Session # H2

But How Will You Pay for It? Maximizing Reimbursement for Behavioral Health Integration in the Fee for Service World

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CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION

Faculty Disclosure

The presenter of this session has NOT had any relevant financial relationships during the past 12 months.

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Conference Resources

Slides and handouts shared by our conference presenters are available on the CFHA website at https://www.cfha.net/page/Resources_2019 and on the conference mobile app.

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Learning Objectives

At the conclusion of this session, the participant will be able to:

- Describe the rules and regulations that presently govern reimbursement for integrated behavioral health
- Identify ways to maximize reimbursement in your organization based on a deeper knowledge of the rules
- Delineate next steps to take to work with your organization to help answer the question of how the service will pay for itself

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Bibliography / Reference

1. Unutzer et al. Long-term cost effects of collaborative care for the late-life depression. American Journal of Managed Care. 2008 Feb: 14(2): 95-100
2. Billing Effectively (and accurately) for Integrated Behavioral Health Services. SAMHSSA – HRSA Center for Integrated Health Solutions. June 6, 2016
3. Reiss-Brennan et al. Journal of Healthcare Management. 2010 March/April; 55(2) 97-114
4. Billing for Integrated Behavioral Health" Primary Care Coding Guidelines. Integrated Primary Care Leadership Collaborative. June 6, 2018. https://healthinsight.org/tools-and-resources/send/394-oregon-behavioral-health-resourcs/1560-billing-for-integrated-behavioral-health-primary-care-coding-guidelines
5. AIMS Center: Advancing Integrated Mental Health Solutions https://aims.uw.edu/news-cms-payment-codes-benefit-collaborative-care

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Learning Assessment

- A learning assessment is required for CE credit.
- A question and answer period will be conducted at the end of this presentation.

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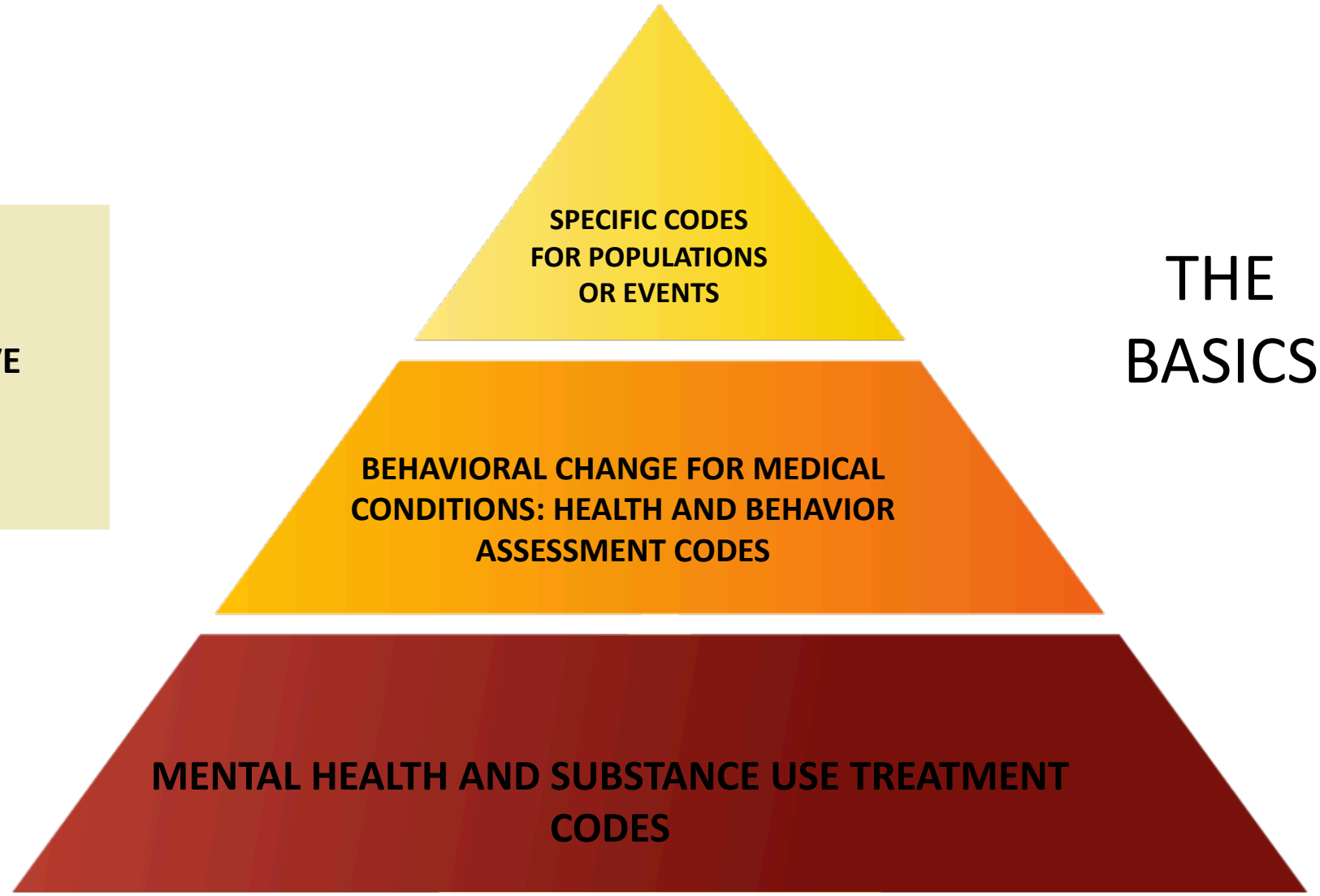
The Goal: Outcome driven, sustainable integrated practice model for patients and providers

THE BASICS

COLLABORATIVE CARE CODES



10 Tips for Success with Reimbursement

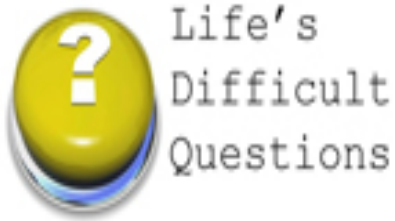
1. Know your service and business model
2. Learn the basics of billing, coding and reimbursement
3. Identify the other codes and where to get more information about these
4. Tie the reimbursement needs to the clinical service delivery
5. Organize your information – How about a grid?
6. Make friends with your billers and coders
7. Plan to get paid
8. Reframe the question
9. Gather resources and keep learning
10. Be humble and persistently curious

Official Disclaimer

- Consultant makes no warranty regarding the manner in which any payor, governmental or private, will accept or deny any claim for reimbursement relating to integrated mental health services.

