The Business of Behavioral Health Integration: Changing the Payment Questions

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Quality Counts, April 2, 2014
Objectives:

Participants will be able to:
1. Identify contractual arrangements, coding and billing that support behavioral health delivery in the present fee-for-service system
2. Describe administrative functions that support maximized service delivery
3. Identify new methods of accounting for the “costs” and “benefits” of behavioral health intervention

Disclaimer:
- This fee-for-service information does not represent how a payer might respond to a claim
- This information does not replace any regulatory information
- Always seek information from your own agency consultants regarding any billing and coding practices
How are behavioral health integration services set up and paid for in the present fee-for-service system?
Or….can behavioral health integration pay for itself?
<table>
<thead>
<tr>
<th>Level of Collaboration</th>
<th>BHC covers all expenses</th>
<th>Practice offers space</th>
<th>Practice offers space and scheduling</th>
<th>Practice employs</th>
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<tbody>
<tr>
<td>Co-located Practice</td>
<td>BHC bills</td>
<td>BHC bills</td>
<td>BHC bills</td>
<td>Practice bills</td>
</tr>
<tr>
<td>Level 3 and 4</td>
<td>BHC schedules</td>
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<td>Separate records</td>
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<td>Streamlined referral and scheduling</td>
<td>Shared responsibility for schedule</td>
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<td></td>
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<td></td>
<td>process</td>
<td>Streamlined processes</td>
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<td>Communication with releases</td>
<td>Communication without need for releases</td>
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<td>Partially Integrated</td>
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<td>BHC bills</td>
<td>Practice bills</td>
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<td>Same record</td>
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<td>Coordinated care</td>
<td>Shared responsibility</td>
<td>Shared responsibility</td>
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<td>Streamlined referral and scheduling process</td>
<td>Streamlined processes</td>
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<td></td>
<td>Releases part of routine</td>
<td>Improved coordination and communication</td>
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<td></td>
<td></td>
<td>Connected to primary care team</td>
<td>Working toward becoming part of primary care team</td>
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<tr>
<td>Fully Integrated</td>
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<td>BHC bills</td>
<td>Practice bills</td>
<td>Practice bills</td>
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<tr>
<td>Level 6</td>
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<td>Separate record</td>
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<td>Same record</td>
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<td>Shared responsibility</td>
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</table>
Basic Models

- Medical practice employs BHC and bills
- Medical practice contracts for BHC and bills
- Medical practice partners with BHC individual or organization and BHC bills
Set up for Maximum Integration

Medical practices do the billing

- No need for patients to “register” in a new organization
- Allowance for additional revenue through health and behavior codes – only allowed in medical billing
- Reduced, more reasonable documentation requirements that better match practice needs
- Both parties share investment in the successful outcome.
Mental Health and Health and Behavior Codes

Mental Health Codes
- 90791: Initial Assessment
- 90832, 90834, 90837: Individual Therapy
- 90846, 90847: Family Therapy
- 90853: Group Therapy

Health and Behavior codes
- 96150: Assessment
- 96151: Reassessment
- 96152: Individual intervention
- 96153: Group intervention
- 96154: Family intervention
Master Level Clinicians

- Medicare - LCSW’s (not LCPC’s) only the mental health codes. Psychologist – mental health and H&B codes
- Medicaid allows: LCSW’s, LCPC’s and LMFT’s, as well as conditional for mental health codes. Differs by practice type for Health and Behavior Codes
- Commercials may differ but generally more inclusive
Psych NP’s/PA’s

- Need to follow rules for E/M codes
- Generally paid by all payers
- Would probably not bill Health and Behavior codes
- Often confusion around “medical” vs. “behavioral” credentialing with the commercial insurers
Medicare reimbursement rates

<table>
<thead>
<tr>
<th>Type of Provider</th>
<th>% physician fee</th>
<th>Notes</th>
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<tbody>
<tr>
<td>MD/DO, Psychologist</td>
<td>100%</td>
<td>Or actual charge, whichever is less</td>
</tr>
<tr>
<td>PA, NP, CNS</td>
<td>85%</td>
<td></td>
</tr>
<tr>
<td>CSW (LCSW)</td>
<td>75%</td>
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</tr>
</tbody>
</table>

