Medicare Optimization

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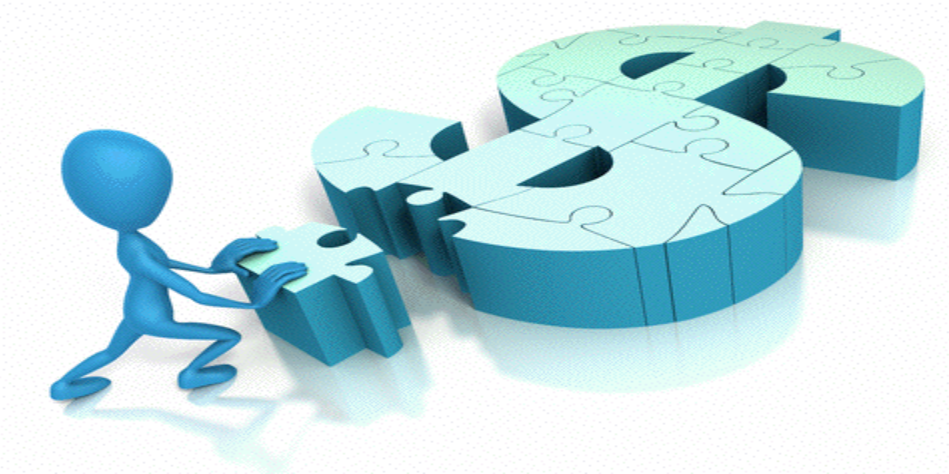


Why Collaborative Care?

Collaborative Care is more **effective** than care as usual (over 80 randomized controlled trials)

- Gilbody S. et al. *Archives of Internal Medicine*; Dec 2006
- Thota AB, et al. Community Preventive Services Task Force. *Am J Prev Med.* May 2012;42(5):521-524.
- Archer J, et al. Cochrane Collaborative. Oct 17, 2012.: 79 RCTs with a total of 24,308 patients

Collaborative Care also more **cost-effective**

- Gilbody et al. BJ Psychiatry 2006; 189:297-308.
- Unutzer et al. Am J Managed Care 2008; 14:95-100.
- Glied S et al. MCRR 2010; 67:251-274.

The Collaborative Care Model

What is it?

- An integrated model of behavioral health designed for primary care
- Introduces two new roles (Care Manager and Psych Consultant) and services to the care team to treat common mental health conditions in primary care

Why is it important?

- Despite the prevalence of mental health conditions such as depression, anxiety, and substance abuse, many people do not receive effective care
- This leads to worsening health outcomes, poor treatment adherence/response, and increased costs

Collaborative Care Team Model

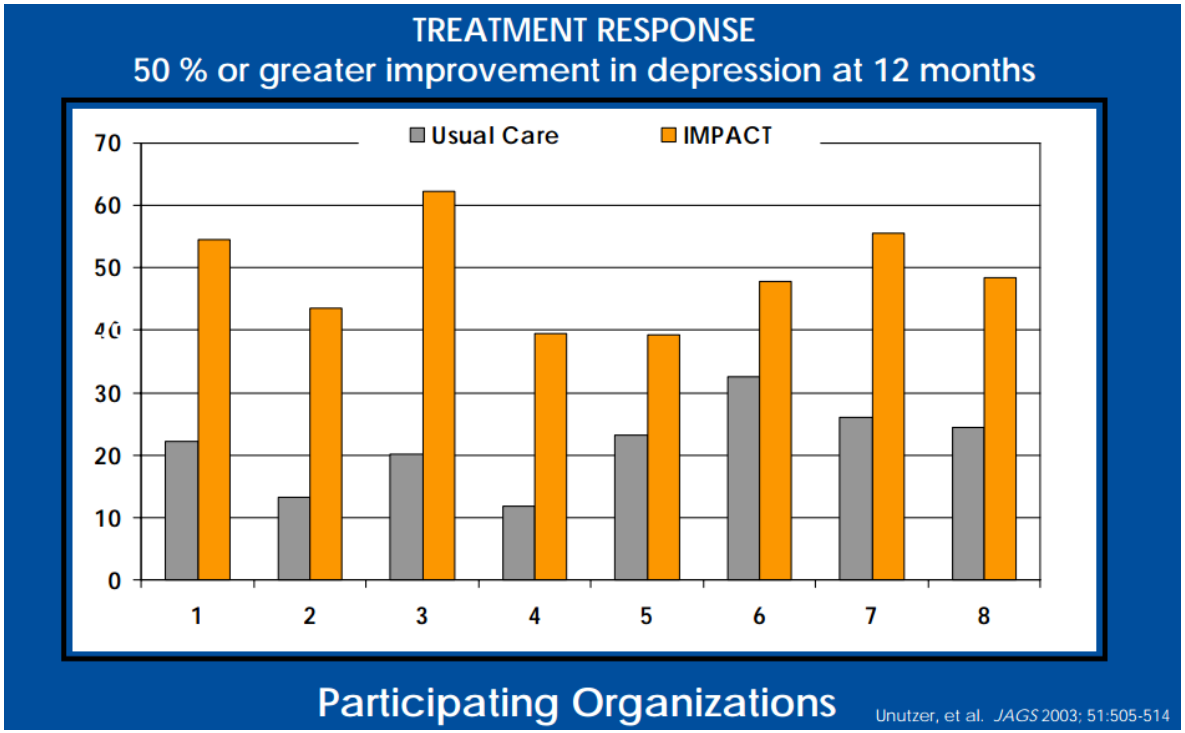
TWO PROCESSES	TWO NEW 'TEAM MEMBERS'	
	BH Care Manager	Consulting Psychiatrist
1. Systematic diagnosis and outcomes tracking PHQ-2/9 & GAD-2/7 to facilitate diagnosis and track outcomes	- Patient education / self management support - Close follow-up to make sure patients don't 'fall through the cracks'	- Weekly caseload consultation for care manager and PCP (population-based) - Diagnostic consultation on difficult cases
2. Stepped Care a) Change treatment according to evidence-based algorithm if patient is not improving b) Relapse prevention once patient is improved	- Support anti-depressant Rx by PCP - Brief talk treatment (behavioral activation, PST-PC, CBT, IPT) - Facilitate treatment change / referral to specialty behavioral health, as needed - Relapse prevention	- Consultation focused on patients not improving as expected - Recommendations for additional treatment / referral according to evidence-based guidelines

