Operationalizing Collaborative Care

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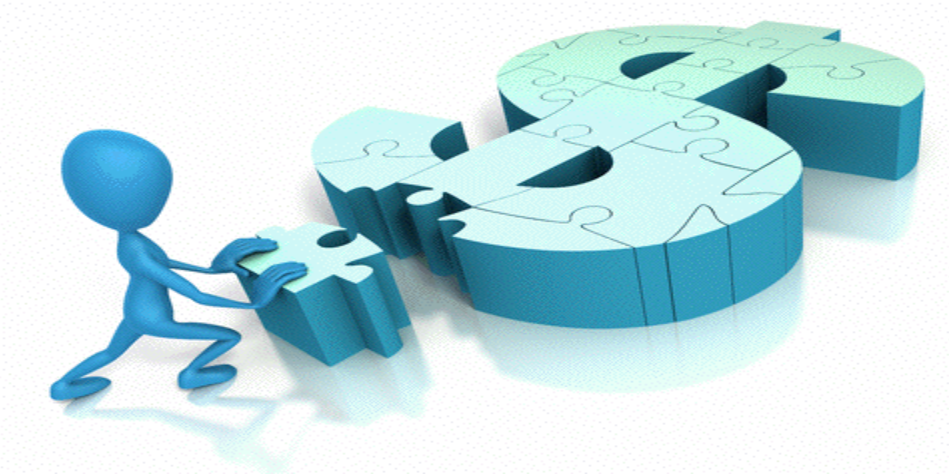


The Collaborative Care Model

What is it?

- An integrated care model that uses a care team of primary and behavioral health care providers to treat mental health conditions such as depression, anxiety, and substance abuse in primary care settings.

Why is it important?

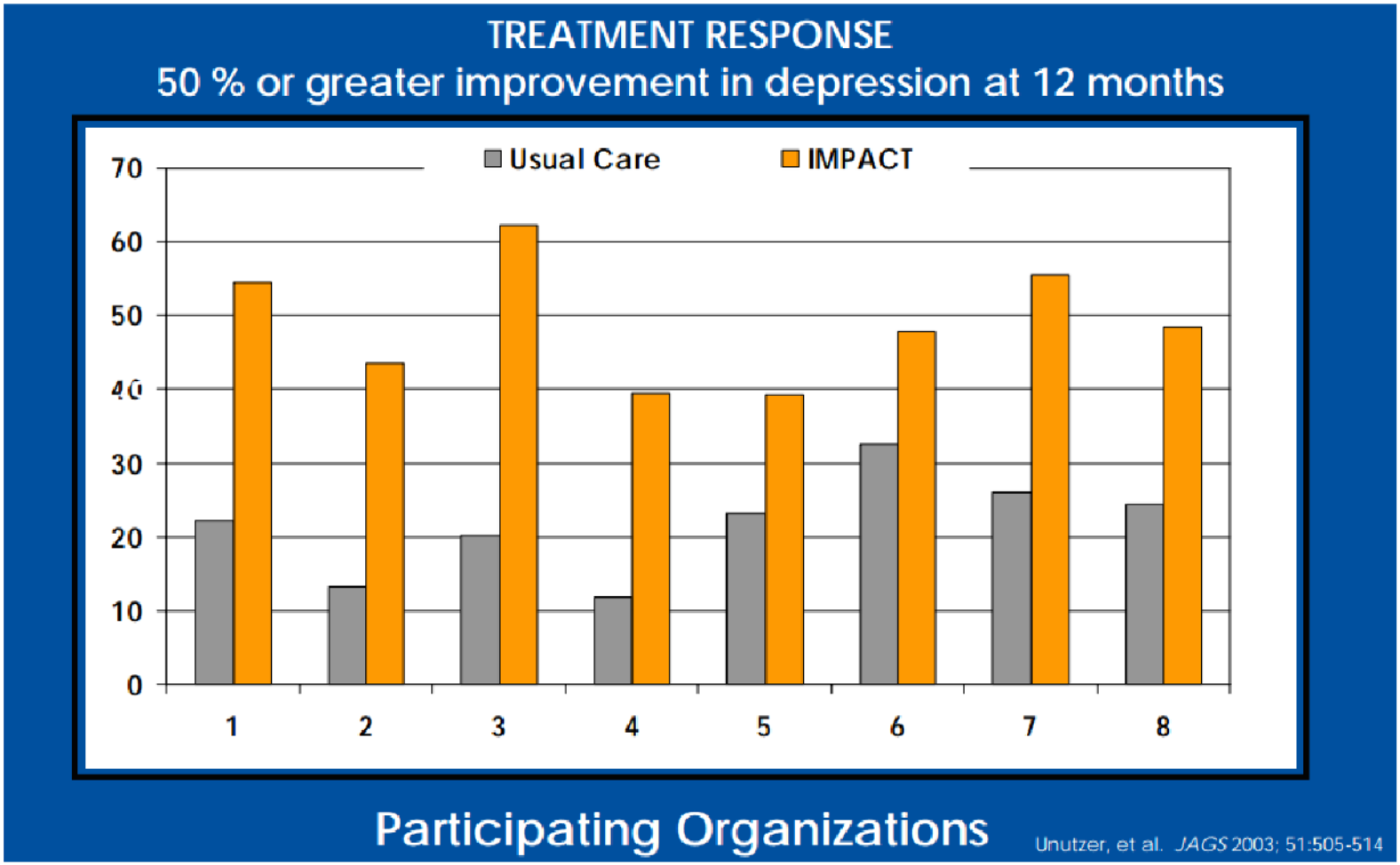
- Despite the prevalence of mental health conditions such as depression, anxiety, and substance abuse, many people – especially low-income individuals - do not receive effective care.