NHIC website: [www.medicarenhiccom](http://www.medicarenhiccom) on Fee Schedule page.
For Commercial Insurances

- Different expectations by payer
- Need to clarify whether in-network medical and/or behavioral health
- Reimburse for Health & Behavior codes?
- Confusion about medical vs. behavioral health service
  - Be clear at point of service
  - Have documentation support service
- Recommendation to bill for service, if service was appropriately delivered, to establish “need” for reimbursement
Some key questions

- Payment for 2 encounters in the same day?
- Reimbursement for Health & Behavior codes?
- Pre-authorization required for mental health visits?
- Full assessment required before treatment can begin?
Plan to get paid

**Pre-hire:** Clarification of financial and billing arrangements

**Hiring Process:** Credentialing and preparation for billing

**BHC Starts:** Orientation of mental health provider and preparation for billing

**Ongoing Support:** Monitoring reimbursement and continuous improvement
Financing integrated Healthcare in Maine as of: March 27, 2012

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Diagnostic Code</th>
<th>Medicare</th>
<th>Federally Qualified Health Centers (FQHC)</th>
<th>State Medicaid</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201-99205 New Pt</td>
<td>May be used only with physical health diagnosis</td>
<td>Paid?</td>
<td>Medicare</td>
<td>Paid?</td>
<td>Medicare</td>
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<tr>
<td>Yes</td>
<td>MD, PA, ANP</td>
<td>Yes</td>
<td>T1015</td>
<td>MD, PA, APRN</td>
<td>Must also report all procedure codes on claim form. See Note A.</td>
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<tr>
<td>99211-99215 Est. Pt</td>
<td>Yes</td>
<td>T1015</td>
<td>MD, PA, APRN</td>
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<tr>
<td>96150 Assessment</td>
<td>Services are secondary to a physical health diagnosis</td>
<td>Yes</td>
<td>Non-physician mental health practitioners</td>
<td>Yes</td>
<td>T1015</td>
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<tr>
<td></td>
<td>Yes</td>
<td>Psychologist only at this time, excludes CSW</td>
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<tr>
<td>96151 Reassessment</td>
<td>Yes</td>
<td>Yes</td>
<td>T1015</td>
<td>MD, PA, APRN, Clinical Psychologist, Clinical Social Worker, Licensed Clinical Professional Counselor</td>
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</table>
# Funding, Licensing and Regulation Grid

Information for the State of Maine - Updated October 2013

<table>
<thead>
<tr>
<th>Commercial and State Funders</th>
<th>MaineCare (Maine Medicaid)</th>
<th>Commercial</th>
<th>Commercial and State Funders</th>
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</thead>
<tbody>
<tr>
<td>E&amp;M</td>
<td>Health &amp; Behavior</td>
<td>Health &amp; Behavior</td>
<td>Psychiatric Services - Commercial or MaineCare</td>
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<tr>
<td>99201-99205</td>
<td>New Pt</td>
<td>MD/NP/PA</td>
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<tr>
<td></td>
<td>96150 Assessment</td>
<td>LCSW/LCPC/PhD</td>
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<tr>
<td>99212-99215</td>
<td>Established Pt</td>
<td>MD/NP/PA</td>
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<td></td>
<td>96151 Re-assessment</td>
<td>LCSW/LCPC/PhD</td>
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<tr>
<td>90833, 90836, 90838 +</td>
<td>Add-on Psychotherapy codes</td>
<td>MD/NP/PA</td>
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<tr>
<td></td>
<td>96152 Ind Intervention</td>
<td>LCSW/LCPC/PhD</td>
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<tr>
<td>90792</td>
<td>Initial Psych Assessment</td>
<td>MD/NP/PA</td>
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<td>96153 Grp Intervention</td>
<td>LCSW/LCPC/PhD</td>
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<td>96154 Family Intervent</td>
<td>LCSW/LCPC/PhD</td>
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<tr>
<td>99371-99373</td>
<td>Phone Consults</td>
<td>Family Physician, Medicaid only, Mass</td>
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<td></td>
<td>Aetna Interpretation of Health Risk Assessment Instrument</td>
<td>Aetna - in Physician practice</td>
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<td></td>
<td>Telephone eval and management service</td>
<td>Aetna - in Physician practice and for Psychiatry</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospital License</th>
<th>Hospital License</th>
<th>Mental Health License</th>
<th>Hospital License</th>
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</table>