- In publishing or otherwise disseminating any Work Product this author makes no representation or warranty regarding the manner in which any payor, governmental or private, will accept or deny any claim for reimbursement relating to integrated mental health services; that the provided is not intended to replace the information contained in the ICD-10-CM and CPT manuals or specific coding, reporting, or reimbursement information that may be disseminated by third-party or government payers; and that providers should seek advice from their own consultants with respect to submission of particular claims or categories of claims for reimbursement by payors.

Tip #1 – Know your service and business model



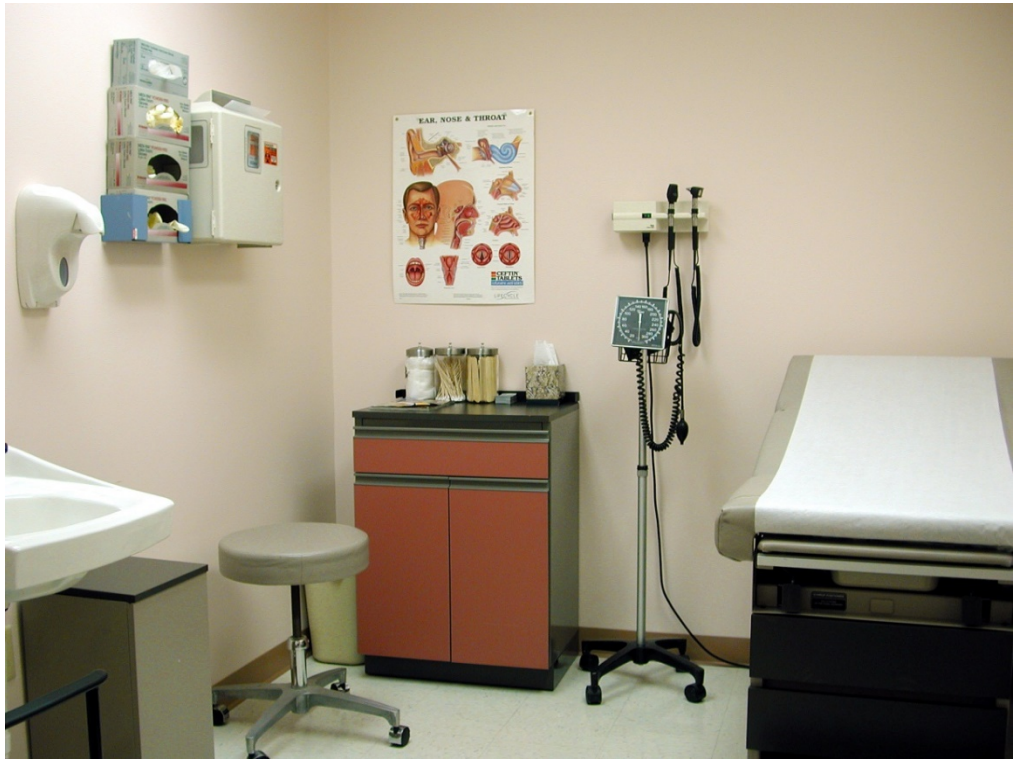
Identify - Level of Integration

Identify - type of practice setting

Identify - who will do the billing

Levels of Integration

		Level	Attributes	Reimbursement
Coordinated	Minimal Collaboration	I	Separate site & systems Minimal communication	Behavioral health clinician or agency bills No cost to med practice
	Basic Collaboration at a distance	II	Active referral linkages Some regular communication	Behavioral health clinician or agency bills No cost to med practice
Co-Located	Basic Collaboration on site	III	Shared site; separate systems Regular communication	Behavioral health clinician or agency bills Space cost to med practice
	Close Collaboration Onsite	IV	Shared site, some shared systems Routine communication and coordination	Behavioral health clinician or agency bills Med practice may support through contract or space
Integrated	Close Collaborative Approaching Integrated Practice	V	Shared site; shared systems Coordinated treatment plans Regular communication	Shared cost or med practice pays for service. Billing through med practice.
	Full Collaboration in a Transformed Integrated Practice	VI	Shared site, vision, systems Shared treatment plans Regular team meetings Population based behavioral health	Med practice bills and pays for service



BHI is different

The Questions for Integrated Care Settings

- **Who** will be delivering the service?
- **What** service will be delivered and what **code** will be used?
- **Who** are the partners doing integration?
- **Where** will the service be delivered?
- **What** is the “facility”? Under what license?
- **Who** will “employ” staff?
- **Who** will do the billing?
- **How** will the reimbursement work? Which insurance will be billed? What are the rules for that insurer?

Potential Partnerships (if BHC is not directly employed by medical setting)

Mental Health agency	⟷	Physician Practice
Mental Health agency	⟷	Hospital Practice
Mental Health agency	⟷	FQHC/RHC
Hospital Behavioral Health	⟷	Hospital Practice
Private MH Clinician	⟷	Physician Practice
Others?	⟷	Physician Practice

Share the Risk and Responsibility

- Clear accountability linked to shared risk
- Clear management roles and expectations
- Shared responsibility for financial success
  - Medical practices do the registration and billing
  - Consider 3 year financial plan to allow for ramp-up and stabilization
- Offer ongoing support to medical practices for maximization of reimbursement

Be ready for the reality of billing and reimbursement

- Mental Health regulations and licensing don't match the primary care setting
- Lack of clarity and understanding about present practices regarding billing and reimbursement
- Problem Areas: Licensing, Record Keeping, Reimbursement – coding and billing, inconsistent expectations from insurers

Tip #2 – Learn the basics of billing, coding and reimbursement

"Ready to walk the Reimbursement Maze?"

Who can get reimbursed for services in medical practices?

Master Level Clinicians

- Medicare - LCSW's only, and only the mental health codes
- Medicaid varies by state but may allow: LCSW's, LCPC's and LMFT's, LMHP's as well as conditional. May also vary by practice type.
- Commercials may also differ but may restrict to fully licensed staff. May vary re: Health and Behavior codes

Psychologists

- Medicare reimburses both mental health and Health and Behavior codes
- Paid by Medicaid and Commercial insurers

Psych NP's/PA's

- Follow rules for E/M codes
- Generally paid by all payers
- Would not bill Health and Behavior codes

Mental Health and Health and Behavior Codes

Mental Health Codes

- Initial Assessment - 90791
- Individual Therapy

  90832 – 30 min (16-37)
  90834 – 45 min (38-52)
  90837 – 60 min (53+)

- Family Therapy 90847, 90846, (not less than 26 min.)
- 90853: Group Therapy

Health and Behavior codes

- 96150: Assessment
- 96151: Reassessment
- 96152:Individual intervention
- 96153: Group intervention
- 96154:Family intervention

E/M codes and Psych NP's

- 90791, Psychiatric Diagnostic (Dx) Eval.
- 90792, Psych Dx Eval. with medical services
- 90791 + 90785, Psych Dx Eval. with interactive complexity
- 90792 + 90785, Psych Dx Eval. with medical services and interactive complexity

- 90833, Psychotherapy with E/M, 30 mins (16-37)
- 90836, Psychotherapy with E/M, 45 mins (38-52)
- 90838, Psychotherapy with E/M, 60 mins (53 or more)

Evaluation & Management (E&M)

- Use E&M codes 99201-99201 or 99211-99215 whenever possible
- Medically necessary services
- Practicing within their scope of practice
- Used in conjunction with a medical or psychiatric diagnosis

Medicare reimbursement rates

Type of Provider	% physician fee	Notes
MD/DO, Psychologist	100%	Or actual charge, whichever is less
PA, NP, CNS	85%	
CSW (LCSW)	75%	
Reduced by any applicable deductible		

NHIC website: www.medicarenhiccom on Fee Schedule page.