Project IMPACT

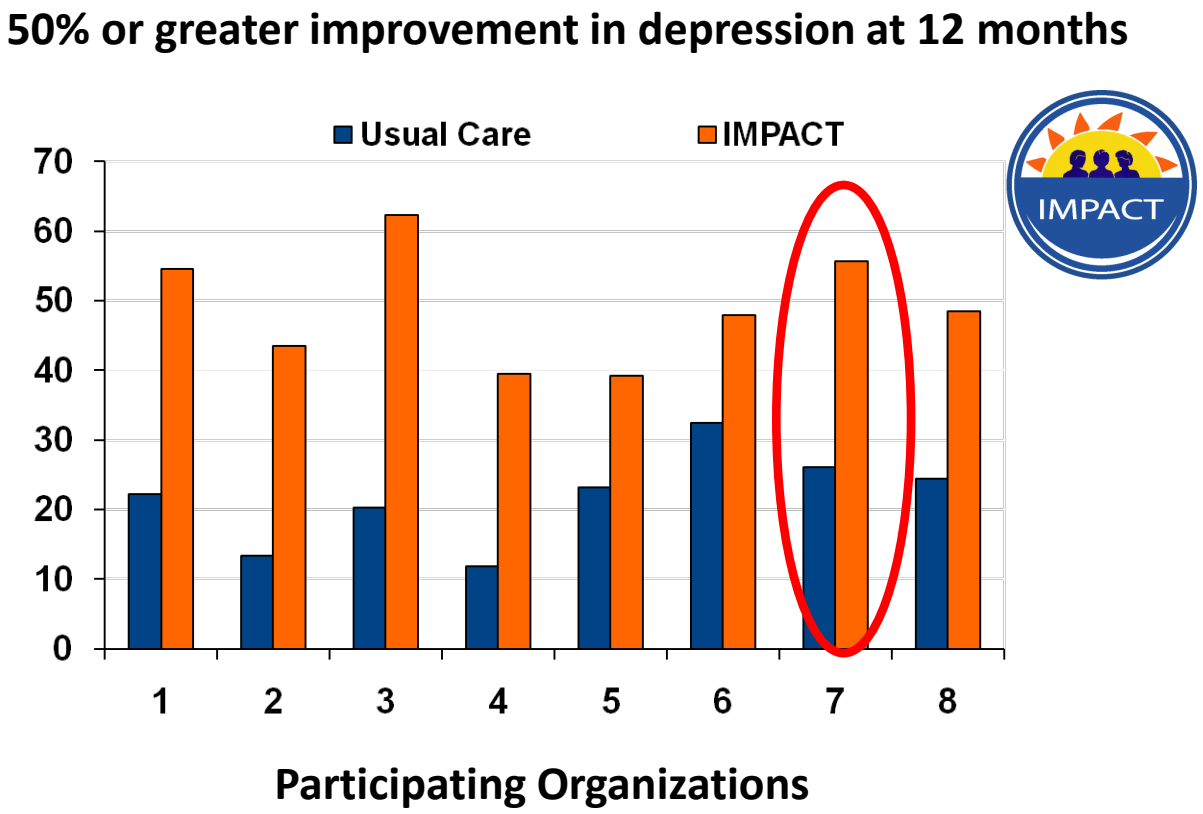
- **I**mproving **M**ood- **P**roviding **A**ccess to **C**ollaborative **T**reatment
  - Primary and behavioral health care services are integrated into the primary care setting to treat depression in patients.
  - IMPACT study
    - 1998-2003
    - 1,801 older adults from 18 primary care clinics across U.S.
    - ½ randomly assigned IMPACT model/Collaborative Care
    - Found that Collaborative Care more than DOUBLED the effectiveness of depression treatment in primary care settings.
    - Highly cost-effective

