



Practice Manager's Meeting 9/30/19 John Laukkanen, HCPF ACC Pediatric Behavioral Health Liaison

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Policy Objectives

- Increase access to behavioral health for low-acuity conditions
- Offer interventions for non-covered diagnoses
- Provide early intervention
- Increase member options on where to receive care

Context (Summarized and Paraphrased)

Because John has been doing integrated health in a clinical setting, some of his answers are more from a clinical perspective; however, his role at HCPF is focused on the actual policy and its implementation. When he is speaking, John wants to be very clear when he is speaking as a former clinician and when he is presenting information through his HCPF/policy lens. HCPF is not advising certain things especially when it comes to practical workflow issues or treatment plan questions that have been submitted. When this was originally rolled out, it was an acknowledgement that certain people were not accessing behavioral health services – they weren't going to go to the community mental health center and weren't going to participate in an open intake process. In general, maybe they were the more lower acuity type of patients and their questions could be resolved in a relatively brief period of time. But, there wasn't really a mechanism or practical space or place for that type of member to receive care. At the same time knowing that SIM had been in the state for several years and there was a great initiative for primary care settings to provide some type of behavioral health intervention. The solution was to see how HCPF could open up access in a primary care setting for that low acuity member and low acuity need. That was the intent of the policy and helpful to keep in the forefront of our minds. John came to HCPF as an advocate for integrated care, but this was not intended to be the solution to integrated care. That is a difficult and nuanced pathway when we are dealing with behavioral health services in a primary care setting – by definition that's integrated care. However, this policy was not thought as a way to expand, improve, and solve for integrated care, but rather looking at a segment of the population and providing greater access for those members. This policy was also a way to provide interventions for non-covered diagnoses – people coming to



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a clinic or mental health provider dealing with functional issues – chronic health issues – things that wouldn't be considered a covered diagnosis from a billing manual perspective. The question was how HCPF could address the functional issues that people are dealing with – that's why the idea of a non-covered diagnosis was considered for these types of benefits to help people who had need. Also, the policy goal was to provide early intervention – because you work with kids, you understand that early intervention is better and HCPF wanted to promote that. Finally, HCPF wanted to increase members' options on where to receive care. This policy didn't add any new codes and HCPF realizes that there have been a lot of conversations in the community about that. John is not part of any conversation at HCPF about opening up any new codes.

Policy

- Must be in a primary care setting (PCMH) [*Billing Provider*]
- Must be provided by [*Rendering Provider*] a
 - Medicaid-enrolled,
 - Masters level or higher,
 - Licensed behavioral health provider
- Must meet medical necessity
- Must follow CPT coding practices
- Must follow documentation requirements

Context (Summarized and paraphrased)

The policy is the ability to provide six psychotherapy sessions within a 12-month period without a covered diagnosis being required. It must be provided in a primary care setting and it's the medical provider who is the billing provider, but the service must be provided by a behavioral health provider – the rendering provider. The behavioral health provider must be



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Medicaid enrolled, licensed behavioral health provider, master's level and higher. They do not need to be a RAE enrolled provider. These services are being billing directly to Medicaid in a fee-for-service model, so the RAEs are not involved in this benefit unless the behavioral health provider wants to provide more than the 6 behavioral health sessions. In this case, the RAE would have to be billed and the provider would need to be enrolled in the RAE as a behavioral health provider. Providers should check with their RAEs as prior authorization may be needed.

There are three caveats to billing Medicaid for the 6 visits– (1) sessions must meet medical necessity; (2) must follow CPT coding practices; and (3) they must follow documentation requirements. As a reminder, there are 5 types of medical homes that can bill for this: (1) clinic; (2) federally qualified health center; (3) rural health center; (4) Indian Health Center; and (5) non-physician practitioner group. In summary – the policy is intended to increase access to behavioral health; no new codes were opened; this is fee-for-service reimbursement for 6 visits and under in a primary care setting; and this does not involve the capitated behavioral health benefit. They actually took money away from the capitated benefit to cover the reimbursement of these services and shifted it into the fee-for-service funding bucket to allow for this policy to be implemented. HCPF still has its capitated behavioral health benefit and HCPF doesn't plan to make any changes to this structure. This is a small carve-out for this group of services. Again, this is not the solution for integrated care.

