ADVANCING INTEGRATED HEALTHCARE

Welcome
2019 IBH Expansion Practices

2019 QUARTERLY ADULT IBH MEETING 5-8-2019

Agenda

Topic ***Presenter(s)***	**Duration**
Introductions & Review of Agenda *Rena Sheehan*	5 minutes
Practices Report Out: 1st 3 months of progress (& challenges)	45 minutes
Review of Billing / Coding Document Review of Sample Adult & Pediatric Schedules Review of IBH Financial Model *Dr Nelly Burdette*	20 minutes with 10-minute discussion
Next Steps *Susanne Campbell*	10 minutes

Practice Report Out:
IBH Baseline Screening Results

Practice Name	***Depression***	***Anxiety***	***Substance Use Disorder***
Blackstone Valley Community Health Care	94.9%	1.5%	6.6%
PCHC Crossroads	97.6%	16.9%	3.4%
PCHC Central	96.4%	96.1%	95.7%
PCHC Randall Square	93.1%	93.6%	92.5%
Prospect Charter Care Physicians	84.0%	7.5%	0.1%
Women's Medicine Collaborative	92.4%	96.7%	96.9%
Coastal Edgewood	85.4%	1.0%	0.0%
Tri County - North Providence	88.8%	88.9%	85.5%
Brown Medicine - Warwick Primary Care	93.7%	85.2%	84.8%

Billing & Coding

Behavioral Health Clinician in Primary Care Billing & Coding Guidance (Revised from ORBH@healthinsight.org) Page 1										
Diagnostic Evaluation										
Code	**Service**	**Description**	**Required Documentation**	**Permissible Diagnoses**	**Tips/Guidelines**	**NHPRI/Optum**	**United/Optum**	**BCBSRI**	**Tufts Commercial**	**Medicare**
90791	Psychiatric diagnostic evaluation (without Medical Service)	Visit with intention of doing a diagnostic assessment, diagnostic clarification, or a biopsychosocial assessment	The assessment concludes with documentation of a diagnosis, rationale for the diagnosis, and a written treatment or disposition plan supported by the assessment and interview data	Psychiatric diagnoses	A psychiatric diagnostic evaluation is an integrated assessment that includes history, mental status and recommendations. It may include communicating with the family and ordering further diagnostic studies. If a person is not in need of mental health services, other disposition information, such as to whom the client was referred, shall be included in the client file. NOTE: 90792 is the code for Psychiatrist and includes evaluation for medication. NOTE: Generally this code cannot be billed the same day as a psychotherapy code. Medicare allows one 90791 every 6 months per episode of care, but 2nd evaluation within a year requires documentation of medical necessity. NOTE: This code is rarely used in IBH as it requires more time and more documentation than is typical for an IBH assessment. Do not use this code unless you are sure you have a way to document this information in the EHR and have considered the implications of having all of this information in the EHR. NOTE: Although this is not a time-based code, an evaluation of this kind generally requires at least 45 minutes.	Yes	Yes	Yes (Special Note for Pedi: BCBSRI recognizes that the eval of child/adol often takes longer than adults and requires add'l collateral contacts that further differentiate this population. BCBSRI allows providers to file with a modifier “TU” for extended 90791-psychiatric dx eval > 75 minutes.	Yes	Yes

Billing & Coding

Behavioral Health Clinician in Primary Care Billing & Coding Guidance (Revised from ORBH@healthinsight.org) Page 2											
Psychotherapy (Time-based codes)											
Code	**Service**	**Time/ Unit**	**Description**	**Required Documentation**	**Permissible Diagnoses**	**Tips/Guidelines**	**NHPRI/ Optum**	**United/ Optum**	**BCBSRI**	**Tufts Commercial**	**Medicare**
90832	Individual Psychotherapy	30 minutes (16-37)	Individual psychotherapy, face-to-face with patient; insight oriented, behavior modifying, supportive, and/or interactive psychotherapy.	Documentation for all time-based codes must include start & stop times (or duration) of session; should highlight diagnosis, symptoms, functional status, MSE where relevant, treatment plan and progress.	Psychiatric/ mental health diagnosis	Note separate codes for family or group therapy. In IBH, the 90832 code will likely be the one used most often.	Yes	Yes	Yes	Yes, but Tufts requires "notification" when any of psychotherapy services are provided, within 30 days of first visit; 8 visits are available until the next "notification" is required; this is not an authorization per se because svcs cannot be denied, but if the notification isn't submitted, claims could be denied	Yes
90834		45 minutes (38-52)									
90837		60 minutes (> 53)					Optum requires preauthorization of this code				
90846	Family Psychotherapy without patient present	N/A	With family/without patient present			Use for parent training sessions if child is not present	Yes	Yes			
90847	Family Psychotherapy	N/A	With family and patient present	Documentation should identify why family therapy is indicated.		Use for parent training sessions if child is present, or other family treatment services					
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Billing & Coding

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Psychotherapy cont.