Medicare rules: What is a Fiscal Intermediary or MAC and why are they important?

- **A** private health care insurer that has been awarded a geographic jurisdiction to process Medicare Part A and Part B (A/B) medical claims …for Medicare Fee-For-Service (FFS) beneficiaries. **CMS relies on a network of MACs to serve as the primary operational contact between the Medicare FFS program and the health care providers enrolled in the program.** MACs are multi-state, regional contractor

Functions include:

- Process Medicare FFS claims
- Make and account for Medicare FFS payments
- Enroll providers in the Medicare FFS program
- Handle provider reimbursement services and audit institutional provider cost reports
- Respond to provider inquiries
- **Educate providers about Medicare FFS billing requirements**
- **Establish local coverage determinations (LCD's)**
- Coordinate with CMS and other FFS contractors

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/

Medicaid

- States have flexibility:
  - Covered mental health services
  - Two services (mental health and medical) on same day
  - Contract with managed care
- Billing:
  - Requires diagnosis and procedure code
  - Some states limit procedures, providers and/or practices that can use these codes

Commercial Insurances – concerns

- Credentialing (or enrollment) process and start-up
- May respond - too many available clinicians in the area, so won't allow credentialing
- Lack of clarity around covered services
- Difficulty finding "experts" to answer specific questions about reimbursement
- Carve outs
  - Different systems
  - Different reimbursement streams
- Problems with "prior auth's" and need for practices to have processes in place
  - Who makes the call?
  - Which insurances require this?

Tip # 3 – Identify the other codes and where to get more information

"Are there any more little details I should know about the healthcare plan?"

Health & Behavior (H&B) Codes
96150 – 96155

Patient

- Underlying physical illness or injury
- Biopsychosocial factor may be affecting medical treatment
- Cognitive capacity for the approach

Physician

- Documents need

Assessment

- Does not duplicate other assessment

Health and Behavior Codes

96150	Assessment	Initial assessment to determine the biological psychological and social factors affecting the physical health and any treatment problems, e.g. health-focused interview
96151	Re-assessment	Re-assessment to evaluate the condition and determine the need for further treatment. Can be performed by clinician other than the one who did the initial assessment
96152	Ind Intervention	Service to modify the psychological, behavioral, cognitive and social factors affecting the pt's physical health and well-being, e.g. using CBT
96153	Grp Intervention	Group sessions typically last 90 minutes and involve 8-10 pts, e.g. Smoking cessation
96154	Fam Intervent	Service to family with pt. present, e.g. relaxation techniques with diabetic child with parent present

Examples

Insurance Ramifications

H&B codes:

- Covered by some insurers, not all
- Discipline reimbursable for some, not all
- Medical benefit: No pre-auth, no carve-out, no different co-pay
- Medical practice bills

Mental Health codes:

- Covered by most insurers
- Generally reimbursable
- Contract & credentialing with behavioral health carve-out needed
- May eventually need pre-auth
- May require larger co-pay

Health and Behavior Codes Documentation

Must include, at a minimum:

- Patient has underlying physical illness or injury
- Biopsychosocial factors affect the treatment of the medical problem
- Evidence that the patient has the capacity to understand or to respond meaningfully
- Clearly defined psychological intervention planned with goals
- Expectations that the psychological intervention will improve compliance with the medical treatment plan
- The response to the intervention
- Rationale for frequency and duration of services

Crisis Codes 90839 and 90840

- Used for urgent assessment and history of crisis state, a mental status exam and disposition.
- Includes psychotherapy, mobilization of resources to diffuse crisis and restore safety, and implementation of psychotherapeutic interventions to minimize risk
- Typically life threatening, complex and requires immediate attention to a patient in high distress e.g. suicidality, homicidality
- Can be coded by DO, MD, APRN, or PA or other qualified health care providers (LSW, LISW, psychology, counselors)

From: Coding and Documentation for Behavioral Health Providers (2016). Diane E. Zucker, M.Ed. CCS-P, Health Care Consultant. Email: dezucker@sbcglobal.net

Crisis Codes 90839 and 90840 - continued

- Does not need to be continuous
- Full attention of the provider (physician or other qualified health care provider) must be devoted to this patient/family
- Patient must be present for some or all of the service
- 90839 – used for the first 30-74 minutes and can only be coded once per date
- 90840 - used for each additional block of 30 minutes (not less than 15 minutes)
- Do not report in conjunction with 90791, 90792, psychotherapy codes 90832-90838 or other psychiatric services

From: Coding and Documentation for Behavioral Health Providers (2016). Diane E. Zucker, M.Ed. CCS-P, Health Care Consultant. Email: dezucker@sbcglobal.net

Noteworthy codes

- Prolonged Service Codes:
  - In the **office or other outpatient setting,** Medicare will pay for prolonged physician services (CPT code 99354) (with direct face-to-face patient contact that requires one hour beyond the usual service), when billed on the same day by the same physician or qualified NPP as the companion evaluation and management codes. The time for usual service refers to the typical/average time units associated with the companion E&M service as noted in the CPT code. You should report each additional 30 minutes of direct face-to-face patient contact following the first hour of prolonged services with CPT code 99355.
- F54 and F59: Psychological and behavioral factors associated with disorders or diseases classified elsewhere.
  - F54 or F59 as initial diagnosis
  - Medical diagnosis as secondary diagnosis
- Telephone consult: 99441,99442, 99443, 98966 - TBD

Billing for Groups

- Medicare does not allow group billing for FQHC's and RHC's but some practices may still deliver group services
- Medicare allows within Provider based practices (non-FQHC or RHC).
- Medicare requires LCSW or Clinical Psychologist for any billing for behavioral health portion of the group

Billing and coding for Group Visits

Currently, there are no nationally accepted standards for coding and billing for group visits.