<table>
<thead>
<tr>
<th>Primary Care Office - Physician Practice</th>
<th>Primary Care Office - Physician Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural Health Clinic</td>
<td>Rural Health Clinic</td>
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<tr>
<td>FQHC</td>
<td>FQHC</td>
</tr>
<tr>
<td>FQHC Look-alike</td>
<td>FQHC Look-alike</td>
</tr>
</tbody>
</table>

* 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
"I'll pause for a moment so you can let this information sink in."
Stop the Madness
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” – wherever you can find them
Assumptions regarding Start-up Costs and Revenue

Year 1 - more investment than return
  - During the start-up period, the mental health clinician will not fill all available slots
  - Some of the work needed for development of successful integrated services is not billable under the current payment system.

Year 2 and 3 - projected to bring in more revenue than expense
Measuring and Improving

- Initial areas of focus: access and productivity
  - Volume
  - No-shows
  - Time to 1st and 3rd
  - Charges and collections
  - RVU’s
- Later areas of focus
  - Patient/Provider/staff experience
  - Clinical and functional outcomes
  - Financial impact
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
Measuring Cost Impact
The Question is Changing

- 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?
Understanding cost impact

- 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?
MaineHealth Plan

- Use claims data
- Aggregate at practice level
- Describe characteristics of integration at practice level
- Quarterly data to look at time trends
- Comparison with matched, non-integrated practices
- Measure total cost of care (TCOC) as PMPM
MaineHealth Plan (2)

- Analyze TCOC for all patients in practice
- Look at subgroups likely to benefit from integration
  - High cost, high risk patients
  - Patients with poorly managed chronic illnesses
- Look at all costs, as well as subsets of costs such as inpatient, outpatient, ED, lab, imaging
Understanding utilization of integrated clinicians

- Claims analysis will allow us to understand which patients are being referred to integrated clinicians
  - Are we targeting the right patients?
What have others shown?

- Intermountain Healthcare article 2010
  - Integration reduced ED utilization compared to non-integrated practices by 40-50%

- 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
Resources

For the old question:

- 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

Resources

- For the new question:
  - 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
ACADEMY PORTAL HOMEPAGE  http://integrationacademy.ahrq.gov/

The Academy
Integrating Behavioral Health and Primary Care

COMING SOON

Integrating Behavioral Health and Primary Care
AHRQ's vision is that the Academy for Integrating Behavioral Health and Primary Care will function as both a coordinating center and a national resource for people committed to delivering comprehensive, integrated healthcare.

Lexicon for Behavioral Health and Primary Care Integration
What's in a name?
"All mature scientific fields have lexicons (systems of terms and concepts) that allow geographically distributed work to take place. . . for practical communication and collaboration among those doing the work of science and practice". The new Lexicon for Behavioral Health and Primary Care

The Academy Web Portal – A Resource Hub
Welcome to this new AHRQ Web portal where you will find the resources you need to advance the integration of primary care and behavioral health care and foster a collaborative environment for dialogue and discussion among relevant thought leaders.

This resource center will facilitate the work of the Academy by being a central hub for information, coordination, dissemination, and networking. The portal is structured around seven topics: Research, Education, Policy, Financing & Sustainability, Clinical & Community, Health Information Technology, Resources, and Collaboration.
Reimbursement Resources

Medicare Links
- http://www.cms.gov/Manuals/IOM/list.asp
- http://www.cms.gov/Transmittals/01_overview.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
Contacts

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