Code	Service	Time/ Unit	Description	Required Documentation	Permissible Diagnosis	Tips/Guidelines	NHPRI/Optum	United/Optum	BCBSRI	Tufts Commercial	Medicare
90853	Group Intervention	N/A	Psychotherapeutic interventions of several patients in one session. The group may consist of patients with different diagnosis but share similar facets of maladaptive emotional or behavioral functioning.	Documentation should include a description of the therapeutic intervention used to alleviate emotional, behavioral or other disturbance. Service must address treatment goals. Group therapy needs to be listed as an intervention in the individual service plan, and why it is indicated rather than individual therapy.	Psychiatric / mental health diagnoses	Focus of group psychotherapy is to assist patient with his/her psychiatric condition. Medicare sets limit of 10 participants; not sure of other insurers. This code can be used in primary care for group treatment as long as there is a mental health component, and not just an educational component; there must be a licensed BHC running the group.	Yes	Yes	Yes	Yes, but see note on previous page	Yes
90849	Multiple family group psychotherapy	N/A	Group therapy sessions for multiple families when similar familial dynamics are occurring due to a commonality of problems in the family member under treatment			This code could be used in pediatric care - e.g. for an ADHD group that includes families (parents and children).					

Psychotherapy for Crisis (Time-based codes)

Code	Service	Time/ Unit	Description	Required Documentation	Permissible Diagnoses	Tips/Guidelines	NHPRI/Optum	United/Optum	BCBSRI	Tufts Commercial	Medicare
90839	Psychotherapy for crisis	First 30-74 minutes	Used when psychotherapy services are provided to a patient who presents in high distress with complex or life-threatening circumstances that require urgent or immediate attention	Documentation highlights immediate emergency requiring crisis response, assessment of danger to self or others, interventions utilized, safety plan development, recommendations, referrals and follow up plans	Psychiatric / mental health diagnosis	These codes are reported by themselves - do not use with evaluation or psychotherapy codes	Yes	Yes	Yes	Yes	Yes
90840		+ 30 minutes				This code is used for each 30-minute unit after the initial 74 minutes. If service is under 30 minutes use 90832.					

Billing & Coding

Behavioral Health Clinician in Primary Care Billing & Coding Guidance (Revised from ORBH@healthinsight.org) Page 4											
Health and Behavior Codes											
Code	**Service**	**Time/ Unit**	**Description**	**Required Documentation**	**Permissible Diagnoses**	**Tips/Guidelines**	**NHPRI/Optum**	**United/Optum**	**BCBSRI**	**Tufts Commercial**	**Medicare**
96150	Initial Assessment	15-minute units*	Used when identifying the psychological, behavior, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems	Per OPTUM: Documentation must include evidence to support that the H&B assessment is reasonable and necessary, and must include the DATE of initial DX, clear rationale of why H&B assessment is required, assessment outcome including mental status and ability to understand and respond meaningfully, and goals and expected duration of interventions.	Medical diagnoses only; Medical record must document the specific underlying medical problem	Used to identify and address psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems. The focus is not on treatment of a mental health disorder. *NOTE: these are billed in 15 minute units but only ONE copay applies per visit no matter how many units you bill for. NOTE: These codes are NOT for patient education.	Under BEACON, these codes were not covered; now under OPTUM we are waiting for confirmation.	Yes, limited to 4 units per episode of care	Yes, can be performed by any licensed MH provider: Psychologist, LICSW, LMHC, LMFT	Yes, but a referral from the primary care provider is required	Yes, but only Psychologists may use these codes
96151	Re-assessment							Yes, limited to 1 unit per day			
96152	Intervention			Per OPTUM: Evidence that the patient can respond meaningfully, clearly defined goals & interventions, response to intervention, rationale for duration, frequency of svcs, time duration of encounter				Yes, limited to 2 units per day			
96153	Group Intervention		2 or more patients								
96154	Family Intervention		With family and patient present								
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Billing & Coding

