School of Continuous Professional Development

SO YOU WANT TO START A CARE COORDINATION PROGRAM:

CARE COORDINATION BASICS ON BILLING AND WORKFLOW

Mark Williams, MD

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DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIP(S) WITH INDUSTRY

Name	Nature of relationship	Company
Mark Williams	Advisory Board Member	Everside Health

REFERENCES TO OFF-LABEL USAGE(S) OF PHARMACEUTICALS OR INSTRUMENTS

Name	Nature of relationship	Company
None	N/A	N/A

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LEARNING OBJECTIVES

- Review the core features of the collaborative care model
- Be able to articulate the role of the care manager
- Articulate the basic elements of billing for CoCM

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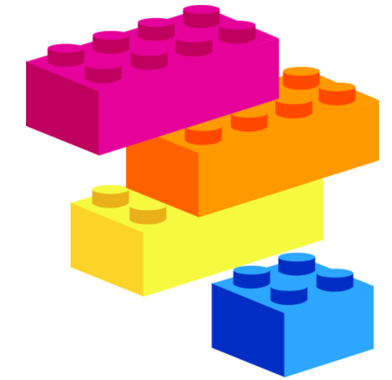
CARE COORDINATION 101



- Built on the following building blocks:
  - Chronic illnesses not well managed in acute care systems – many mental health conditions are chronic
    - Measurements available
    - Silos of specialty, primary care, and community are hard for patients to navigate
  - Access to mental health specialty care is poor
  - Evidence collected over 15-20 years has repeatedly shown that outcomes are improved with collaborative care

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EVIDENCE THAT IT WORKS

Original IMPACT trial focusing on depression (patients 65 and older)

- Double response rate at 12 months for depressed adults (45% vs 19%)
  - Same result in all 8 organizations (18 clinics total)
    - Unutzer J. Jama 2002

Mayo experience when implementing the same model (age 18 and older)

- Three month and six-month response significantly better than practice as usual (PAU)
  - Six-month response (69% for intervention group versus 53% PAU)
  - Six-month remission (53% versus 31%)
    - Both statistically significant
      - Shippee, J Ambulatory Care Management 2013

- Meta-analysis of 79 Randomized Controlled Studies support efficacy

  Archer et al, Collaborative care for depression and anxiety problems, 2012

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Other Evidence:

- CoCM is linked to better medical outcomes for patients with diabetes, cardiovascular disease, cancer, and chronic arthritis
- Faster improvement—
  - Time to depression remission was 86 days in a CoCM program while in usual care it was 614 days
    - Garrison et al, JAM Fam Med, 2016
- A major reason for this has to do with **treat to target**
  - Mayo found that more medication adjustments were made in care coordination than in practice as usual
    - DeJesus et al., Clinical Practice and Epidemiology in Mental Health 2013
- Inertia happens in clinical care – both on the patient side (depressed) and the practice side (busy)

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COLLABORATIVE CARE OF OTHER CONDITIONS

Higher levels of evidence

- Depression
  - Adults/adolescents*
  - With medical conditions*
  - In women's health
- Anxiety*
- PTSD
- Chronic Pain
- Substance Use Disorders*