Project IMPACT

- **I**mproving **M**ood- **P**roviding **A**ccess to **C**ollaborative **T**reatment
  - Primary and behavioral health care services are integrated into the primary care setting to treat depression in patients.
  - IMPACT study
    - 1998-2003
    - 1,801 older adults from 18 primary care clinics across U.S.
    - ½ randomly assigned IMPACT model/Collaborative Care
    - Found that Collaborative Care more than DOUBLED the effectiveness of depression treatment in primary care settings.
    - Highly cost-effective

http://aims.uw.edu/impact-improving-mood-promoting-access-collaborative-treatment/

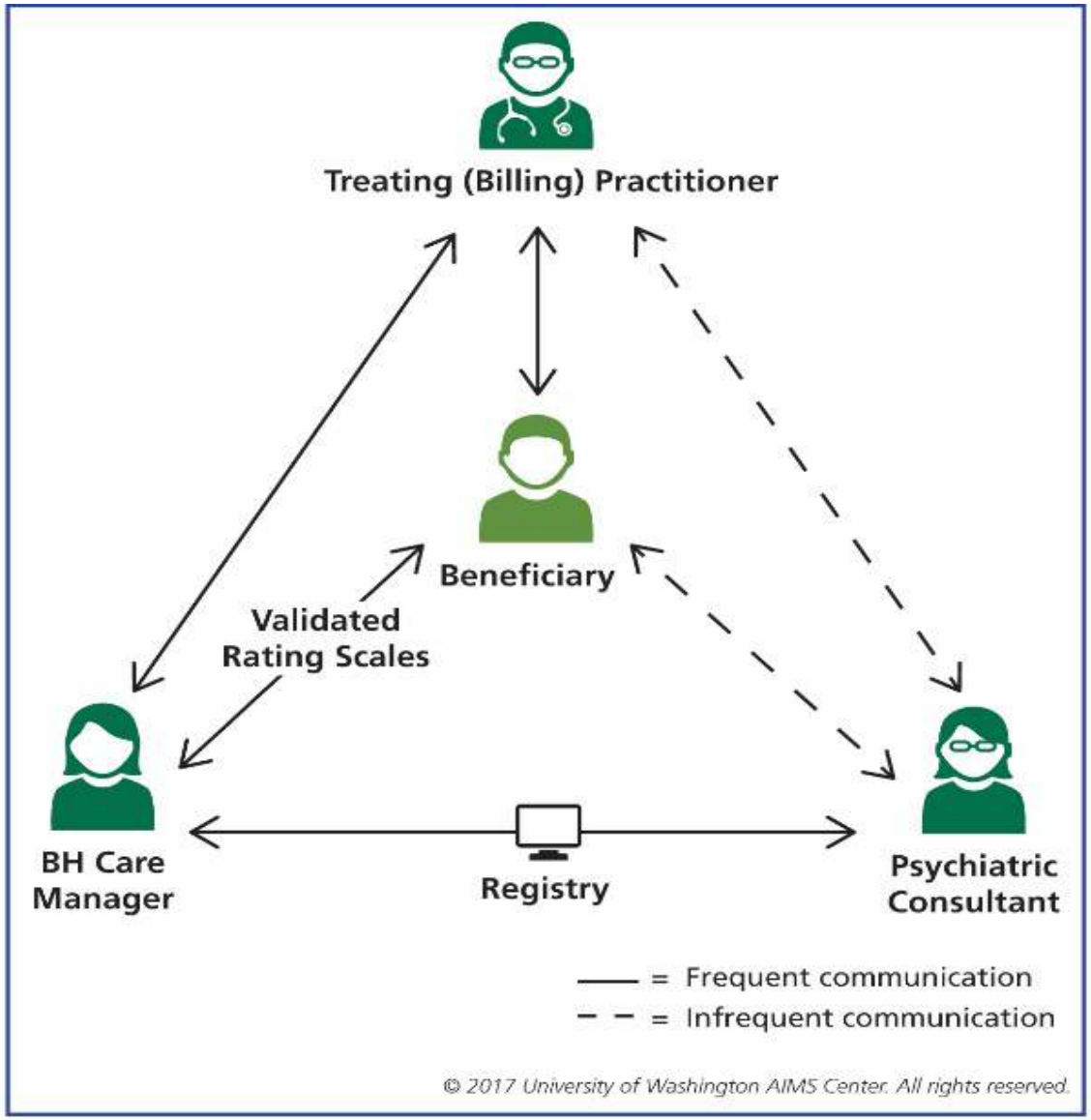
Project IMPACT- Study Outcome



5 Core Components of Collaborative Care

1. Patient-Centered Team
2. Population Based Care
3. Measurement-based "Treatment to Target"
4. Evidence-based care
5. Accountable Care

Patient-Centered Team



Collaborative Care Confusion !

- To Collaborative Care or not to Collaborative Care
- Not a solo model – one of many EBP in an integrated care setting
- Don’t think “either or” think patient centered
- “All of my patients want therapy”

Billing Medicare and Commercial Plans

- Many organizations do not know they can bill other payers
- Its important to bill across all payers –even if they are only a small percentage of your mix
- All time based
- All monthly case rates

Reimbursement Across the Board !

- Commercial and Medicare reimburse case rates for collaborative care
- Masters level licensed staff are able to provide care
- Third party payers are reimbursing Medicare codes (let us know if you don’t get paid)

Staffing

- On site needs to “be available if requested”
- Providers can be telephonic- licensed in state
- License preferred not required
- Allows to expand staffing (LMFT, LMHC)
- Staff do not need to be credentialed or eligible provider
- Addiction can be addiction specialist (think MAT)

Individual Visits

- Can be EITHER billed independently or as part of the time for monthly rate
- Until provider is credentialed or if provider not able to be credentialed count time towards monthly rate
- Medicare-LMHC would be time based vs. LMSW “incident too” vs. LCSW billing directly
- May need to vary by staff and payer if you want to optimize
- You can bill for both each month
- “Flag” for too many in person visits (traditional mh)