Several years ago the American Academy of Family Practitioners (AAFP) sought to clarify Medicare billing requirements and received the following response from the Western regional Medicare contractor:

"...**under existing CPT codes and Medicare rules, a physician could furnish a medically necessary face-to-face E&M visit (CPT code 99213 or similar code depending on level of complexity) to a patient that is observed by other patients. From a payment perspective, there is no prohibition on group members observing while a physician provides a service to another beneficiary."**

American Academy of Family Physicians (AAFP). Coding for Group Visits. Retrieved on July 9, 2014 from http://www.aafp.org/practice-management/payment/coding/group-visits.html

Common Billing Practice

- Document clearly
- Emphasize the medical management component
- Use medical E/M code 99213 (rarely 99214)
- If more than one clinician billing (i.e, a physician and psychologist) differentiate services provided to avoid duplicate billing
- Patient education is not directly reimbursed under current system, except in specific cases such as diabetes self management education (DSME) by a certified diabetes educator (CDE)

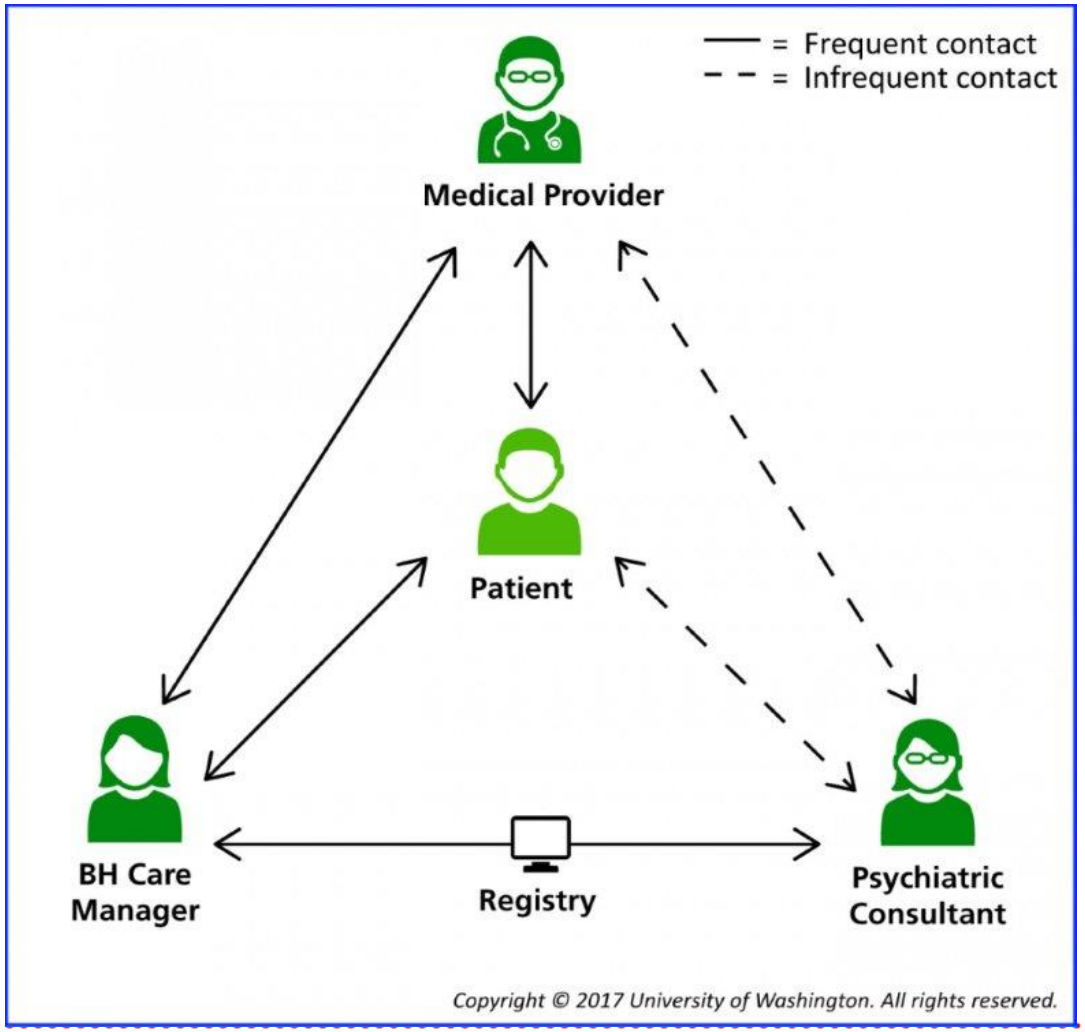
Putting Group Visits into Practice in the Patient Centered Medical Home. Stephanie Eisenstat MD, Karen Carlson MD and Kathleen Ulman PhD. Massachusetts General Hospital 2014

Ways to bill for groups in primary care

- Medical before or after group:
  - Behavioral health delivers group services - bills
  - Medical provider bills for the medical visit as well.
- Medical “pull out” of group:
  - Medical provider “pulls out” patients throughout group session – bills for medical visit
  - Behavioral health bills for group, minus time away with provider
- Medical provider bills for the group
- Can the medical provider and behavioral health clinician both bill for the group at that same time? That is unclear!

Payers allow 2 services on the same day as long as one is medical and one is behavioral health under provider-based rules.

Collaborative Care - CoCM Team Based Care



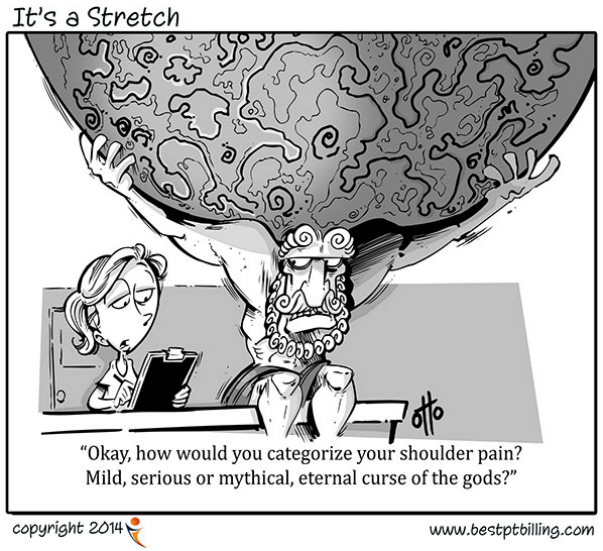
Codes and Times

Behavioral Health Integration Coding Summary				
BHI Code	**Behavioral Health Care Manager or Clinical Staff Threshold Time**	**Assumed Billing Practitioner Time**	**Payment/Pt (Non-Fac) Primary Care Settings**	**Payment/Pt (Fac) Hospitals and Facilities**
CoCM First Month (99492)	70 minutes per calendar month	30 min	$142.84	$90.08
CoCM Subsequent Months (99493)	60 minutes per calendar month	26 min	$126.33	$81.11
Add-On CoCM (Any month) (99494)	Each additional 30 minutes per calendar month	13 min	$66.04	$43.43
General BHI (99484)	At least 20 minutes per calendar month	15 min	$47.73	$32.30
BHI Initiating Visit (AWV, IPPE, TCM or other qualifying E/M)	N/A	Usual work for the visit code	Usual	Usual

References for Collaborative Care Codes

1. https://aims.uw.edu/collaborative-care/implementation-guide The AIMS Center. University of Washington Psychiatry and Behavioral Sciences
2. Frequently Asked Questions about Billing Medicare for Behavioral Health Integration (BHI) Services. March 9, 2017
3. CMS CoCM Fact Sheet: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Behavioral-Health-Integration-Fact-Sheet.pdf
4. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/
5. Behavioral Health Integration Services. CMS. Medicare Learning Network. ICN 909432 May 2017.

