Financing IMPACT

Jürgen Unützer, Diane Powers &
Virna Little

Key References

- Bachman J, Pincus H, Houtsinger JK, Unützer J. Funding Mechanisms for depression care management: opportunities and challenges. *General Hospital Psychiatry*. 2006; 28: 278-288.

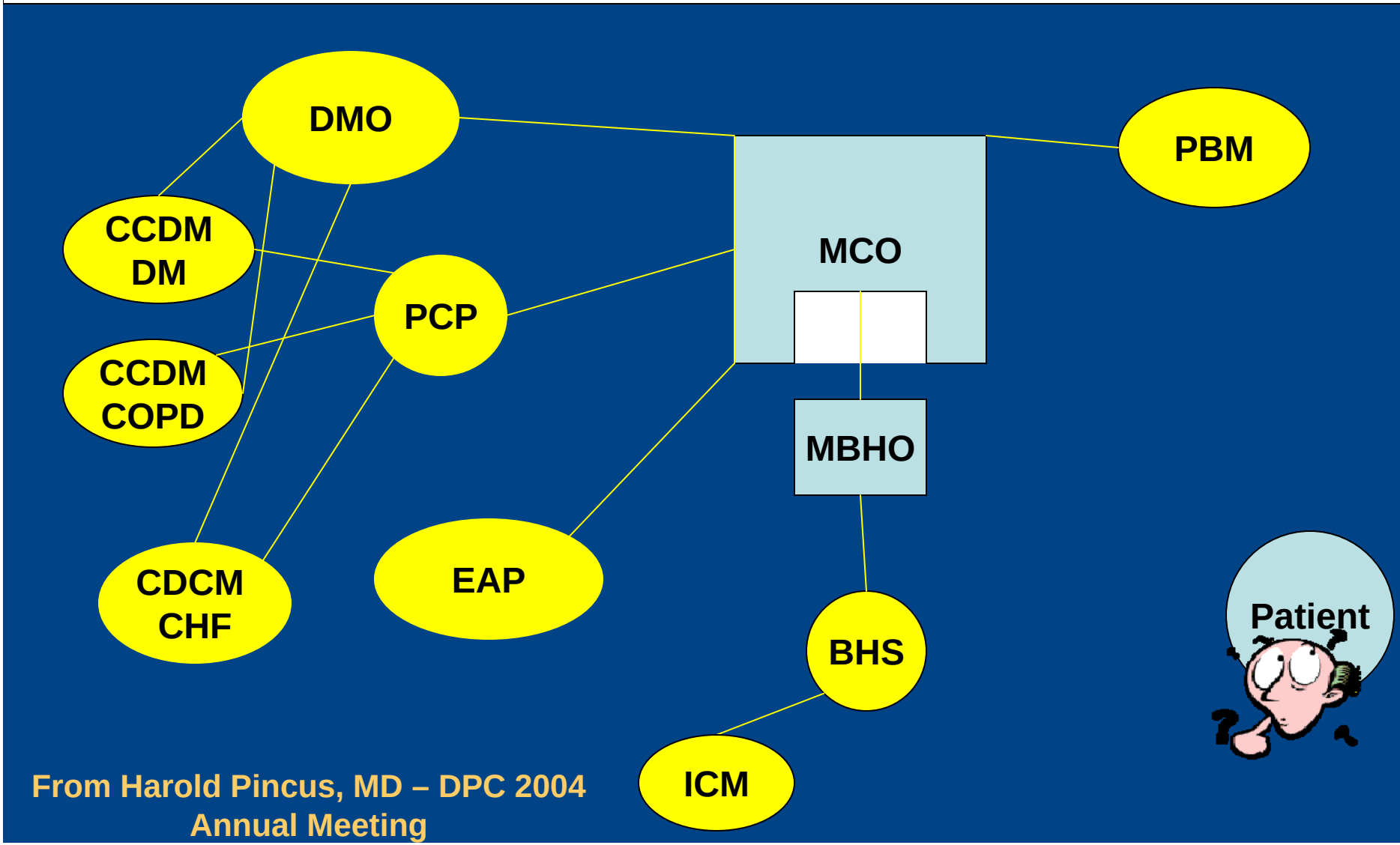
- Goldberg RJ, Oxman TE. Billing for the Evaluation and Treatment of Adult Depression by the Primary Care Physician. *Prim Care Companion J Clin Psychiatry*. 2004;6(1):21-26.

