Overview of A to Z

• Introduction and Overview
  – On-the-ground view of how to sustain integrated care
  – Focus on the integration of BH into primary care
• Direct Revenue
  – Billing codes and insurers
  – Grant opportunities
  – Documentation
• Indirect Value
  – A model for improving PCP efficiency and satisfaction
• Questions
Learning Objectives

1. Identify direct billing codes for BH reimbursement.

2. Identify specific examples of indirect value BH brings to primary care.

3. Describe appropriate BH documentation for primary care.

The Challenges of Billing

- Fee for service
- Capitated
- Pay for performance
- State differences
  - Two visits same day
  - Billing codes
  - Licensure
- County differences
- Insurers
Getting Started, Get Involved

- State Primary Care Associations
- Collaborative and National Organizations
- Community Stakeholders
- Legislative Action Committees
- Primary Care Behavioral Health Toolkits
  - Job descriptions
  - Billing guides
  - Care pathways
  - Models for integration
  - Manuals for integration

Direct Revenue: H&B Codes Basics

- Behavioral Health Billing with Health and Behavior Codes
Patients who may benefit from evaluations and treatments that focus on the biopsychosocial factors related to the patient’s physical health status such as patient adherence to medical treatment, symptom management and expression, health-promoting behaviors, health-related risk-taking behaviors, and overall adjustment to medical illness.

H&B Codes

Debuted in 2002
For use with a primary physical health diagnosis
– Secondary psychological focus only
– Billed in 15-minute increments
– Used by psychologists, RN, LCSW (practice dependent), other non-physicians w/ behavioral care scope

(Reference: Daniel Bruns, PsyD, SAMHSA, State Primary Care Association Integration Recommendations)
H & B Codes Basics

96150: Initial assessment
96151: Re-assessment
96152: Follow-up intervention 1:1
96153: Follow-up intervention group (2 or more pts)
96154: Intervention, family w/ pt

96150 Initial Assessment

• Onset and history of initial diagnosis of physical illness
• Clear rationale for H&B assessment
• Assessment outcome including mental status and ability of patient to understand
• Goals and expected duration of intervention
• Length of time for assessment
96151 Re-Assessment

- Significant change in mental or medical status requiring assessment
- Date of change in status requiring reassessment
- Clear rationale for reassessment
- Clear indication of precipitating event
- Length of time for reassessment

96152-96153 Follow Up 1:1 or Group

H&B Intervention procedures are used to modify the psychological, behavioral, emotional, cognitive and social factors identified as important to or directly affecting the patient’s physiological functioning, disease status, health and wellbeing utilizing cognitive, behavioral, social and/or psychological procedures designed to ameliorate specific disease related problems.

Documentation:

1. Evidence that patient has capacity to understand
2. Clearly defined psychological intervention
3. Goals of the intervention
4. Information that the intervention should help improve compliance
5. Response to intervention
6. Rationale for frequency and duration of services
7. Length of time for intervention
96154 Intervention with Family

Is considered reasonable and necessary for patient and family care.

- When the family directly participates in the patient's care
- Where family involvement is necessary to address the biopsychosocial factors that affect compliance with the medical plan of care

Documentation

Length of Time:
Established contact for Integrative care in room consultation. Obtained verbal consent for integrative care.

Appearance:
Motor:
Affect:
Behavior/Medical Concern: ***
Rationale for frequency and duration of services

Focus: Mgmt of Physical Health Concerns with specific goals

Intervention: Services for improving a patient's health by modifying cognitive, emotional, social, and behavioral factors that affect prevention, treatment, adherence, or management of a specific health problem or symptom: ***

Action: Agenda Setting, Integrative Chart Mgmt in PC note, Self-Monitoring encouragement, Motivational Enhancement, CBT, self mgmt support strategies ***

Response:
Plan:
Agenda Setting for PCP:
Federally Qualified Health Centers can bill for face-to-face encounters with an LCSW and Psychologist for Health and Behavioral assessment and intervention codes. However, psychology and psychiatric services are among those Medi-cal services for which utilization controls have been specified CCR Title 22, Sections 51304 and 51309.