Evidence being developed

- Bipolar Disorder*
- ADHD

*We have experience with these with varying levels of success

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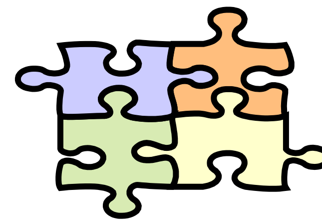
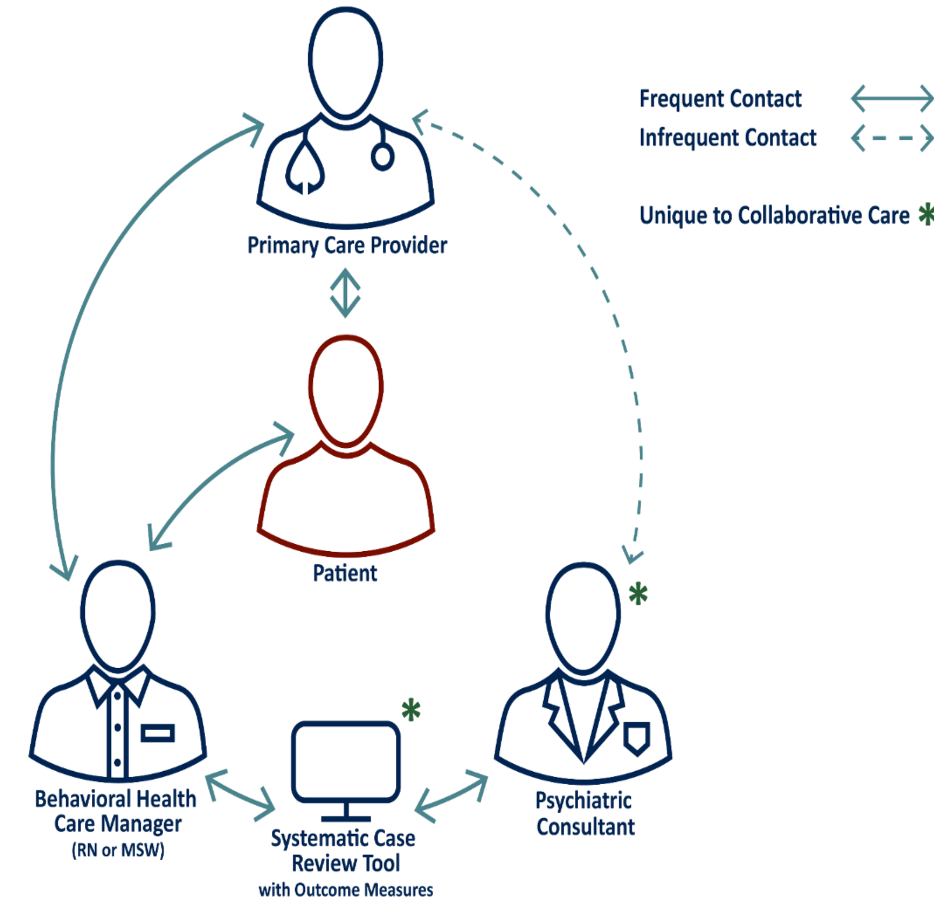
KEY COMPONENTS



- A **patient** with a chronic condition that can be measured
    - Depression – use the PHQ-9 (must measure)
- A **care manager/coordinator** –RN, social worker, etc.
- A **registry** to track outcome data to make sure we pay attention to the patient most needy of care
- **Psychiatric provider** reviewing weekly the patient to make sure latest evidence used to addressed depression
- **Primary care provider** open to suggestion and willing to keep involved in the care of that patient



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OUTCOME MEASURES

- Response Rate
  - 6 and 12 month
    - 50% reduction in PHQ-9 score
- Remission Rate
  - 6 and 12 month
    - PHQ-9 score < 5
- Requires keeping track of patient outcomes…

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MAYO ADULT CARE COORDINATION CRITERIA

- Inclusion criteria
  - 18 or older paneled to an Mayo Clinic primary care provider
  - PHQ-9 of ≥ 10
  - Current diagnosis of depression, including the following:
    - Major Depression, Single Episode
    - Major Depression, Recurrent
    - Persistent Depressive Disorder (Previously Dysthymic Disorder)
    - Others depression diagnoses (Post Partum Depression, etc.)
- Exclusion criteria
  - Severe Neurocognitive Disorder
  - Bipolar disorder