- National Council for Community Behavioral Healthcare:
  http://www.nccbh.org/WHO/INDUSTRY/PCI.HTM

- HRSA Slides on BH Reimbursement in Primary Care Settings:
  ftp://ftp.hrsa.gov/TPR/billing-behavioral-1slide-per-page.pdf

- HRSA Provider Reimbursement Technical Assistance Materials:
  http://www.hrsa.gov/reimbursement/TA-materials.htm

Complexity



From Harold Pincus, MD – DPC 2004 Annual Meeting

Financing for collaborative depression care varies

Private insurers

- Capitated (HMOs): Mental Health and Pharmacy Benefit carved-in vs. carved-out
- Fee For Service: reimbursement rules vary by insurer, provider type
- P4P (e.g., Aetna Chairman's Initiative)

Reference: Bachman et al, Gen Hosp Psychiatry, 2006

Financing for collaborative depression care varies

Public insurers

- Federal: VA, FQHCs, FFS Medicare, Medicare Advantage (HCC payment method provides new incentives)
- States: variation among Medicaid plans / financing for mental health services in primary care

Reference: Bachman et al, Gen Hosp Psychiatry, 2006

Financing for collaborative depression care varies

Disease Management industry

- ? Potential to deliver cost-effective depression care management
- ? Collaboration with medical groups / providers

Reference: Bachman et al, Gen Hosp Psychiatry, 2006

Financing for collaborative depression care varies

Medical groups and providers

- Risk sharing (Mental Health carved-in vs. carved out)
- Key issues: license, scope of practice, independent vs. 'incident to physician billing'

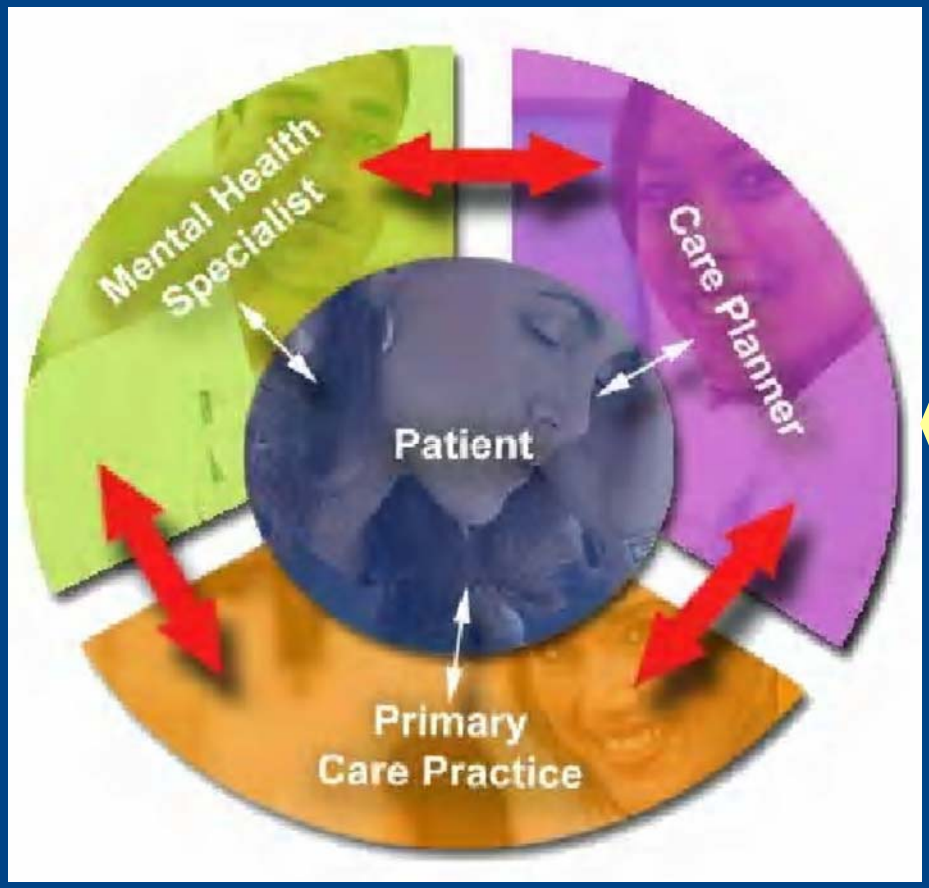
Reference: Bachman et al, Gen Hosp Psychiatry, 2006