H & B Codes Basics

• Who reimburses for these codes?
  – Medicare
  – Over 50 private insurance companies
  – Medicaid varies (see next slide)

• May not bill psych CPT code same day
States use of Medicaid’s Health and Behavior Assessment/Intervention (HBAI) codes (96150-96155 CPT Series)

State Restrictions*

<table>
<thead>
<tr>
<th>State</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>AK</td>
<td>96150-96154; Physician, therapists, and audiologists can bill</td>
</tr>
<tr>
<td>CA</td>
<td>96150-96153 only</td>
</tr>
<tr>
<td>CT</td>
<td>Can bill only on physician fee schedule, not psychologist fee schedule</td>
</tr>
<tr>
<td>DC</td>
<td>96151-96153 only</td>
</tr>
<tr>
<td>GA</td>
<td>96150-96151; only billable for Level 2-4 practitioners</td>
</tr>
<tr>
<td>HI</td>
<td>Prior Authorization for physicians (but not for FQHCs) under 96150, no prior authorization for 96151-96153</td>
</tr>
<tr>
<td>ID</td>
<td>Non-physician receive 82% payment</td>
</tr>
<tr>
<td>KS</td>
<td>Only 96150 is billable and only for beneficiaries up to age 1</td>
</tr>
<tr>
<td>KY</td>
<td>96150-96154 only</td>
</tr>
<tr>
<td>ME</td>
<td>96150-96154 only</td>
</tr>
<tr>
<td>MD</td>
<td>96150-96152 only</td>
</tr>
<tr>
<td>MN</td>
<td>96150-96154 only</td>
</tr>
<tr>
<td>NV</td>
<td>96150-96154 only; billable for Qualified Mental Health Professionals or Qualified Mental Health Associate</td>
</tr>
<tr>
<td>NM</td>
<td>96150-96151 only; billable for psychologists</td>
</tr>
<tr>
<td>ND</td>
<td>96150-96152 &amp; 96154; psychiatrists and psychologists</td>
</tr>
<tr>
<td>OH</td>
<td>96150 billable for individual physician, 96152 billable for individual psychologist or physician or physician group, 96153 billable for more practitioners</td>
</tr>
<tr>
<td>OK</td>
<td>96150 billable for individual physician, 96152 billable for individual psychologist or physician or physician group</td>
</tr>
<tr>
<td>SC</td>
<td>96150-96154; 96150 only billable for physician, 96151-96154 billable for physician and more practitioners</td>
</tr>
</tbody>
</table>
Direct Revenue: Psychotherapy Code Basics

- Behavioral Health billing with Psychotherapy Codes

Psychotherapy Code Basics

January 1st, 2013 New CPT Codes
- Required when billing patients, third-party payers, Medicare, Medicaid, and private insurers
Psychotherapy Code Basics

• New Code 90832: Psychotherapy, 30 minutes with patient and/or family member (Historically and no longer 20-30 minutes)

• New Code 90834: Psychotherapy, 45 minutes with patient and/or family member (Historically and no longer 45-50 minutes)

• New Code 90837: Psychotherapy, 60 minutes with patient and/or family member (Historically and no longer 75-80 minutes)

Psychotherapy Code Basics

• Face-to-face services with the patient and/or family member with the patient present for some or all of the service.

• Face-to-face time may differ than actual code time billed.
  90832: (30 min.) 16 to 37 minutes
  90834: (45 min.) 38 to 52 minutes
  90837: (60 min.) 53 minutes or longer
Psychotherapy Code Basics

• The psychotherapy codes should not be billed for any sessions lasting less than 16 minutes.

  – Does this mean BH providers only complete interventions at 16 minutes and above?

Documentation

• Start and Stop Times / Minutes face to face
• Justification for treatment
• Diagnosis
• Goals
• Mental Status
• Interventions
• Response to Tx / Progress / Outcomes
• Prognosis
• Risk
• Plan
Documentation

- The patient
- The auditor
- The attorney
- The pcp
- Other clinical staff
- Yourself / Other BH

Direct Revenue: Alternative Codes

- Consultation Codes
  - Diagnosis Code: V40.9 Unspecified mental or behavioral problem
  
  - Procedure Code: 99242 Office consultation for a new or established patient

- Aetna 1-888-632-3862 www.aetna.com
**Alternative Codes: 99242**

1) Expanded problem-focused history
2) Expanded problem-focused examination
3) Straightforward medical decision making
4) Counseling and coordination of care with other providers or agencies.
5) Low severity, 30 min. face-to-face.