Tip # 4 – Tie the reimbursement need to the clinical service delivery through good documentation



Mental Health Documents

1. Initial Assessment
2. Treatment Plan – within 30 days or 3 sessions. Medicare- not needed for “a few brief sessions”
3. Progress Notes

Medicare:

- Documentation fully supports medical necessity
- Providers are exempt from submitting “psychotherapy notes” – defined as “notes recorded…which document or analyze the contents of a counseling session and that are separated from the rest of the medical record”

Initial Assessment 90791

- Must include: complete medical including past, family and social
- Psychiatric history
- Mental Status Exam
- Establishment of initial diagnosis
- Evaluation of patient's ability and capacity to respond to treatment
- Initial plan of treatment
- Can be done:
  - At onset of illness
  - If a new episode of illness occurs
  - After a hiatus
  - Or on admission or readmission to an IP setting
- Not timed but rather an "event"

The Treatment Plan

- Individualized
- Must state:
  - Type of treatment, e.g. CBT
  - Amount of treatment, e.g. 4- 8 sessions
  - Frequency of treatment, e.g. every other week
  - Duration of services, e.g. 6 months
  - Diagnosis
  - Anticipated goals and specific objectives
  - “Not required if only a few brief services will be furnished” - Medicare

Therapeutic interventions

- 90832 – 90838 – Individual Therapy - 30 to 60 minutes
  - Report actual time spent
- 90847 and 90846 – Family Therapy – when the primary purpose is the treatment of the patient's condition
  - Can't be reported for less than 26 minutes
- 90853 – Group treatment – involving no more than 12 patients. Actual time must be recorded.
  - Notes can be similar to Progress Notes, or
  - Notes can contain two portions:
    - Common language for all patients – key issues presented
    - That particular patient's participation and any significant changes in status

Progress notes

Must include:

- Name of patient and date of service
- Type of service, e.g. Individual, Family
- Time element – exact time
- Modalities and frequency of treatment furnished
- A note for each encounter that includes: diagnosis, symptoms, functional status, focused MSA, treatment plan, prognosis and progress to date
- Identity and credentials of person performing the service

Too much information?
Stop the Madness!

Tip #5 – Organize your information: How about a grid?

Funding, Licensing and Regulation Grid

Information for the State of Maine - Updated October 2013

MaineHealth

Commercial and State Funders			*MaineCare (Maine Medicaid)*			*Commercial*			*Commercial and State Funders*					
E&M			**Health & Behavior**			**Health & Behavior**			**Psychiatric Services - Commercial or MaineCare**					
									MaineCare Section 65- (Translate codes into H codes)			**Commercial or MaineCare Section 90 or Section 45**		
99201-99205	New Pt	MD/NP/PA	96150	Assessment	LCSW/LCPC/PhD	96150	Assessment	LCSW/LCPC/PhD						
99212-99215	Established Pt	MD/NP/PA	96151	Re-assessmen	LCSW/LCPC/PhD	96151	Re-assessmen	LCSW/LCPC/PhD	90791	Initial Psych Assess	/LCSW, LCPC, LMFT/PhD	90791	Initial Psych Assess	LCSW, LCPC, PhD,
90833, 90836, 90838 +	Add-on Psychotherapy codes	MD/NP/PA	96152	Ind Interventi	LCSW/LCPC/PhD	96152	Ind Interventi	LCSW/LCPC/PhD	90832, 90834, 90837	Psycho therapy	Psych MD etc /LCSW, LCPC, LMFT/PhD	90832, 90834, 90837	Psycho therapy	LCSW, LCPC, PhD,
90792	Initial Psych Asessment	MD/NP/PA	96153	Grp Interventi	LCSW/LCPC/PhD	96153	Grp Interventi	LCSW/LCPC/PhD	90846-90847	Family Tx with or	/LCSW, LCPC,	90846-90847	Family Tx with or	MD/NP/PA
			96154	Family Interve	LCSW/LCPC/PhD	96154	Family Interve	LCSW/LCPC/PhD	90792	Initial Psych Assess	Psych MD, NP, PA	90792	Initial Psych Assess	Psych MD, NP, PA
99371-99373	Phone Consults	Physician, Medicaid only. Mass												
99242	Admin and Interpretation of Health Risk Assessment Instrument	Aetna - in Physician practice												
99443	Telephone eval and management service	Aetna - in Physician practice and for Psychiatry												
Hospital License						Hospital License						Hospital License		
									Mental Health License			Private MH Practice License		
						Private MH Practice License			Private MH Practice License			ary Care Office - Physician Prac		
Primary Care Office - Physician Practic						mary Care Office - Physician Practi								
Rural Health Clinic			Rural Health Clinic			Rural Health Clinic			**Rural Health Clinic			**Rural Health Clinic		
FQHC			FQHC			FQHC			**FQHC			**FQHC		
FQHC Look-alike			FQHC Look-alike			FQHC Look-alike			**FQHC Look-alike			**FQHC Look-alike		

* Section 90 allows for reimbursement for LCPC's, LMSW's and LCSW's

** FQHC's and RHC's bill under Section 31 and Section 103, respectively, in MaineCare, not 65 or 90.

This document represents the best information we have at the time and continues to evolve as coding changes and becomes clearer. Always consult with your organization's billing/coding experts.