Bachman et al, 2006

7 funding mechanisms for depression care management

- practice-based, fee-for-service
- practice-based, health plan contract
- global capitation
- flexible infrastructure support
- health-plan-based
- third-party-based under contract to health plan
- hybrid models

Aetna Program



Three Component Model or 3CM™

- Additional reimbursement to PCP for treating patients with depression
- Training for PCPs and their office staff in effective treatment of depression
- Access to a Care Planner who offers phone support to PCP and patient
- Phone access to behavioral specialist for consultation
- Referral to local behavioral health specialist, if needed

Goldberg & Oxman, 2004

Table 1. American Medical Association CPT Codes and Medicare Fee Schedule for Depression-Relevant Diagnosis and Management[a,b]

Code	Description	Time (min)	Allowable Fee	Medicare Payment
Psychiatry codes				
90801	Initial evaluation	N/A	$144.31	$115.45
90804	Counseling	20–30	$66.22	$33.11
90805	Counseling and medical evaluation and management	20–30	$72.60	$36.30
90806	Counseling	40–50	$99.09	$49.55
90807	Counseling and medical evaluation and management	40–50	$105.40	$52.70
90862	Pharmacologic management	N/A	$52.25	$26.13
General office evaluation and management codes[c]				
99204	Initial evaluation: comprehensive	45	$136.44	$109.15
99212	Straightforward follow-up	10	$37.86	$18.93
99213	Low complexity follow-up	15	$53.07	$26.53
99214	Moderate complexity follow-up	25	$82.80	$41.40
99215	Complex follow-up	40	$120.99	$60.49

[a]Data from the American Medical Association.[4]
[b]Medicare fees are regional. Listed fees in this table are for Rhode Island; other states will vary.
[c]Time is the controlling factor when counseling comprises > 50% of the visit.
Abbreviations: CPT = Current Procedural Terminology, N/A = not applicable.

Medicare Reimbursement: 908xx codes can be used by non-mental health professionals

Commercial Payers: Generally do not allow use of 908xx by PCPs (usually because of 'carve-out' to third party)

Medicaid: Rules vary widely by state

HRSA (Health Resources & Services Administration)

Medicaid Reimbursement Issues

- In most states BH carved out
- Contractual arrangements and eligible providers vary widely by and county
- Biggest documentation/coding problems in BH relate to 'medical necessity', esp. with 'incident to' services

  Elements of 'Incident to':

  - integral part of physician's professional practice
  - generally not itemized separately on bill
  - commonly furnished in physician's office or clinic
  - furnished under physician's direct personal supervision
- E&M (992xx) and Therapy (908xx) cannot be billed on same day to most Medicaid programs

HRSA Medicaid Guide, 2003

Codes?	E&M New 99201 thru 99205 Est'd 99211 thru 99215	Initial Assessment 90801 Insight 90802 Interactive	Psychotherapy 90804 20 90805 90806 ↓ 90807 90808 80 Min. 90809	Behavioral Assessment 96150 thru 96155
Where?	Medical Office or other O/P Facility	Behavior Health Office or other O/P Facility	Behavior Health Office or other O/P Facility	Behavior Health Office or other O/P Facility
What?	Medical Visit that can include Counseling 10 ↓ 60 Min. 10 ↓ 40 Min.	Psychiatric Diagnostic Interview Exam Interactive Dx. Interv. Using play Equip., etc.	Individual Psychoth. Insight Oriented Face-to-Face W/patient Individual Psychoth. w/ medical mgmt.	Used to identify the psychological, behav-ioral, emotional cogni-tive and social factors important to physical health. Patients not diagnosed with mental illness.
Who?	Physician, NP, Other Medical Clinicians	Psychiatrist, LCSW, CP, NP, Other (Payer criteria)	All	Clinical Psychologist, NP, Other for Medicare
Service Emphasis	Medical	Behavioral Health Initial Assessment	On-going Individual Psychotherapy	Biopsychosocial factors important to Physical Health problems and treatments

Mauer, NCCBH; 2006

CPT codes adopted in 2002 to address primary-care-based BH services delivered in coordination with PCP services.