**Alternative Codes: 99242**

6) PCP referred, co-located (lease agreement) or integrated behavioral health (BH).
7) 3 sessions reimbursed through BH benefit, billed by BH provider, within the primary care setting.
8) BH communicates to pcp with written reports on interventions and progress.
9) PSY, LCSW, LPC, or Master’s level
Alternative Codes: CPSP CA

Comprehensive Perinatal Service Programs:
• Comprehensive program which provides a wide range of culturally appropriate services to pregnant women from conception through 60 days postpartum.

• Similar programs and benefits in other states.

CPSP Providers

• Marriage, Family and Child Counselors
• Registered Dietitians
• Health Educators
• Certified Childbirth Educators (ASPO/Lamaze, Bradley, ICEA)
• Comprehensive Perinatal Health Workers (CPHW)
  – At least 18 years old
  – Minimum one year paid perinatal experience
  – High School Diploma
• Physicians
• Certified Nurse Midwives
• Physician Assistants
• Registered Nurses
• Licensed Vocational Nurses
• Social Workers
• Psychologists
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**ASU Health Solutions**

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• Social Workers
• Psychologists
## Direct Revenue: Grants

- Federal Grants
- Substance Abuse and Mental Health Services
  [http://beta.samhsa.gov/grants](http://beta.samhsa.gov/grants)
- National Institute of Mental Health
- Robert Wood Johnson Foundation
- Human Resources and Services Administration
- Agency for Healthcare Research and Quality
- Disease specific (ie: Ryan White)
- Team Up & Be creative!

## Grants

- National Institute for Health Care Management:
- State Associations, Primary Care Associations, and County/Local Grants
- Review All Grants for Inclusion
- Health and Human Services Grants
  [http://www.hhs.gov/grants/](http://www.hhs.gov/grants/)
- Medicaid
  [www.medicaid.gov](www.medicaid.gov)
- Education Grants
Business Case for BH

Cost of behavioral health:
- Employee costs
- Equipment and tools
- Learning/training and recruitment
- Space
- Staff, vetting, culture change

Management:
- Establish minimum of average BH billable visits
- FTE vs Contracting for specialty services
- Screening practices
- Quality improvements activities
- Dashboards
- Stakeholders
- Same day billing

Business Case for BH

- Executive Team Benefit Review
  - Screening (reimbursement)
  - Successful prevention/education
  - Population health mgmt
  - Productivity support
  - Direct reimbursement (tx)
  - Provider & staff satisfaction
  - Team based benefits
Business Case for BH

- Increasing physician focused visits
- Improving patient satisfaction
- Improving provider satisfaction
  - Reduction in overutilization
  - Increased access to care
  - Increased self mgmt & community support efforts
  - Improved multidisciplinary care teams
    - Physician focus
  - Employee wellness and retention

A Clinical Model for *Indirect* Value

Or, How to Make a Service a *Necessity*
Rather than a *Nicety*
Common Misconceptions

• Direct revenue is “be all and end all”
  – Many services break-even or make some money, but few are getting rich
• Cost-offset will convince them
  – Important to policy-makers, administrators but not to providers
  – Few tangibles, hard to measure
• Improved clinical outcomes is crucial
  – Few tangibles
  – Makes PCPs nervous!

What Do Clinics Care About?

How can our PCPs meet productivity goals and be more satisfied?
The Challenges of Primary Care

• Sample patient:
  – Just released from jail
  – No insurance
  – No records
  – Reported past dx of bipolar, ADHD, depression, PTSD, cocaine abuse, others(?)
  – Has been on lithium, buspar in jail, but not sure they’re helping. Can’t recall others
  – “Oh, yeah, I also have HIV.”
  – 20-min visit

ASU Health Solutions

The Challenges of Primary Care

• The past two weeks:
  – Over-crowded waiting room
  – 2 new PCPs, 2 new front desk staff
  – Undergoing remodel
  – Patient events:
    • 1 suicide
    • 1 standoff b/w 8 police and pt in clinic for 2 hrs
    • 1 pt feigned passing out/hitting head in lobby
    • 1 time-intensive sexual abuse case (Spanish)
    • 1 subpoenae for a custody trial

ASU Health Solutions
To Summarize…

Primary Care is Stressful Work!