Developed by Mary Jean Mork, Neil Korsen, Girard Robinson and MaineHealth Funding and Licensing workgroup - based on information available. Contact morkm@mmc.org

SAMHSA-HRSA Center for Integrated Health Solutions

Making Integrated Care Work

NATIONAL COUNCIL | SAMHSA | HRSA

Interim Financing Solutions for Integrated Healthcare in Texas As of: March 1, 2011

	CPT Code	Diagnostic Codes	Federally Qualified Health Centers							
			Comm. Ins		Medicare		Texas Medicaid			
			Paid?	Credentials	Paid?	Credentials	Paid?	Code	Credentials	Comments
E & M Codes	99201-99205 New Pt	May be used with Mental Health Diagnostic codes as well as physical health codes	Yes	MD, PA, ANP	Yes	MD, PA, ANP	Yes	T1015	MD,PA,ANP	
	99211-99215 Est. Pt		Yes		Yes		Yes	T1015		
Health and Behavior (HABI) Codes	96150 Assessment	Must be associated with a primary care diagnosis to be utilized	Yes	Often PhD Psychologist only. May vary for plan. Consult commercial plan for more information	Yes	Non-physician mental health practitioners Psychologist only at this time; excludes CSW	No		Licensed Healing Arts Professions Nurses	***CURRENTLY ONLY BILLABLE FOR KIDS IN PILOT PROGRAM; NOT LISTED AS BILLABLE IN AN FQHC; APPEARS TO BE*** BILLABLE IN OTHER PRACTICES ACCEPTING MEDICAID
	96151 Reassessment		Yes		Yes		No			
	96152 Individual Int.		Yes		Yes		No			
	96153 Group Int.		Yes		Yes		No			
	96154 Family + Patient		Yes		Yes		No			
	96155 Family w/o Pt		Yes		No		No			
Telemedicine	90801-Assess/ Psych.Eval				Yes	-Physician -Nurse Practitioner -Physician Assistant -Clinical Nurse Specialist -Clinical psychologist* -Clinical social worker* *Cannot bill for psychotherapy services that include medical evaluation and management services under Medicare. May not	No	GT Modifier is required	QMHP and/or Psychiatrist/ Nurse/ANP	***TELEMEDICINE IS NOT BILLABLE IN AN FQHC; APPEARS TO BE*** BILLABLE IN OTHER OUTPATIENT PRIMARY CARE PRACTICES
	90802				Yes		No			
	90862 Med Mgmt				Yes		No			
	99201 – 99205 New Pt				Yes		No	GT Modifier is required	MD, PA, ANP	
	99211 -99215 Est. Pt.				Yes		No			
	99241-99245				No[1]		No			
	99251 -99255				No		No			
	F-U Inpt Consul - limited				Yes					
	F-U Inpt Consul –				Yes					

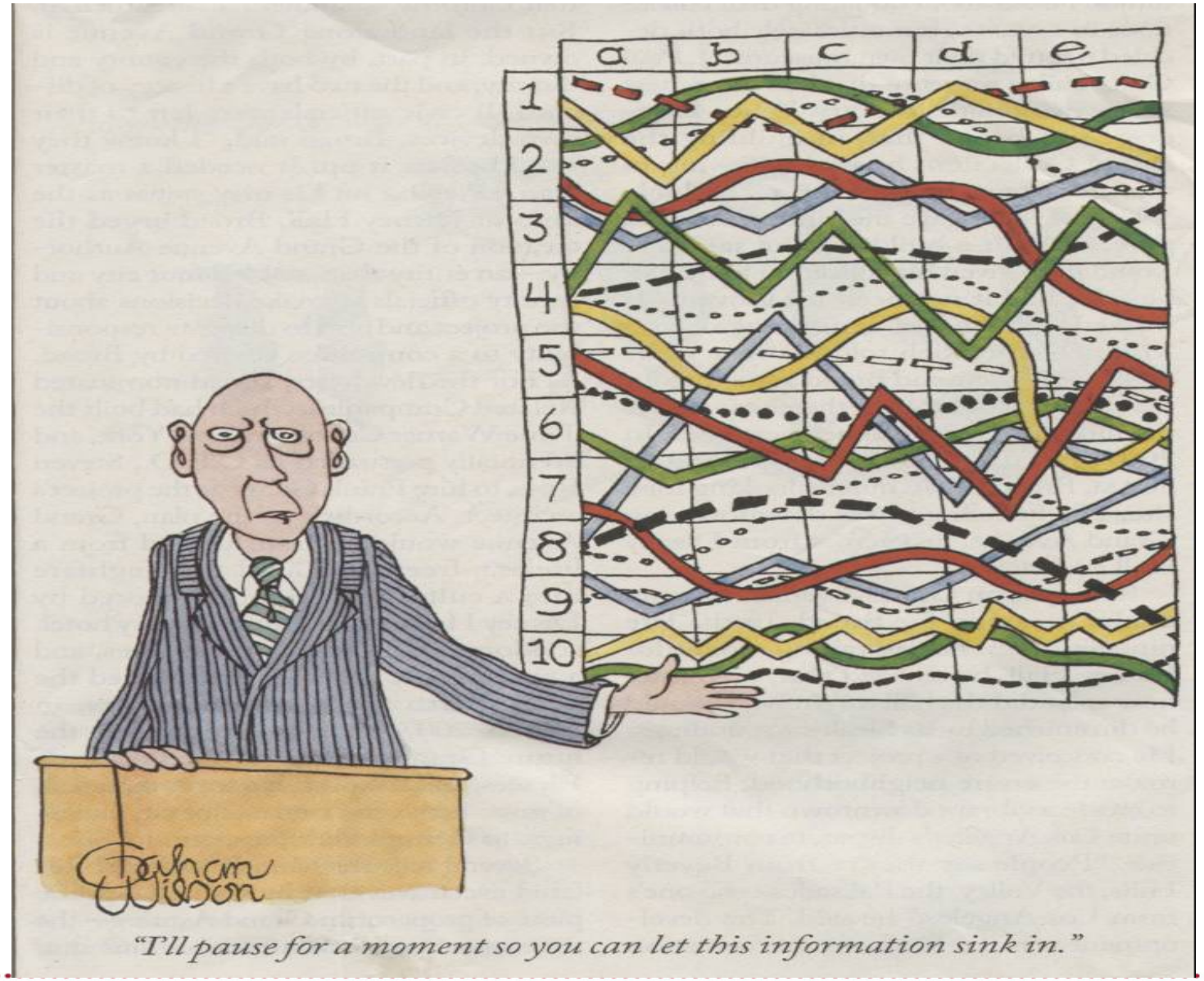
Diagnostic Evaluation								
Code	**Service**	**Description**	**Required Documentation**	**Permissible Diagnosis Examples**	**Tips/Guidelines**	**RVUs**	**Medicare**	**Oregon Medicaid**
90791	Psychiatric diagnostic evaluation	Visit with intention of doing a diagnostic assessment, diagnostic clarification, or a biopsychosocial assessment	The assessment concludes with documentation of a diagnosis, rationale for the diagnosis, and a written treatment plan supported by the assessment and interview data	Psychiatric diagnoses	The assessment identifies factors of mental illness, functional capacity, and gathers additional information used for the treatment of mental illness. Determination of a person's need for mental health services, based on the collection and evaluation of data obtained through interview and observation, of a person's mental history and presenting problem(s). 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.	3	Yes [2]	Yes [3]