TABLE 1: CPT Codes for Behavioral Health Services Related to Medical Conditions

CPT Code	Service Description
96150	Behavior assessment, clinical interview, behavior observations, psycho-physiological monitoring: face to face, 15 minute intervals
96151	Re-assessment
96152	Behavioral intervention; face to face, 15 minute intervals
96153	Group intervention (2 or more patients)
96154	Family intervention with patient present
96155	Family interventions without patient present

Adopted by Medicare

Adoption by Medicaid and private sector plans is occurring on state-by-state basis

Mauer, NCCBH; 2006

FQHCs (Federally Qualified Health Centers)

- BH staff can be employed by FQHC directly or 'rented' from CMHC

- 'Direct' or 'Ownership' model

BH services within scope of FQHC clinic are billed to patient's insurer (if one exists) AND clinic collects supplemental state Prospective Payments up to avg. cost of a clinic visit

- 'Rental' model

CMHC staff see patients at FQHC and chart/ bill under auspices of FQHC, either 'incident to' physician services, for specific BH codes at enhanced FFS rate or as part of Prospective Payment calculation

Managed Care: IMPACT Value Proposition

- Improved Care for Depression will
- Lower depression
- Improved physical functioning
- Improved patient and provider satisfaction
- Improved cost-effectiveness of care
- Improved total revenue (under Hierarchical Condition Coding)