http://aims.uw.edu/impact-improving-mood-promoting-access-collaborative-treatment/

Project IMPACT- Study Outcomes



Co-Location is NOT Integration



Billing Medicare and Commercial Plans

- Many organizations do not know they can bill other payers
- Its important to bill across all payers –even if they are only a small percentage of your mix
- All time based
- All monthly case rates

Reimbursement Across the Board !

- Commercial and Medicare reimburse case rates for collaborative care
- Masters level licensed staff are able to provide care coordination
- Third party payers are reimbursing Medicare codes (let us know if you don’t get paid)

Staffing

- On site needs to “be available if requested”
- Providers can be telephonic- licensed in state
- Must be licensed or have experience
- Allows to expand staffing (LMFT, LMHC)
- Staff do not need to be credentialed or eligible provider

Individual Visits

- Can be EITHER billed independently or as part of the time for monthly rate
- MHSC difficulty credentialing so counting time as part of case rate
- Until provider is credentialed or if provider not able to be credentialed
- Medicare-LMHC would be time based vs. LMSW “incident too” vs. LCSW billing directly
- May need to vary by staff and payer if you want to optimize
- You can bill for both each month
- “Flag” for too many in person visits (traditional mh)

BHI Coding Summary non FQHC

BHI Code	Behavioral Health Care Manager or Clinical Staff Threshold Time	Activities Include:
CoCM First Month (G0502) (CPT 99492)	First 70 minutes per calendar month	• Initial Assessment • Outreach/engagement • Entering patients in registry • Psychiatric consultation • Brief intervention
CoCM Subsequent Months (GO503) (CPT 99493)	60 minutes per calendar month	• Tracking + Follow-up • Caseload Review • Collaboration of care team • Brief intervention • Ongoing screening/monitoring • Relapse Prevention Planning
Add-on CoCM (Any month) (G0504) (CPT 99494)	Each additional 30 minutes per calendar month	• Same as Above
General BHI (G0507) (CPT 99484)	At least 20 minutes per calendar month	• Assessment + Follow-up • Treatment/care planning • Facilitating and coordinating treatment • Continuity of care

BHI Coding Summary FQHC

BHI Code	Behavioral Health Care Manager or Clinical Staff Threshold Time	Activities Include:
CoCM First Month (G0512)	First 70 minutes per calendar month	• Initial Assessment • Outreach/engagement • Entering patients in registry • Psychiatric consultation • Brief intervention
CoCM Subsequent Months (GO511)	60 minutes per calendar month	• Tracking + Follow-up • Caseload Review • Collaboration of care team • Brief intervention • Ongoing screening/monitoring • Relapse Prevention Planning

Considerations

- Rates adjust by region so will vary across the state –or your organization if you cover a large region
- Rates adjust by provider such as a nurse practitioner
- Rates are adjusted yearly
- FQHC's/RHC use the G codes for Medicare and the CPT codes for commercial plans
- Patients can be enrolled in multiple initiatives , like CCM
- Don't exclude specialty providers , cardiology, addiction , pulmonary etc.
- Consider special populations like MAT or HIV
- Referral in the chart and recognition of dx by provider

Time Based Inclusions

- Psychiatric consultation
- Discussions, case reviews with primary care
- Registry management
- Telephonic work
- Discussions with collaterals
- In person visits (to be continued)
- If its not documented its not done !
- Case management/concrete services carved out
- 90% attached to billable event (10% capacity)
- 90% of events billable (may mean not including items)

Common Workflows

- Entry in electronic health record one long documentation
- Create a collaborative care schedule (carve out of productivity reports)
- Allows for documentation to support billing in one place and ease for pcp to see activity
- Remember lock outs or auto close may need to be adjusted
- Non visit or phone encounters
- Close at end of month, change provider and add cpt code

The 99494 Code

- Many payers have or will have a “ceiling”
- More add on time indicates trend to traditional services and can be flag
- Some payers are requiring authorization for multiple add on codes
- Cannot be billed independently , must accompany a 99492 or 99493
- Caseload of 90 lends to multiple types of care

The 99484 Code

- The “other” behavioral health code
- Cannot be used by FQHC providers
- Can be used when you don’t make the time for a month- as example the first month
- “fall back” to ensure billable months

1. **Can the General BHI code be billed for the same patient in the same month as the CoCM codes?**

   No, as noted in the CY 2017 PFS final rule, (81 FR 80242), a single practitioner must choose whether to report the general BHI code or the CoCM codes in a given month (service period) for a given beneficiary. However, in many cases, it may be appropriate for a single practitioner to report the general BHI code or the CoCM codes for the same beneficiary over the course of several months.