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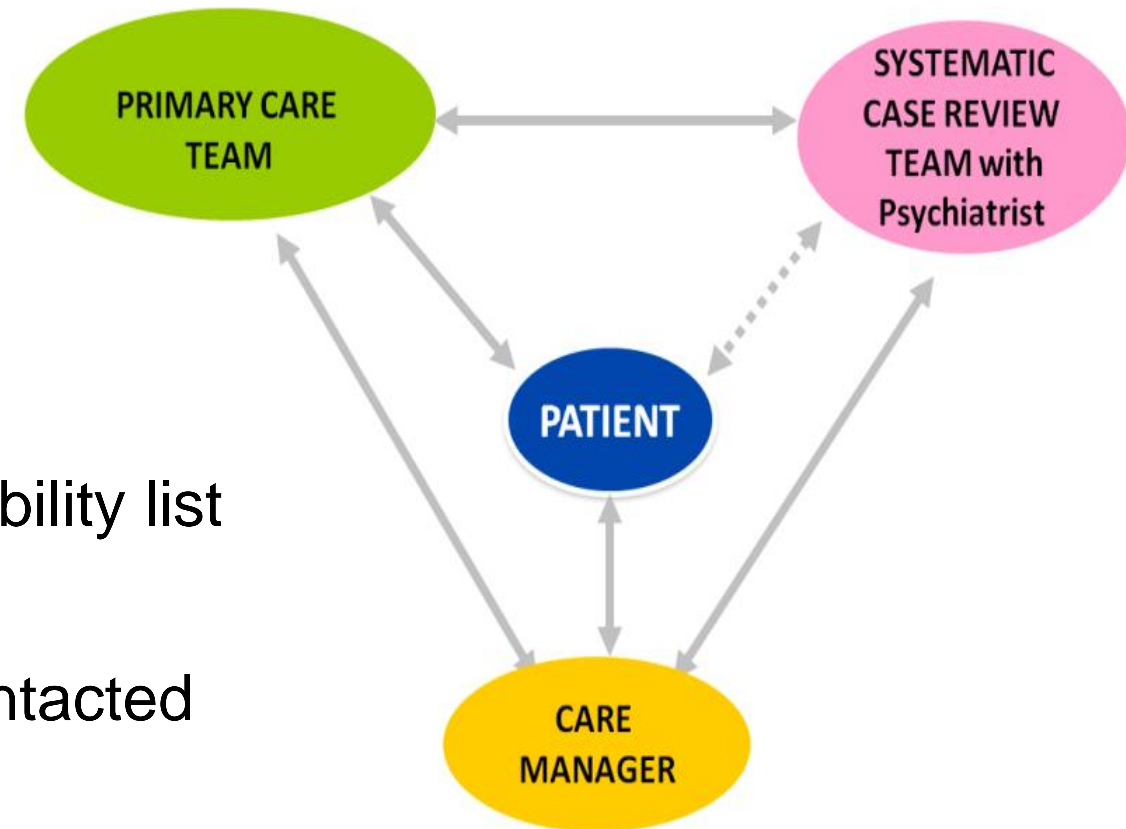
HOW DOES IT WORK IN CLINIC?



- Patient see by Primary Care/show up on eligibility list
  - PHQ-9 score ≥ 10 (moderate)
- Patient introduced to RN care coordinator/contacted
- Patient agrees to participation?
  - More data gathered from patient
    - GAD7, MDQ, AUDIT
    - Past history, social situation, meds, etc.
- Data entered into a **registry** and presented to Psychiatrist (meet once/week) in systematic case review (SCR)

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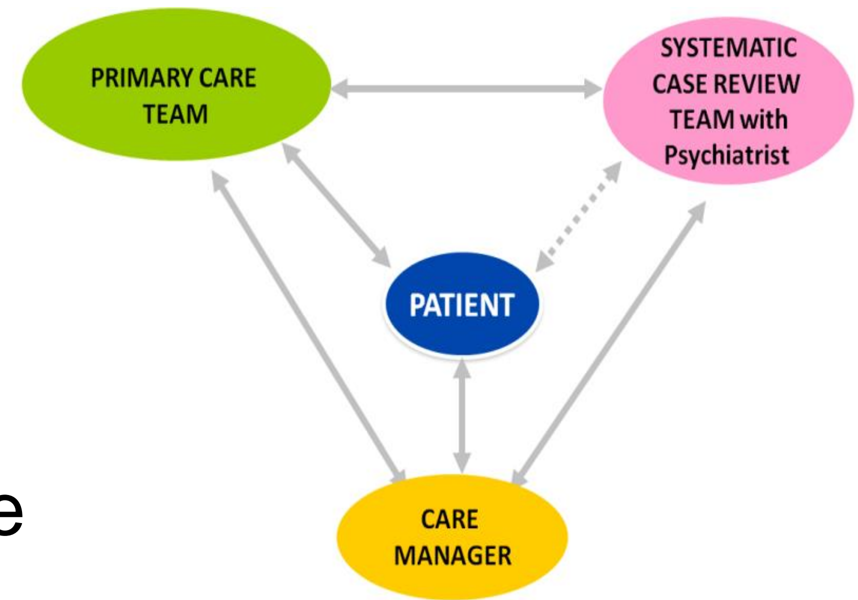
THEN WHAT HAPPENS?