IMPACT Program Cost

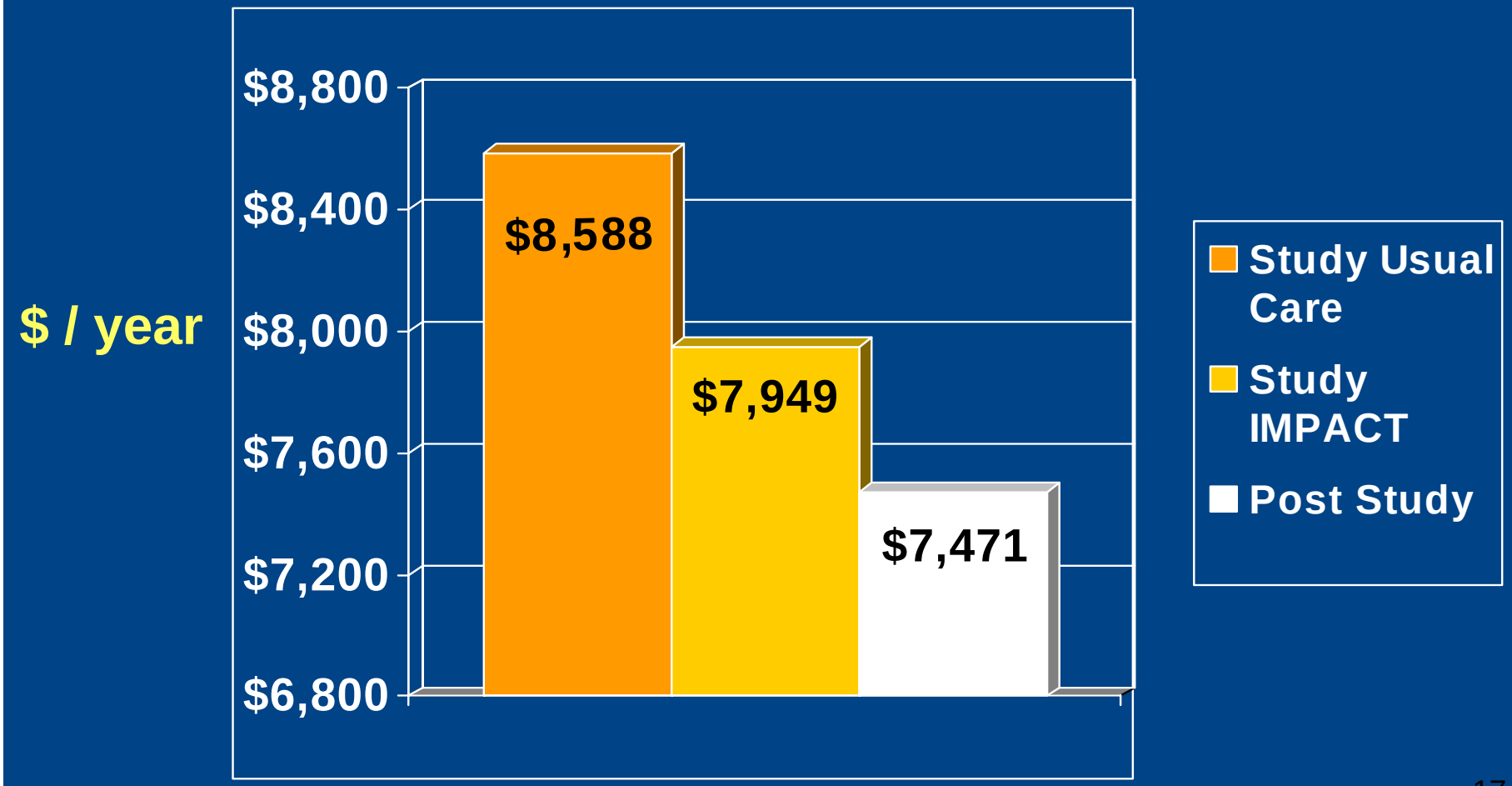
Cost / participant for 12 months: $450

- Care manager time,
- Consulting PCP/psychiatrist time
- Program materials
- + 30 % overhead

If 3 % of patients are using the program each year, the cost PMPM (for one year) = $1.12

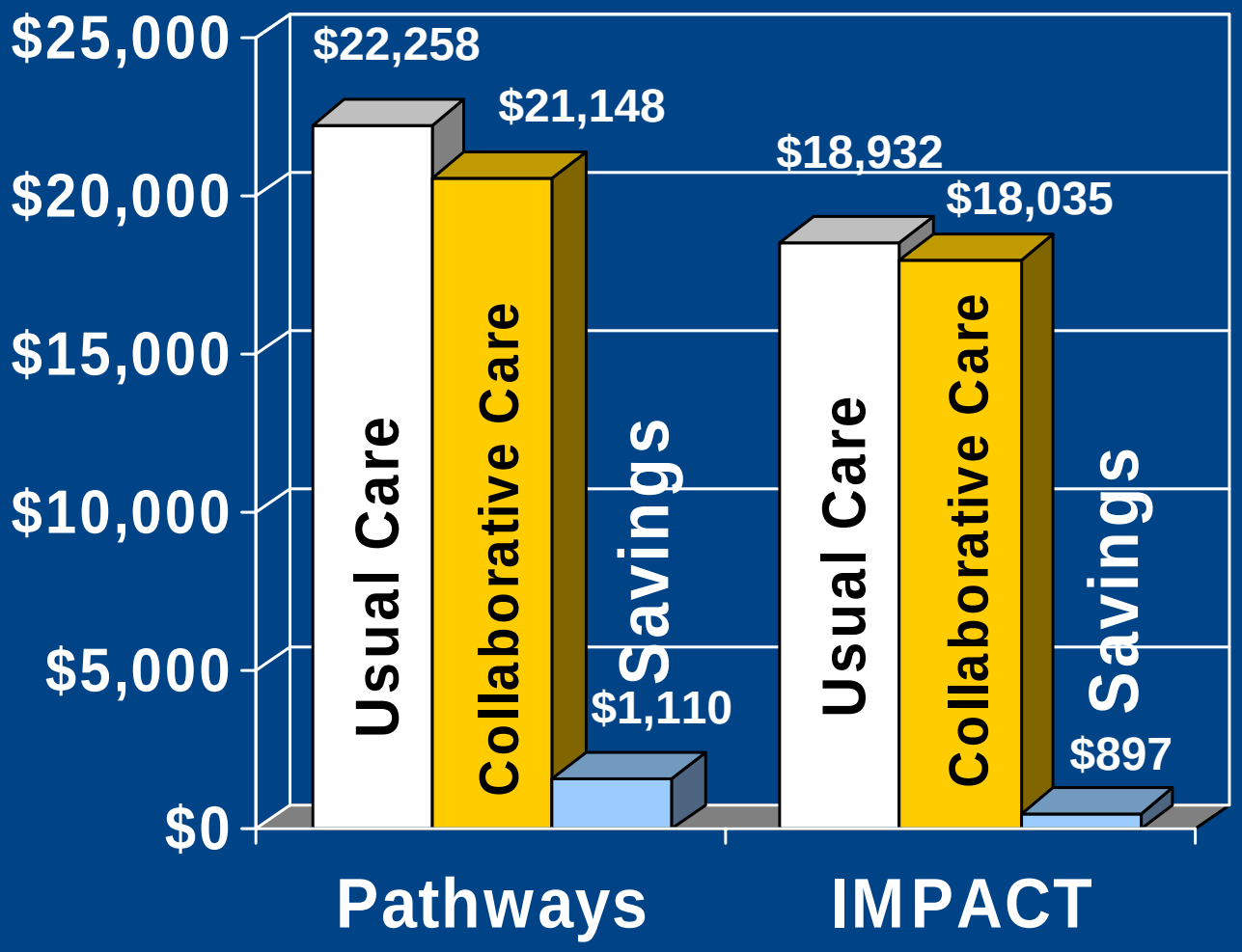
1 FTE care manager for 6,000 primary care patients