Procedure Codes:

Context (Summarized and paraphrased)



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John referenced the Uniform Service Coding Standards Manual which is updated every 6 months. There will be an October update, but it will be primarily cosmetic – no major changes. The link is <https://www.colorado.gov/pacific/hcpf/mental-health-rate-reform-0>

The six behavioral health codes are as follows:

- Diagnostic evaluation without medical services (90791)
- Psychotherapy – 30 minutes (90832)
- Psychotherapy – 45 minutes (90834)
- Psychotherapy – 60 minutes (90837)
- Family psychotherapy without patient (90846)
- Family psychotherapy with patient (90847)

John referenced the 90791-coding page. The 90791 code is the evaluation code.

Myth: A 90791 is required before using the psychotherapy codes

- A 90791-encounter code is not required to initiate short term behavioral health services in primary care unless you do an evaluation first

These codes are not unique to these six visits: community health centers use them; school-based health centers use them. These are general psychotherapy codes.

John then shifted his focus not as a HCPF representative, but as a clinician who did integrated care. It is important to shift our thinking from traditional therapy and what that looks like and what it's going to look like in a primary care setting. These are



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two very different modes of treatment. When we start looking at what the required documentation is and how this would look in a pediatric primary care setting. For example, what does a mental status look like for a 4-year-old. When you start to think about the kids that practices are seeing, the mental status exam might be more through observation and what is developmentally appropriate. As you look at the technical requirements for documentation, John developed and used templates that were appropriate for a medical record. The documentation is going to look very differently than what you would see in a community mental health center setting or another setting. If the documentation is a barrier to using these codes, we should think about “why” they are perceived as barriers. Policy, in and of itself, isn't mandating any specific format. As a clinician, it is often difficult to make the adjustment as to what notes look like doing behavioral health services in a primary care setting. When looking at the lens of doing the work in a primary care setting, we need to look at the documentation requirements through that lens.

Myth: A formal treatment plan is required to use the psychotherapy codes

- A formal treatment plan is not required
- The Plan part of a SOAP note is sufficient
- See link for example SOAP note

Responses to submitted questions:

- Clinics do not need to do a 90791 as the first visit in order to use the psychotherapy codes
- All licensed clinicians should use 90791, not H0031. Per the Coding Manual for H0031: Licensed MHPs, when completing a full assessment with mental status and diagnosis should use procedure code 90791.
- A treatment plan is not a requirement for the STBH services.



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- Follow up question: someone noted that a SOAP note has a treatment plan component. Response: the policy does not require a treatment plan. As a clinician, there might be a treatment plan. HCPF would defer to the individual organization with respect to their requirements for a plan.

Diagnosis and Treatment Plan

Context (Summarized and paraphrased)

John referenced the coding manual that describes the range of covered diagnoses and codes under the capitated benefit. Before the 6 STBHS, behavioral health specialist had to use those codes to bill. It doesn't always translate well when you have a medical provider describing symptoms and asking the behavioral health specialist to address those symptoms. The behavioral health specialist had to have a covered diagnosis and as a clinician, there wasn't always a diagnosis, especially in kids. In this benefit, it is irrelevant – you don't need to follow the parameters. Any diagnosis that has a letter and number to it can be used – dementia, autism, etc. A behavioral health provider probably isn't treating the autism, but maybe autism is the diagnosis in the medical chart and the behavioral health specialist is helping to manage a behavioral, anxiety or school complexity component within the primary care setting. So, you have that diagnosis in the chart, and you can use it. Some of the Z and V codes (social determinant of health codes) would also be appropriate – for example, you have a family experiencing homelessness and the behavioral health provider is brought in for referral or other services. You could use a Z code that is related to that visit. It doesn't have to be a billable diagnosis to use the code for those interventions and services. It was previously asked what needs to be in the note. There are types of things that we are considering to meet those regulatory standards. John would encourage providers to think creatively – not recklessly. We are all trying to accomplish a clinically appropriate, medically necessary service and we're trying to document in a way that can be reimbursed for the service. John then referenced a video: <https://www.youtube.com/watch?v=e8QHgSxaYdo>