Behavioral Health Clinician in Primary Care Billing & Coding Guidance (Revised from ORBH@healthinsight.org) Page 5										
BH Screening										
Code	**Service**	**Description**	**Required Documentation**	**Permissible Diagnoses**	**Tips/Guidelines**	**NHPRI/Optum**	**United/Optum**	**BCBSRI**	**Tufts Commercial**	**Medicare**
96110	Developmental screening (milestone survey, speech & Language delay screen)	Administration and interpretation of developmental screening tool and recommendations provided to patient/family/provider based assessment; completed as part of a primary care visit	Screening tool and score/results; recommendations	Intellectual Disabilities, Communication Disorders, Autism Spectrum Disorders, Specific Learning Disorder, Motor Disorders.	Used with pediatric patients only; Coverage depends on patient's age. Usually < 18.	Yes	Yes	Yes	Yes	Yes
96127	Brief emotional/be-havioral assessment (PSC, PHQ, GAD, CRAFFT, ADHD scale etc.)	Should be used to report a brief assessment for ADHD, depression, suicidal risk, anxiety, substance abuse, eating disorders, etc.	Document the validated screening instrument used and follow up plan		Can be used for depression screening for adolescents, alcohol and drug use in adolescents, and behavioral assessments in children and adolescents.	Yes	Yes	Yes	Yes	Yes
96161	Caregiver-focused health risk assessment for benefit of patient.	Should be used for screening Post Partum Depression in new mothers	Document the validated screening instrument used and follow up plan		Billed under baby's name, not the mother's.	Yes	Yes	Yes	Yes	Yes
NOTE: USE SBIRT CODING ON THE NEXT PAGE WHEN INTERVENTIONS ARE DELIVERED IN ADDITION TO THE SUBSTANCE USE SCREENING										
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Billing & Coding

Behavioral Health Clinician in Primary Care Billing & Coding Guidance (Revised from ORBH@healthinsight.org) Page 6											
Alcohol & Substance Services (SBIRT) (Time-based codes)											
Code	**Service**	**Time/ Unit**	**Description**	**Required Documentation**	**Permissible Diagnoses**	**Tips/Guidelines**	**NHPRI/Optum**	**United/Optum**	**BCBSRI**	**Tufts Commercial**	**Medicare**
99408 (Medicare: G0396)	Alcohol and/or substance abuse structured screening and brief intervention services; intended for INITIAL evaluation, not for patients who have already been identified	15-30 minutes	Must use a validated screening instrument; perform an intervention based on score on screening instrument	Must record the instrument used and the nature of the intervention; must document time of session;	These are not considered MH or SUD services for patients with established dx or those referred for tx.	**BCBSRI: Medical provider ONLY can bill these codes.**	Yes	Yes	Yes	Yes	Yes
99409 (Medicare: G0397)		Greater than 30 minutes									
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Billing & Coding

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Psychiatric Collaborative Care (monthly)

Code	Service	Description	Required Documentation	Permissible Diagnoses	Tips/Guidelines	NHPRI/ Optum	United/ Optum	BCBSRI	Tufts Commercial	Medicare
99492	Initial psychiatric collaborative care management First 70 minutes in the first calendar month for behavioral health care manager activities, in consultation with a psychiatric consultant and directed by treating provider or other qualified health care professional	Must include: Outreach and engagement of patients; Initial assessment, including administration of validated scales and resulting in a treatment plan; Review by psychiatric consultant and modifications, if recommended; Entering patients into a registry and tracking patient follow-up and progress, and participation in weekly caseload review with psychiatric consultant; and Provision of brief interventions using evidence-based treatments such as behavioral activation, problem solving treatment, and other focused treatment activities.	Per BCBSRI: Documentation must be appropriate to the services provided	Psychiatric/ Mental health Diagnosis	**These codes are billed by the treating provider; psychiatrist and BHC or BH Manager bill "incident to" the treating provider**			Yes NOTE: CoCM services are covered and not separately reimbursed for providers unless a provider has submitted a program description and received approval from BCBSRI		Yes NOTE: An initiating visit is required prior to billing for the 99492, 99493, 99494, and 99484 codes. This visit is required for new patients and for those who have not been seen within a year of commencement of integrated behavioral health services. This visit will include the treating provider establishing a relationship with the patient, assessing the patient prior to referral, and obtaining broad beneficiary consent to consult with specialists that can be verbally obtained but must be documented in the medical record. Medicare beneficiaries must pay any applicable Part B co-insurance for these billing codes.
99493	Subsequent psychiatric collaborative care management First 60 minutes in a subsequent month for behavioral health care manager activities	Must include: Tracking patient follow-up and progress; Participation in weekly caseload review with psychiatric consultant; Ongoing collaboration and coordination with treating providers; Ongoing review by psychiatric consultant and modifications based on recommendations; Provision of brief interventions using evidence based treatments; Monitoring of patient outcomes using validated rating scales; and Relapse prevention planning and preparation for discharge from active treatment.								
99494	Initial or subsequent psychiatric collaborative care management Each additional 30 minutes in a calendar month of behavioral health care manager activities listed above.				Listed separately and used in conjunction with 99492 and 99493.					
99484	**General BHI**	Per CMS: Used to bill monthly services furnished using BHI models of care other than CoCM that similarly include "core" service elements such as systematic assessment and monitoring, care plan revision for patients whose condition is not improving adequately, and a continuous relationship with a designated care team member. CPT code 99484 may be used to report models of care that do not involve a psychiatric consultant, nor a designated behavioral health care manager (although such personnel may furnish General BHI services).						In the process of refining and revising this code		The Centers for Medicare & Medicaid Services (CMS) expects to refine this code over time, as more information becomes available regarding other BHI care models in use.

