1885 (benchmark > 40%)** **NQF 710 and 711 (benchmark > 20%)**
Experience– patient and provider **Functional – work, school, homelessness** **Utilization/Cost** • ED visits, 30 day readmits, med/surg/ICU, overall cost	

Source: Lori E. Raney et al, Integrated Care: A Guide to Effective Implementation; American Psychiatric Association Press; 2017

BUILD A RELATIONSHIP

- The future is about value based payment and other alternative payment models.
- A relationship build on trust will allow you to advocate for specific incentives based on what you know you are good at.
- Ask questions, be a good partner, and avoid “seeing what happens”
- Loss of trust will cost you far more in the future.

HMA

LORI RANEY
Principal
lraney@healthmanagement.com