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John then referenced the SOAP handout that is the brief summary of the YouTube video. This person takes a traditional SOAP note and creates a formula. Subjective plus Objective equals your Assessment and Plan. As clinicians, you are writing a note for the medical team's use. John wanted to highlight the Plan part of the note. At some point, this can serve as a robust plan if your entity's guidelines require a treatment plan. It may not be signed, but in the comments, you can add any additional information. It can address all of the appropriate parts of what is happening in that encounter. Within the Plan, you can document the following:

- 1 **A**ssure Safety (Plan as needed)
- 2 **B**ehaviors to practice (i.e. "Pt will practice deep breathing 3x/week for next 2 weeks.")
- 3 **C**ontact Plan (return visit, call, by whom, when?)
- 4 **D**rug Compliance (Not generally a part of pediatric practice, except for chronic health conditions.)

John would encourage the Care Team to focus not on the barriers, but how the practice can make this work within their setting.

Responses to submitted questions:

- Since no diagnosis is required, any appropriate dx is allowed, including Illness Unspecified (R69) and Behavior Problems (R46.89) – there is no list – as long as it is medically necessary
- John then gave a pediatric example of how to use the 6 visits with a medical diagnosis instead of a behavioral health diagnosis. He recounted his time as a clinician when his clinic had an Asthma Clinic and Obesity Clinic. In the case of the child with asthma – non-compliance with use of the inhaler; what to do when he's having an asthma reaction; mom's not sure on how to help him self-advocate when the child needs to go ask to go to the nurse. The provider has tried a variety of things and the behavioral health specialist is pulled into that encounter to address the asthma



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complexity and what that looks like. The behavioral health specialist is not used to unpack the medical aspects of treating the child's asthma, but the behavioral and social sides of what is happening with that kid.

- John then gave another example of when he was a clinician involving skin conditions/rashes. A child would want to participate in gym and would not want to be excluded but had no follow up plan to deal with his/her sweaty skin which then promoted itching and scratching. Then the child would have to go the nurse. It's really helping with behaviors and barriers for following through with a plan that the physician had crafted. Sometimes the behavioral health person could go in and address some of the underlying reasons like stigma issues, isolation, teasing and bullying that wasn't really addressed on the medical side. Those are some of the ways that behavioral health folks can engage families with medical conditions.
- Obesity was another one that was huge. There are lots of medical interventions that a provider will try and then refer to a behavioral health solution for other approaches, such as motivational interviewing and engaging the child. You might unpack a diagnosis within the physical condition like depression. It could be something totally unrelated like the child has difficulty saying no to mom when she has prepared a plate of food or maybe some social or cultural factors or the type of food or the time of dinner. Then maybe we want to talk about how we change certain types of family behaviors. So, that's a physical health condition that a behavioral health person can provide an intervention for and then maybe then discover other behavioral or mental health conditions happening as well.