Psychotherapy									
Code	**Service**	**Time/ Unit**	**Description**	**Required Documentation**	**Permissible Diagnosis Examples**	**Tips/Guidelines**	**RVUs**	**Medicare**	**Oregon Medicaid**
90832	Psychotherapy	30 minutes (16-37)	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, face-to-face with the patient	Documentation should highlight therapeutic communication, attempts to alleviate the emotional disturbances or change maladaptive patterns of behavior and encourage personality growth and development	Psychiatric/ mental health diagnosis	Used for the treatment of mental illness and behavior disturbances in which the clinician establishes a professional contract with the patient and through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage personality growth and development. For use with planned face-to-face, insight oriented therapy.	1.5	Yes [2]	Yes [3]
90834		45 minutes (38-52)					2	Yes [2]	Yes [3]
90837		60 minutes (53 or greater)					3	Yes [2]	Yes [3]

Psychotherapy Continued…									
Code	**Service**	**Time/ Unit**	**Description**	**Required Documentation**	**Permissible Diagnosis Examples**	**Tips/Guidelines**	**RVUs**	**Medicare**	**Oregon Medicaid**
90846	Family Psychotherapy without patient present		With family/without patient present		Psychiatric/ mental health diagnosis	May be excluded in some subscriber's contracts.		Yes [2]	Yes [3]
90847	Family Psychotherapy	N/A	With family and patient present	Documentation should highlight therapeutic communication with patient and family, related to therapeutic attempts to alleviate dynamics that impact the patient's condition, or reduce the impact the patient's condition has on the family.		Service provides psychotherapeutic intervention jointly with family members as they relate to the patient's treatment. Can include family dynamics that impact patient's condition, or how patient's condition impacts the family. Therapeutic intervention aimed at improving interaction between family members and patient including reviewing records, behavior, communication and decision making regarding treatment and psychoeducation.		Yes [2]	Yes [3]

Group Psychotherapy								
Code	**Service**	**Time/ Unit**	**Description**	**Required Documentation**	**Permissible Diagnosis**	**Tips/Guidelines**	**Medicare**	**Oregon Medicaid**
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.	Psychiatric/ mental health diagnoses	Focus of group psychotherapy is to assist patient's with solving emotional difficulties and to encourage personal growth and development. Max therapist/patient ratios = 1/8	Yes [2]	Yes [3]
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			Focus of intervention is to assist patients and their families with similar issues to meet face to face with clinician and assist in solving emotional difficulties and to encourage personal growth and development and improve their functioning skills. Max therapist/ patient ratios = 1/8 (total individuals)	Yes [2]	Yes [3]

Psychotherapy for Crisis								
Code	**Service**	**Time/ Unit**	**Description**	**Required Documentation**	**Permissible Diagnosis Examples**	**Tips/Guidelines**	**Medicare**	**Oregon Medicaid**
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		Yes [2]	Yes [3]
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.	Yes [2]	



"I'll pause for a moment so you can let this information sink in."

Tip # 6 – Make friends with your billers and coders and anyone else who can help

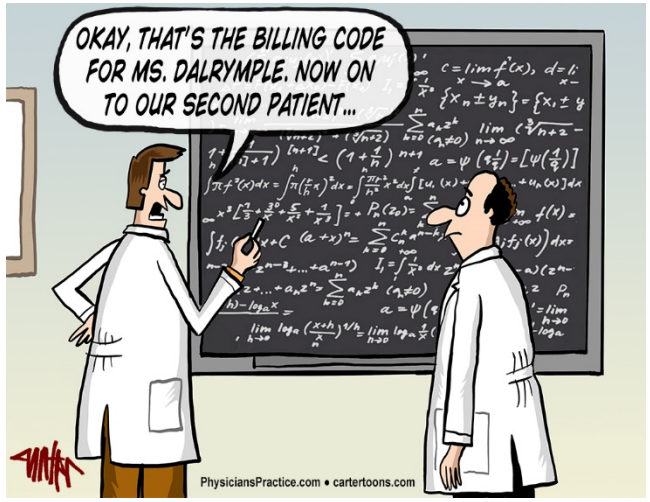
Who to go to for help

- Billing and coding supervisors
- Internal auditors
- Regional or state-wide integrated policy groups
- “People who know what they’re talking about” – where ever you can find them