1. **Are the BHI codes limited to Medicare beneficiaries with certain behavioral health conditions/diagnoses?**

   No, as provided in the CY 2017 PFS Final Rule (81 FR 80232), the BHI codes may be used to treat patients with any mental, behavioral health or psychiatric condition that is being treated by the billing practitioner, including substance use disorders. We did not limit billing and payment for the BHI codes to a specified set of behavioral health conditions. The services require that there must be a presenting mental, psychiatric or behavioral health condition(s) that, in the clinical judgment of the billing practitioner, warrants BHI services. The diagnosis or diagnoses could be either pre-existing or made by the billing practitioner and may be refined over time.

Reimbursement

- Will vary some but most follow Medicare
- Appears to be “auto added” and mostly does not need to be added to contracts
- Outreach to payers difficult as codes are so new
- Suggest dropping claims
- Cigna and Affinity Medicare
- Often denial problem with claim form

1. **Is written consent required?**

   Prior beneficiary consent is required for all of the BHI codes, recognizing that any applicable rules continue to apply regarding privacy. The consent will include permission to consult with relevant specialists, including a psychiatric consultant, and inform the beneficiary that cost sharing will apply to in-person and non-face-to-face services provided. Consent may be verbal (written consent is not required) but must be documented in the medical record.

1. **Is a new patient consent form required each calendar month or annually?**

   No, a new consent is only required if the patient changes billing practitioners, in which case a new consent must be obtained and documented by the new billing practitioner prior to furnishing the service.

Depression Screening Simplified

Behavioral Health Screening Utilization: Depression	
Code	Description
1. G8431 (with HD modifier)	# of individuals screening for clinical depression is documented as being positive and a follow-up plan is documented.
1. G8510 (with HD modifier, replaces 99420)	# of individuals screening for clinical depression is documented as negative, a follow-up plan is not required
1. CPT code 96127	# of individuals screened with a brief emotional/behavioral assessment with scoring and documentation, per standardized instrument
1. G0444	# individuals receiving annual depression screening, 15 minutes
1. CPT 96161	Administration of caregiver-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument - Maternal depression screening during well-child visit, billed using child's ID number.

CCM-99490

- Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:
- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient,
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline,
- Comprehensive care plan established, implemented, revised,

Transitions of Care

CPT Code 99495 covers communication with the patient or caregiver within two business days of discharge. This can be done by phone, e-mail, or in person. It involves medical decision making of at least **moderate** complexity and a face-to-face visit within 14 days of discharge. The location of the visit is not specified. The work RVU is 2.11.

CPT Code 99496 covers communication with the patient or caregiver within two business days of discharge. This can be done by phone, e-mail, or in person. It involves medical decision making of **high** complexity and a face-to-face visit within **seven** days of discharge. The location of the visit is not specified. The work RVU is 3.05.

Instrument	Abbreviation	CPT code
Ages and Stages Questionnaire - Third Edition	ASQ	96110
Ages and Stages Questionnaire: Social-Emotional	ASQ:SE	96127
Australian Scale for Asperger's Syndrome	ASAS	96127
Beck Youth Inventories - Second Edition	BYI-II	96127
Behavior Assessment Scale for Children - Second Edition	BASC-2	96127
Behavioral Rating Inventory of Executive Function	BRIEF	96127
Briggance Screens II	(No Abbreviation)	96127
Brief Infant and Toddler Social Emotional Assessment	BITSEA	96127
Connor's Rating Scale	(No Abbreviation)	96127
Denver II	(No Abbreviation)	96110
Kutcher Adolescent Depression Scale	(No Abbreviation)	96127
Modified Checklist for Autism in Toddlers	M-CHAT	96110
Patient Health Questionnaire	PHQ-2 or PHQ-9	96127
Parents' Evaluation of Developmental Status	PEDS	96110
Pediatric Symptom Checklist	PSC	96127
Pediatric Symptom Checklist - Youth Report	Y-PSC	96127
Screen for Child Anxiety Related Disorders	SCARED	96127
Strength and Difficulties Questionnaire	SDQ	96127
Substance Abuse and Alcohol Abuse Screening	CRAFFT	96127
Vanderbilt Rating Scales	(No Abbreviation)	96127

Questions/Thoughts

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