- Psychiatrist makes recommendations into the patient chart for the primary care provider
- Primary care provider writes all prescriptions
- Psychiatrist and nurse care manager stay involved until the patient reaches remission
- Patient is discharged back to their primary care team

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THE CARE MANAGER’S ROLE

- Coordinates the overall effort of the treatment team and ensures effective communication among team members
- Provides the psychiatrist advice to the patient’s provider, and based on the final decision of the provider shares the treatment plan with the patient
- Between provider visits, regular medication monitoring and psychoeducation
- Offers brief behavioral health interventions (using evidence-based techniques such as motivational interviewing, behavioral activation, and problem-solving treatment)
- Co-creates the relapse prevention plan with the patient
- Participates in systematic case review; Close collaboration with the provider and psychiatric consultant
- Supports the PCP by providing proactive follow-up of treatment response, alerting the PCP when the patient is not improving, supporting medication management, and facilitating communication with the psychiatric consultant regarding treatment changes

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BEHAVIORAL HEALTH CARE MANAGER

The BHCM is a core member of the Collaborative Care team. The CoCM is a licensed professional responsible for supporting and coordination the mental and physical health care of patients on an assigned patient caseload with the patient's medical provider and, when appropriate, other mental health providers.

- Engages patient to help patient move from passive to active role in health/team, participates in relapse prevention
- Connects, coordinates and provides needed services to patient
- Is organized and has ability to prepare information in an effective, and efficient way for the SCR with the psychiatrist
- Monitors population/case load regularly using the patient registry and SCR tool to ensure patients are not get lost to treatment
- Works closely with the PCP to facilitate patient engagement and education
- Performs structured outcomes-based assessments along with risk assessment and safety planning
- Systematically tracks treatment
- Provides brief behavioral interventions and supports medication management

Helpful Qualities: Interpersonal skills, ownership and advocacy, meeting patient where they are, tenacity, comfort with both depression and medical conditions, humility curiosity, discipline, creativity

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CHALLENGES

- Finding patients
  - Primary care referrals – warm handoffs
  - Use of an eligibility list
- Getting patients to agree and stay engaged
  - May only get 50% to agree
    - Important to be ‘talked up’ by the primary care provider
    - Need several ways to link up with a patient (in person, portal, etc.)
- Encouraging change
  - What to do with a patient who talks the talk but is not making changes
- Finding outside resources
- Billing challenges

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MANAGEMENT OF THE PROGRAM

- Use of a population-based registry to manage an expected caseload
  - 50-70 patients per 1.0 FTE IBH RN CC
- Weekly SCR with a psychiatrist
  - 2 hrs of psychiatry time per 0.8-1.0 FTE IBH RN CC

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PROGRAM TENETS

- PCP maintains care of the patient and is responsible (if in agreement) for acting on treatment recommendations provided by the psychiatrist
- Evidenced based strategies such as health coaching, motivational interviewing, behavioral activation, and goal setting are utilized in partnership with the patient
- Contacts with patients will be through phone, portal, and in-person clinic visits
- Patients are typically in the program 6 to 12 months

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PROGRAM END

Graduation

- Remission of depression
  - PHQ-9 score < 5
- Relapse prevention plan developed with patient (should be ongoing throughout)

Reached Maximum Benefit

- Patient and/or SCR team agree maximum amount of progress achieved from care coordination
  - Patient did not reach remission but demonstrated stability
  - Lack of progress over timeframe
    - Rarely more than 12 months

There are of course, those who are lost to follow up or drop out
We try to reengage for 2 months and then may let them go