KPSC Lower total health care costs



Grypma, et al; *General Hospital Psychiatry,* 2006

Depression & Diabetes Lower Costs Over 2 Years



Katon et al, 2006

IMPACT
in Medicare Advantage

Hierarchical Condition Category (HCC) Payment Methodology:

HCC Code 55 (Depression) adds ~ $400 to monthly payment for Medicare Advantage patient

Additional revenue can easily outweigh the estimated program cost of ~ $1.00 PMPM (per member per month)

- S. Levine, MD

Care Management Program: Sample Service Agreement

Medical Group / Center:_____ Start Date: _____

Target Depression Population(s) with expected annual screening / treatment volume:

–

–

Care Manager FTE Allocation(s): _____

-

Consulting Psychiatrist FTE Allocation(s): _____

-

_ Agree to implement Collaborative Care Model.

_ Agree to screen __ % of adult primary care patients each year (a min of ___ screens each year).

_ Agree to document depression diagnosis and initial PHQ-9 scores on 80 % of patients screening positive for depression, 80 % of those who have a claims diagnosis of depression, and 80 % of patients with antidepressant prescriptions (a min of __ patients with diagnosis of major depression / PHQ-9 score / year).

_ Agree to document each patient follow-up (incl. PHQ-9 score). Minimum # of follow-up contacts with PHQ-9 score for patient diagnosed with depression is 3 in initial 12 weeks.

_ Patients identified with depression will be appropriately managed, treated and monitored for improvement. Patients who do not respond to initial treatment will have a change in treatment plan documented within 12 weeks of initial treatment.

_ Program goal is to achieve a 50 % reduction in initial PHQ-9 score or a PHQ-9 score less than 5 for at least 50 % of patients identified as having moderate depression or higher on initial PHQ-9 after 12 weeks in treatment.

Signed by: _____ on _____ (date)

Billing and Reimbursement in a Fee for Service Practice

Carol D. Saur, MSN, RN, CS

Clinical Nurse Specialist
Adult Psychiatric-Mental Health Nursing
IMPACT Depression Care Manager
Duke University

Objectives

Describe professional, legislative, and organizational, and third party payor scope of practice issues

Discuss diagnostic coding (ICD-9), procedure coding (CPT), documentation requirements, and billing options

Identify Depression Care Manager (DCM) performance measures

Mental Health Practitioners: (HEDIS)

- Doctor of Medicine (MD) or Osteopathy (OD)
- Psychologist
- Registered Nurse (RN)
- Clinical Social Worker
- Marital and Family Therapist
- Professional Counselor