Stress Among PCPs

- Unmet patient expectations
- Threats of litigation
- Interpersonal conflicts
- Coping with the death of patients
- Inadequate patient care space*
- Lack of essential supplies*
- Lack of specialists for the underserved*
- Cultural/Language/Financial barriers*

* SAFETY NET SYSTEM
Stress Among All Staff

- Heavy workload*
- Understaffing*
- High intensity of work*
- Risk of injury or harm
- Job insecurity
- Poor communication skills by superiors
- Unpleasant physical environment

* ESPECIALLY IN SAFETY NET SYSTEM

Consequences for the Bottom Line

- Direct and Indirect effects of stress on critical organizational measures:
  - Job performance
  - Absenteeism*
  - Errors in treatment
  - Quality of care*
  - Patient satisfaction
  - Turnover*

*Known financial burden in organizations
PCP Turnover is Expensive

- Signing bonuses, relocation costs
- Recruiting costs around $40,000
- Lost revenue with an open position
  - A PCP can generate $1M per year
  - Reduced productivity of associated staff
- Locum tenens costs
- Credentialing, training for new PCP
- Low productivity during start-up
- Total cost $250,000-$1M for 1 PCP

Takeaways

- Primary care is stressful, and…
- The stress is costly
- How did we get into this mess? Much of it has to do with behavior…
How Did We Get Into This Mess?

Patients with psychosocial issues are higher utilizers

- Of 14 common sx in primary care, only 16% had organic etiology (Kroenke 1989)
- Anxiety, loneliness drive visits (Fries, 1993)
- Half of high-utilizers have a psych or CD problem (Friedman, 1995)
- Patients with psych disorder utilize 50% more physical health services (Simon et al, 1995)
How Did We Get Into This Mess?

• Wide range of behavioral issues, ages in primary care
  – Chronic disease mgmt
  – Somatic complaints with lifestyle/stress component
  – Sub-threshold problems
  – Preventive health
  – All manner of psychiatric, substance abuse problems
  – Infants through older adults

How Did We Get Into This Mess?

• PCPs insufficiently trained and supported
  – 10 or 15 mins per visit
  – 3 complaints on average/visit
  – Insufficient training in behavioral interventions
  – Over 3 dozen urgent but unpaid tasks everyday
  – Need 7.3 hrs/day to implement all USPSTF recommendations
  – 15,000 new PCPs needed to implement healthcare reform
  – Overworked, underpaid—stressed!
Implications

• Integrating primary care is needed
• But, integration must address needs
  – Generalist
  – Accessible
  – High productivity
  – Team-Based
  – Routine care component
  – Must be a Teacher
  – Population-based strategies

Not All “Integration” is the Same

• WA State care coordination model (IMPACT)
  – Started in 2007 in 2 counties
  – Expanded to 100 CHCs and 30 CMHCS state-wide in 2009
  – 25,000 pts total (all years) as of 2012
• PCBH model
  – 8,000 pts in 2012 alone at HealthPoint
The PCBH Model

- Consultant model
- Member of primary care team, work side-by-side
- Goal is to improve PCP mgmt of behavioral issues
  - Wide variety of interventions and goals
  - Brief visits, limited follow-up
  - Immediate feedback to PCP
  - Any behaviorally-based problem, any age
- Aim for immediate access, minimal barriers
- Rooted in population health principles

The Behavioral Health Consultant

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Consultant</th>
<th>Therapist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary consumer</td>
<td>PCP</td>
<td>Patient/Client</td>
</tr>
<tr>
<td>Care context</td>
<td>Team-based</td>
<td>Autonomous</td>
</tr>
<tr>
<td>Accessibility</td>
<td>On-demand</td>
<td>Scheduled</td>
</tr>
<tr>
<td>Ownership of care</td>
<td>PCP</td>
<td>Therapist</td>
</tr>
<tr>
<td>Referral generation</td>
<td>Results-based</td>
<td>Independent of outcome</td>
</tr>
<tr>
<td>Productivity</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>Care intensity</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td>Problem scope</td>
<td>Wide</td>
<td>Narrow/Specialized</td>
</tr>
<tr>
<td>Termination of care</td>
<td>Pt progressing toward goals</td>
<td>Pt has met goals</td>
</tr>
</tbody>
</table>

ASU Health Solutions
Sample Clinic Day: What to Look For

• Variety of methods for getting pt to the BHC
  – Before PCP
  – PCP and BHC in room together
  – After PCP