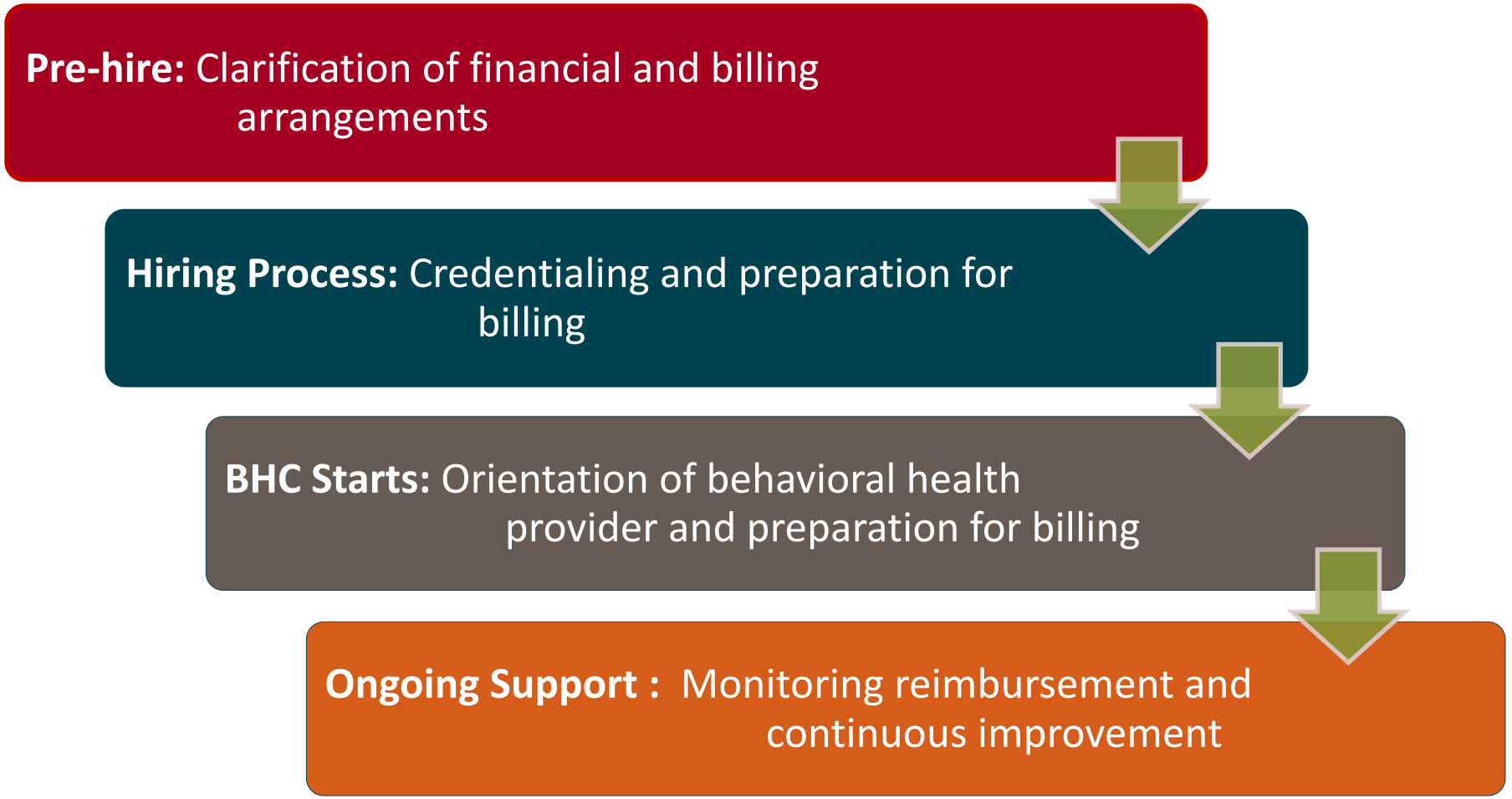
Work group for reimbursement

- Purpose: Sharing information about billing and reimbursement
- Process:
  - Coming from different perspectives Clarifying, explaining, investigating, and re-clarifying with every piece of new information
  - Coming to shared understanding of the present landscape
- Identifying areas for change
  - Understand the current rules in detail
  - Identify opportunities and barriers
  - Use your understanding to make recommendations to regarding the most effective way to organize services to maximize reimbursement
  - Target the barriers that are highest priority or that we are most likely to be able to change

Tip # 7 – Plan to get paid and evaluate your progress



Plan to get paid



Integrated Practice Start-up Elements

- Licensing
- Contracts
- Credentialing
- Registration
- Scheduling
- First visit
- Subsequent visits
- Charge entry
- Medical Records
- Release of Information

Administrative Team Meeting: the “friendly forum”

Clinicians, provider rep, billers/coders, practice managers, leadership

- Data - show rates, referrals, volume: What’s working, not working? Targets?
- Payment information: Codes reimbursed/ denied
- Communication issues/improvement suggestions: R/t patients, providers, practice
- Clinical practice issues: E.g. length of sessions, frequency/duration of treatment

Tip # 8 – Reframe the question: What is the cost of integration? Or: What is the cost impact of integration?

Finances: Know the questions and the answers

- **The old question was:**
  - **Can behavioral health integration pay for itself?**
- **The new question is:**
  - **What is the impact of behavioral health integration on health care costs?**

- Additional questions to ask:
  - How well integrated is the practice?
    - » How long has practice been integrated?
    - » How much integrated clinician time?
  - How well is integration being targeted?

What have others shown?

- Intermountain Healthcare article 2010
  - **Integration reduced ED utilization compared to non-integrated practices by 40-50%**
    - » Reiss-Brennan et al, Journal of Healthcare Management, 2010 March/April; 55(2): 97-114.
- Collaborative care for depression
  - **Initial cost of $580 per patient to implement the model led to decrease in total cost of care of $3300 on average over four years**
    - » Unutzer et al, Long-term cost effects of collaborative care for late-life depression. American Journal of Managed Care. 2008 Feb; 14(2):95-100.

…and comparisons

- "Integrated practices" vs. non-integrated practices – Intermountain Healthcare. Report that **an investment of $22 PMPY in integrated services decreased medical costs by $115** PMPY. Decrease was in ED and IP utilization. (Reiss-Brennan, et al. JAMA. 2016)
- BHC days vs. non-BHC days. On BHC days there was a 42% increase in patient volume of all types **resulting in $1,142 more revenue generated** (Gouge et al. Southern Medical Journal. 2016)
- "Reach" of BHC within clinics (% of panel) indicates that **broader reach was connected with overall healthcare savings.** (Peterson, et al. Families, Systems and Health. 2017)

Value beyond the $$$ bottom line

- Provider satisfaction
- Patient satisfaction
- Improved access to behavioral health
- Improvement in PHQ scores
- Improvement in chronic disease indicators
- Reduction in unnecessary ED use
- Reduction in hospitalization or re-hospitalization
- Retention rates for BHC's
- Care coordination for patients with complex needs
- And again – PROVIDER SATISFACTION!

Tip # 9 – Gather resources and keep learning.

Tip # 10 - Be humble and persistently curious

Other recommendations….

- Keep costs down, monitor ongoing financial results and aim for break-even
- Investigate and be willing to develop alternative payment models
- Acknowledge link between providers and coders. Focus on the front end
- Train all staff from the beginning and ongoing
- Track the money
- Take time with BHC re: coding and documentation
- Behavioral health billing requires time, resources and connections to “experts”
- Use internal auditor to monitor
- Link to national experts and developing data support for integration

Reimbursement Resources

Medicare Links

- http://www.cms.gov/Manuals/IOM/list.asp
- http://www.cms.gov/Transmittals/01_overview.asp
- Medicare Documentation Guidelines for Evaluation and Managements Services 95 & 97 http://www.cms.gov/MLNEdWebGuide/25_EMDOC.asp
- NHIC http://www.medicarenhic.com/
- CMS National Correct Coding Initiative

http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html/nationalcorrectcodinited

Other

- www.thenationalcouncil.org – the National Council for Community Behavioral Healthcare
- www.ibhp.org – Integrated Behavioral Health Project
- www.mainehealth.org/mentalhealthintegration
- www.cfha.org

Watch for webinars on reimbursement

Resources

- SAMHSA Center for Integrated Health Solutions
  - Monograph on making the business case, with a spreadsheet that allows calculation of costs and revenues
  - Targets CHC's but applicable to other types of practices
  - http://www.integration.samhsa.gov/resource/the-business-case-for-the-integration-of-behavioral-health-and-primary-care
- Health Partners Total Cost of Care calculator
    - Describes a methodology for measuring total cost of care and resource use
    - Includes indexing method that allows comparison across sites
    - First TCOC methodology endorsed by National Quality Forum
    - https://www.healthpartners.com/public/tcoc/

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"Start where you are.
Use what you've got.
Do what you can."
Arthur Ashe

Session Survey

Use the CFHA mobile app to complete the survey/evaluation for this session.

CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION

Join us next year in Philadelphia, Pennsylvania! Thank you!