Scope of Practice Considerations

- National standards of practice (professional certification)
- State practice acts (licensure)
- Agency or organizational requirements (internal credentialing)
- Third-party payor requirements (Medicare rules and regulations)

Professional Certification

e.g., American Nurses Credentialing Center (ANCC) Board Certification requires:

- Current active RN license
- Master's or higher degree in nursing
- Academically prepared in specialty area
- Minimum of 500 hours of practice with supervision/consultation in specialty area
- Endorsement by 3 professional colleagues
- Passing the national certification examination

Professional Recertification

ANCC Recertification (every five years)

- Practice requirements: 1500 hours
- Educational requirements (2 of 5):
  - Continuing education credits (75 hours)
  - Academic credits
  - Presenter/lecturer credits
  - Published article or book chapter
  - Preceptorship

Legislative Requirements

The Clinical Nurse Specialist (CNS) must:

- **Have an unrestricted license to practice as a Registered Nurse (RN) in North Carolina (NC)**
- **Have completed a graduate degree in a clinical nursing specialty from an accredited educational institution**
- **Be currently certified in a clinical specialty as a CNS by the American Nurses Credentialing Center**

- *North Carolina Administrative Code 21:36.0228*
- *Medicare Carriers Manual 2160.CNS Services*

Scope of Practice: Psychotherapy

The NC Board of Nursing recognizes that psychotherapy is within the scope of practice of an RN

- **Who has completed an advanced academic degree-granting program which prepares the RN for advanced practice as a clinical nurse specialist**
- **May seek professional credentialing to further assure the public of that person's competence to perform such an activity**

- *North Carolina General Statutes 90-171.42 (b)*
- *Administrative Rule 21NCAC 36.0223(a)(1)(C)*

Scope of Practice: Psychotherapy with E/M

If state law authorizes nonphysician practitioners to perform mental health services and evaluation and management services that would otherwise be furnished by a physician or incident to a physician's services,

CNSs could bill for psychiatric diagnostic interview and any of the psychotherapy CPT codes that include medical evaluation and management.

- *Federal Register: November 2, 1998 (Vol.63, No.21)*

Organizational By-laws, Policies, and Procedures

- Position description
- Credentialing
- Provider number
- Fee schedule
- Visit types
- Compliance requirements
- Medical liability insurance
- Clinic integration

ICD- 9 Diagnostic Coding

Medicare coverage includes:

- Major depressive episode, single episode (296.20-.25)
- Major depressive episode, recurrent (296.30-.35)
- Panic disorder (300.01)
- Generalized anxiety disorder (300.02)
- Hysteria (300.11-.13)
- Phobias (300.20-300.29)
- Obsessive-compulsive disorder (300.3)
- Dysthymia (300.4)

Billing: 'Without Physician' (WP)

- DCM bills directly as an 'in-network' provider
- Practice guidelines for 'Incident to' remain the same
- Patient's co-pays are higher (specialty care)
- Medicare reimburses CNS at 85% of MD UCS

‘Incident to’ Billing

DCM bills as a Non-Physician Provider and ‘incident to’ the Primary Care Provider

- PCP initiates a course of collaborative treatment
- PCP (or covering MD at the practice site) is available in the clinic area to provide supervision
- PCP signs off on the notes for patient visits within 7 days of the visit
- PCP retains prescribing authority and accountability
- PCP retains primary care relationship with the patient

CPT Coding: DCM Services

- **Psychiatric diagnostic interview examination** (90801)
- **Psychotherapy Individual** (90804, 90806, 90806)
- **Family psychotherapy** (90846, 90847)
- **Group psychotherapy** (90853)
- **Psychotherapy with medical evaluation and management services** (90805, 90807, 90809)

Provider Performance Measures

- Arrived appointments per day
- Patients seen per net session
- Cancel rate
- No show rate
- Charges and wRVU's per work day
- New visits per day
- Bump rate

DCM Performance Measures: Satisfaction

Patients

- Survey
- Subjective feedback to their PCPs
- Observed improvement in clinical and functional status

Primary Care Providers

- Subjective feedback and expressions of appreciation
- Requests for assistance identifying specialty care resources
- Requests for 'on spot' urgent mental health consultation

Consult with Colleagues