• Variety of problems and ages
  – Clinical (MH, SA, Beh Med, all ages)
  – Case management/Care coordination

• Variety in the goals of visits
  – PCP-prep
  – Treatment augmentation
  – Medication and treatment planning

Sample Clinic Day

• **9:00 PCP wants meds rec**
  – 52 y/o homeless, ? ADHD vs bipolar

• **9:30 Question re disability expiring**
  – 64 y/o Russian-speaker, depression

• **10:00 PCP says “I don’t know her problem”**
  – 62 y/o, psychiatrist d/c’d, on 3 meds from 3 Drs

• **10:30 Open→WH w/ PCP in exam room**
  – 12 y/o autism, ADHD, showing tics, hall’s
Sample Clinic Day (cont’d)

- **11:00** N/S→WH in exam room, PCP-prep
  - 6 y/o ADHD, insomnia, enuresis
- **11:30** Planned f/u from 1 week earlier
  - 20 y/o Spanish-speaker, depressed w/ SI
- **1:00** Team mtg (15-min talk on pain, 5-min on tobacco cessation)
- **2:00** Cx→same-day appt for NRT refill

Sample Clinic Day (cont’d)

- **2:30** Open→WH for CSA
  - 60 y/o severe etoh, chronic arm pain
- **3:00** Planned f/u after 2 weeks
  - 47 y/o homeless, MDD w/ psychosis, acute SI due to meds
- **3:30** Planned f/u after 1 month
  - 45 y/o homeless, MDD, wants disability
- **4:00** Cx→WH for PCP prep on new pt
  - 16 y/o expelled from school, needs risk assessmt
- **4:30** Open→Same-day f/u after 4 mos
  - 20 y/o seeking disability for PTSD, dep
Does it Work?

Clinical Outcomes

- USPSTF recommendations
  - Various problems
  - Various intervention models
  - Various provider backgrounds
- AHRQ (2008) review
  - Adding behavioral component improves outcome
  - No clear model superiority
- PCP influence
  - Increased PCP use of behavioral interventions (Mynors-Wallace, 1998)
  - Increased PCP confidence for behavioral health conditions (Robinson, 2000)
Clinical Outcomes for PCBH

- 71% of patients improved, even the most severe
  - Patients with more severe impairment at baseline improved faster than less severe (Bryan et al., 2012)
- Patients receiving just 2-3 visits showed broad improvement in sx, functioning, well-being
  - These changes were robust and stable during 2-year follow-up
    - Ray-Sannarud et al., 2012; Bryan et al., 2009)
- Most patients who attend 2, 3 or ≥ 4 visits show clinically significant change
  - Cigrang et al., 2006

PCBH Dissemination, Finances

- Many large CHC organizations
  - Cherokee, Salud, Mountain Park, Access
- Standard of care in all branches of the DoD
  - All now utilize a PCBH service
- Various VISNs of the VA
- Less common in private, for-profit organizations
- Strong financial reports
  - Large study underway in OR
Provider Impact

- All PCPs reported:
  - Satisfaction with the BHC service
  - Improved job satisfaction
  - Better able to address behavioral problems
  - Recommend the service for other sites
- A majority (> 80%) said because of BHC:
  - More likely to continue with HealthPoint
  - Able to see more patients in 20 minutes
  - Recognize behavioral issues better

Patient Satisfaction

- 90% said visit length “just about right”
- 76% were satisfied w/ ability to get appt
- 86% felt BHC understood their problems
- 89% said it was helpful to meet w/ BHC
- 65% said physical health improved
- 72% said mental health improved
Conclusions

• Both “Top Down” and “Bottom Up” growth is crucial to developing a service
• Indirect (bottom up) value comes from a model that improves PCP efficiency and satisfaction
• The PCBH model is built to help the PCP provide more efficient and effective care

Post-test Questions

1. True or False: Both H&B and traditional psychiatric codes can be utilized for billing behavioral health services in primary care dependent on service provided, diagnosis, and targeted outcome.

2. True or False: Integrated care allows the PCP to focus on medical tasks, which generate higher revenue.

3. Which of these is not an essential piece of BH documentation in primary care:
   A. Dream analysis and transference
   B. Recommendations for primary care physician
   C. Measureable self management goals, which assist with assessing progress
   D. Brevity
The A to Z of Revenue Opportunities in Primary Care Behavioral Health

Thank you! Contact Us for Consultation!

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