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FINANCIAL SUSTAINABILITY AND DOCUMENTATION

- Psychiatric Collaborative Care Management (CoCM) and Behavioral Health Integration (BHI) CPT codes
  - CMS released CPT Codes in 2017
- Creates opportunity to bill for RN care coordination services using collaborative care model
  - Billed *Incident To* by the IBH care coordinator
- *Bills are based on the total minutes spent by a behavioral health CC in a month*
- Medicare providing coverage but also some Medicaid and commercial plans as well

  - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Care-Management.html)

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CPT CODES

Month	Minutes (Per Calendar Month)	CPT Code
Initial Month	36-70 minutes	99492
Subsequent Months	31-60 minutes	99493
Add On (Any Month)	Each additional 30 minutes	99494
General Behavioral Health Integration	At least 20 minutes	99484
Initial or subsequent when under above codes	Initial (16-34); Subsequent (15-30)	G2214

FQHCs and RHCs can bill for these services using HCPCS code G0512 (for the initial 70-minute or subsequent 60-minute visits).

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ELIGIBLE CONDITIONS FOR BILLING

- Any mental, behavioral health, or psychiatric condition being treated by the billing practitioner, including substance use disorders, that, in the clinical judgment of the billing practitioner, warrants behavioral health intervention (BHI) services.
- The diagnosis or diagnoses could be either pre-existing or made by the billing practitioner and may be refined over time.

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CMS Requirement	Look to Document Internal Adherence
PCP recommendation for care coordination	EHR Documentation in EPIC we use a SmartPhrase *.ccrecommend*
In-person visit with PCP within last 12 months	• Chart Review • MC HP IBH Adult Care Coordination Eligibility Report
Education to patient on care coordination and billing and documentation	• Care Coordinator Brochure (Billing Sites) Patient Education Module EHR Documentation
Documentation of patient consent	Document in EHR with a SmartPhrase *.CCRNCONSENT*
Initial assessment	EHR documentation with SmartPhrase *.IBHCCADULTENROLLMENT*

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CMS Requirement	Internal Adherence
Use of Patient Reported Outcomes	• PHQ-9 • GAD-7
Individualized treatment plan	Longitudinal Plan of Care
Weekly psychiatric consultation on every patient*	• Systematic Case Review (SCR) Task • EHR documentation with *.IBHSCR* SmartPhrase
Tracking patient follow-up and progress using a population-based registry	• IBH (Adult) Program (Smartform) • MC HP IBH Adult Care Coordination SPR/SCR Incomplete Tasks Report
Use of evidenced-based intervention	• Behavioral Activation • Motivational Interviewing

*Deeper dive in weekly SCR meetings on subset for a monthly note
Others are mentioned but not reviewed unless a need (ED visit for example)

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COMMON CHALLENGES

- Mixture of insurances coming into the clinic
  - Try to waive cost sharing or copays if possible.
  - If not, be prepared to have the conversation with patients about billing
- Competing billing codes for care of these patients
  - Review what can/cannot be billed concurrently
  - Rule of thumb – only bill for a given unit of time caring for a patient once

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LEARNING ABOUT THE COLLABORATIVE CARE MODEL

- American Psychiatric Association
  - Free training Psychiatry, Primary Care, Care Managers
    - https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/get-trained
- University of Washington AIMS Center
  - https://aims.uw.edu/
- Center for Medicare and Medicaid Studies (CMS) information on billing
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

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SUMMARY CARE COORDINATION 101

- Care coordination for adult depression has been studied and implemented in many settings with lots of information available
- Keeping track of your outcomes
  - Satisfaction and access will improve
  - Outcomes will improve if the model is implemented correctly
- Adapting to new patient groups and/or new sites is possible
- Reimbursement is now available and can help sustain the program

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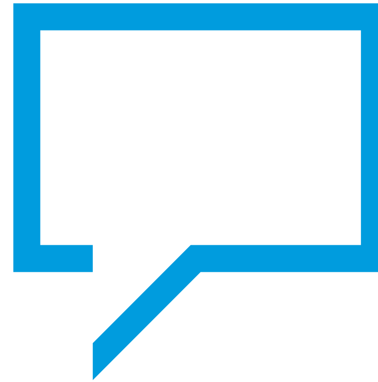
QUESTIONS & DISCUSSION



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