Types of Services

Context (Summarized and Paraphrased)

A question was submitted to CCHAP on whether a clinic can use the 6 visits codes for pregnancy related depression that the clinic identifies through screening to support the mom and baby together. Further, can the clinic record the information in



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the child's record. PRD impacts a child – if you are screening that mom in a pediatric setting for PMAD – yes you can use the 6 visits for that. The second part of the question is more problematic on where to record the information. CCHAP published a white paper that provides guidance on this issue. Part of the conversations included whether a clinic should open a chart for the mom but if you are only a pediatric practice whether you want charts created for adults. These are questions the clinic has to address – there are a variety of options. John then spoke from his clinical perspective, not from a HCPF perspective. If you are a clinician and if you are going to document anything in the child's chart about a parent, it should be as benign as possible. Another parent or guardian has access to that medical record and you would not want a mother's mental health condition and past trauma in a child's chart. A practice should come up with a way in which you can keep this child-focused and the dyad between that mother and child like nursing, sleeping that might be impacted by a mother's mental state. Practices should be very cautious about what is put in that chart. There is a protocol, RADAR, that deals with domestic violence in a pediatric setting that may be a good resource and again illustrates that there are certain things that you may not want to put in the chart. Practices need to decide how they will record things in the chart, but CCHAP's white paper can provide guidance.

The 6 visits policy was intended for low acuity and for the people who didn't experience significant trauma who need longer term services. From a HCPF perspective, HCPF isn't reading notes to see if something is low acuity – it's not the intention of the policy.

The therapy modalities that are probably best suited to the 6 visits is any modality that has been validated for brief interventions. Behavioral activation can be a great intervention, as well as mindfulness, CBT and other interventions with the goal of seeing some improvements in behavior change. If it can't be addressed in six sessions, you may not be the most appropriate person to be addressing the issues within a primary care setting.



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Billing

Context (Summarized and Paraphrased)

In response to a question submitted to CCHAP (can we use the 6 visits codes for a session with our behavioral health provider the same day as the medical visit for the child? Can the behavioral health visit happen during or immediately after the medical visit?), John indicated that yes, the policy was intended to operate in this way.

Another question involved whether a clinic has to use all 6 visits or whether the behavioral health specialist can see a family or child once and that is okay. John indicated that a clinic didn't have to use all 6 visits. John gave the example of a child that was involved in a car accident and was afraid to get into cars – that may be a one-time intervention where you don't need to bring a family back 5 or 6 times.

HCPF is the payer and claims are to be submitted to the Colorado InterChange.

Episode of Care

Context (Summarized and Paraphrased)

John shared that when he was a clinician he was used to using episode of care to distinguish various things that were happening in a family's or child's life. He used the example of a new sibling and behaviors that involved tantrums and acting



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out and then dealing with adjustments at day care or preschool, etc. There are three ways to look at defining episode of care. First, you can define it by diagnosis – however, when you look at how to manage it within HCPF's computer systems, HCPF will have to give the coders a list of every possible diagnosis and acuity, but it would limit the ability to provide flexibility to providers. The other way to define an episode of care is through a timeframe. The goal of the policy was that the visits would be short-term – at some level, it's hard to define an episode of care within a timeframe. The final way to define episode of care is through clinical expertise -that isn't a helpful way for HCPF to manage a benefit. Episode of care is what everyone wants, but there are honest technical, logistical challenges to get there. HCPF continues to look at this by looking at the data around utilization. If you know that the treatment is going to be long-term, that is not the patient you want to start treatment with using the 6 visits. As clinicians, we don't want families to have to retell their stories to a variety of people in a variety of settings. Maybe an approach is to use the 6 visits to help them prepare or commit to longer term therapy.

Other Questions - Reimbursement

HCPF isn't considering raising rates for these services to better align with medical reimbursement for the same type of service.

Disclosure and Consent for the 6 visits

Per DORA's requirements all licensed behavioral health clinicians or registered psychotherapists should be providing consents and disclosures. As a former clinician, John worked within his clinic to weave this into the larger clinic's consent and disclosure paperwork. The previous question about consent is complicated and it's not a HCPF policy – it's a DORA policy and should be figured out with DORA. There is a confidential and consent handbook for schools and goes through everything that you need for consent and confidentiality for adolescents. HCPF is working on a FERPA/HIPAA crosswalk about the process for getting information from a child's school.



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