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Sample BH Schedules

Monday/ Wednesday/Friday	Tuesday	Thursday
8:30am: Huddle	11:30am: Huddle	11:30 am: IBH Weekly Mtg
9am: BLOCK	Noon: BLOCK	12:00pm: IBH Weekly Mtg
9:30am: Open	12:30pm: Open	12:30pm: Huddle BLOCK
10am: Open	1pm: Open	1pm: Open
10:30am: BLOCK	1:30pm: BLOCK	1:30pm: Open
11am: Open	2pm: Open	2pm: Open
11:30am: Open	2:30pm: Open	2:30pm: Open
Noon: LUNCH Block	3pm: LUNCH Block	3pm: LUNCH Block
12:30pm: Open	3:30pm: Open	3:30pm: Open
1pm: Open	4pm: Open	4pm: Open
1:30pm: Open	4:30pm: Open	4:30pm: Open
2pm: Block	5pm: BLOCK	5pm: BLOCK
2:30pm: Open	5:30pm: Open	5:30pm: Open
3pm: Open	6pm: Open	6pm: Open
3:30pm: Open	6:30pm: Open	6:30pm: Open
4pm: Open	7pm: Open	7pm: Open
4:30pm: BLOCK	7:30pm: BLOCK	7:30pm: BLOCK

Example #1	Example #2
8:30am: Huddle	9:30: BLOCK
9am: BLOCK	10am: Open
9:30am: Open	10:30am: Open
10am: Open	11:00: BLOCK
10:30am: BLOCK	11:30am: Open
11am: Open	12:00pm: Open
11:30am: Open	12:30: LUNCH Block (or HUDDLE)
Noon: LUNCH Block	1pm: Open
12:30pm: Open	1:30pm: Open
1pm: Open	2:00pm: Open
1:30pm: Open	2:30pm: Block
2pm: Block	3pm: Open
2:30pm: Open	3:30pm: Open
3pm: Open	4pm: Open
3:30pm: Open	4:30pm: Open
4pm: Open	5:00pm: Open
4:30pm: BLOCK	5:30pm: BLOCK
Same as adult schedule	Later start time, later end time to better accommodate children's schedules
Allows for 11 scheduled appts, time to catch up or run over if necessary during BLOCKED or unscheduled times, and 10-20% no show	Allows for 12 scheduled appts, time to catch up or run over if necessary during BLOCKED or unscheduled times, and 10-20% no show; makes scheduling huddle more difficult but may increase # of patients seen

General recommendation for Pediatric IBH scheduling:

1. Prioritize annual visits, new pts, children<5, and planned joint visits in the A.M.
2. Prioritize follow-up appointments during after school hours
3. Establish BHC schedule based on individual practice patterns and needs; this may change over time
4. In some circumstances the BHC might opt for longer appointments; i.e. using 2 slots rather than 1 for more complicated families or presentations; billing codes for family therapy (90846/7) or a longer psychotherapy intervention (90834) can be used for those sessions.

IBH Financial Model

Next Steps