BHI Coding Summary non FQHC

BHI Code	Behavioral Health Care Manager or Clinical Staff Threshold Time	Activities Include:
CoCM First Month (CPT 99492)	First 70 minutes per calendar month	• Initial Assessment • Outreach/engagement • Entering patients in registry • Psychiatric consultation • Brief intervention
CoCM Subsequent Months (CPT 99493)	60 minutes per calendar month	• Tracking + Follow-up • Caseload Review • Collaboration of care team • Brief intervention • Ongoing screening/monitoring • Relapse Prevention Planning
Add-on CoCM (Any month) (CPT 99494)	Each additional 30 minutes per calendar month	• Same as Above
General BHI (CPT 99484)	At least 20 minutes per calendar month	• Assessment + Follow-up • Treatment/care planning • Facilitating and coordinating treatment • Continuity of care

BHI Coding Summary FQHC

BHI Code	Behavioral Health Care Manager or Clinical Staff Threshold Time	Activities Include:
CoCM First Month (G0512)	First 70 minutes per calendar month	• Initial Assessment • Outreach/engagement • Entering patients in registry • Psychiatric consultation • Brief intervention
CoCM Subsequent Months (GO511)	60 minutes per calendar month	• Tracking + Follow-up • Caseload Review • Collaboration of care team • Brief intervention • Ongoing screening/monitoring • Relapse Prevention Planning

Considerations

- Rates adjust by region so will vary across the state –or your organization if you cover a large region
- Rates adjust by provider such as a nurse practitioner
- Rates are adjusted yearly
- Patients can be enrolled in multiple initiatives , like CCM – not FQHC
- Don’t exclude specialty providers , cardiology, addiction , pulmonary etc. (may need approval)
- Consider special populations like MAT or HIV
- Referral in the chart and recognition of dx by provider

Time Based Inclusions

- Psychiatric consultation
- Discussions, case reviews with primary care
- Registry management
- Telephonic work
- Discussions with collaterals
- In person visits (to be continued)
- If its not documented its not done !
- Case management/concrete services carved out
- 90% attached to billable event (10% capacity)
- 90% of events billable (may mean not including items)

Common Workflows

- Entry in electronic health record one long documentation
- Create a collaborative care schedule (carve out of productivity reports)
- Allows for documentation to support billing in one place and ease for pcp to see activity
- Remember lock outs or auto close may need to be adjusted
- Non visit or phone encounters
- Close at end of month, change provider and add cpt code

The 99494 Code

- Many payers have or will have a “ceiling”
- More add on time indicates trend to traditional services and can be flag
- Some payers are requiring authorization for multiple add on codes
- Cannot be billed independently , must accompany a 99492 or 99493
- Caseload of 90 lends to multiple types of care

The 99484 Code

- The “other” behavioral health code
- Cannot be used by FQHC providers
- Can be used when you don’t make the time for a month- as example the first month
- “fall back” to ensure billable months

1. **Are the BHI codes limited to Medicare beneficiaries with certain behavioral health conditions/diagnoses?**

   No, as provided in the CY 2017 PFS Final Rule (81 FR 80232), the BHI codes may be used to treat patients with any mental, behavioral health or psychiatric condition that is being treated by the billing practitioner, including substance use disorders. We did not limit billing and payment for the BHI codes to a specified set of behavioral health conditions. The services require that there must be a presenting mental, psychiatric or behavioral health condition(s) that, in the clinical judgment of the billing practitioner, warrants BHI services. The diagnosis or diagnoses could be either pre-existing or made by the billing practitioner and may be refined over time.

Reimbursement

- Will vary some but most follow Medicare
- Appears to be “auto added” and mostly does not need to be added to contracts
- Outreach to payers difficult as codes are so new
- Suggest dropping claims
- Cigna
- Often denial problem with claim form

1. **Is written consent required?**

   Prior beneficiary consent is required for all of the BHI codes, recognizing that any applicable rules continue to apply regarding privacy. The consent will include permission to consult with relevant specialists, including a psychiatric consultant, and inform the beneficiary that cost sharing will apply to in-person and non-face-to-face services provided. Consent may be verbal (written consent is not required) but must be documented in the medical record.

1. **Is a new patient consent form required each calendar month or annually?**

   No, a new consent is only required if the patient changes billing practitioners, in which case a new consent must be obtained and documented by the new billing practitioner prior to furnishing the service.

Questions/Thoughts

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