

# Behavioral health integration webinar series: Billing & coding 101

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On Oct. 6, 2020, the Behavioral Health Integration (BHI) Collaborative presented the second webinar in the Overcoming Obstacles webinar series: "Behavioral Health Billing & Coding 101: How to Get Paid."

View the video or the webinar slides (PDF).

## About the event

Physician experts discuss how to bill and get paid for behavioral health care services. This webinar highlights how the provision of these services is a valuable use of physician time and effort and will provide broad introduction to behavioral health billing and coding. Physicians are provided with both accurate and actionable information and real-world examples.

## Speakers

- Leslie Prellwitz—Director, CPT Content Management & Development, American Medical Association
- Jacob Atlas—Senior practice manager, department of psychiatry, Northwestern Medicine

## Transcript

**Host:** All right. Well, good evening everyone and welcome to the BHI Collaborative's Overcoming Obstacles series, sustaining behavioral health care in your practice. Before we begin, I'd like to just go over a few housekeeping items. Please utilize the chat box for any questions that you might have throughout today's presentation. We encourage attendees to interact and share comments or questions in the chat box while our panelists are presenting. Please note that this webinar is being recorded and both the recording and the slides will be shared in an email following the event. A survey will also be included in that email. The folks that are part of our BHI Collaborative encourage

you to share your feedback as we plan future events.

This educational series is part of a suite of ongoing activities by the BHI Collaborative dedicated to equipping physicians with the necessary knowledge to sustain a whole person, integrated and equitable approach to physical, mental, and behavioral health care in their practices during the COVID-19 pandemic and beyond. These webinars are a collective product of eight of the nation's leading physician organizations established to catalyze effective and sustainable integration of behavioral and mental health care into physician practices. With an initial focus on primary care, the BHI Collaborative is committed to ensuring a professionally satisfying, sustainable physician practice experience and will act as a trusted partner to help overcome the obstacles that stand in the way of meeting patients' mental and behavioral health needs.

Today's webinar titled Behavioral Health Billing and Coding: How to Get Paid, will provide practices and systems with a broad introduction to behavioral health coding and how to get paid for such services. We will also explore an example of how such billing and coding activities can work in a practice setting. At the end of tonight's discussion, we will have a Q&A with our experts to explore common issues or concerns that you may be experiencing.

Before I introduce our speakers, I would like to note that today's webinar is being made available to the public and is being recorded as I noted. Please note that the purpose of this webinar is informational only, and you should consult with a professional advisor for a specific medical, legal, financial, or other advice. This webinar and CPT are copyrighted by the American Medical Association. Please take a moment to carefully review this notice. So without further ado, I am very pleased to introduce Leslie Prellwitz and Jacob Atlas. Leslie is the Director of CPT Content Management & Development at the AMA, and Jacob Atlas is a Senior Practice Manager of Psychiatry at Northwestern Medicine. Thank you both for joining us today. And with that, I will turn to Leslie to kick things off for us. Leslie.

**Prellwitz:** Great. Thank you and good evening everyone. I'm hearing a little bit of an echo there. All right. That's better. Great to be able to talk with everyone today. My name is Leslie Prellwitz. I'm the director of CPT content management & development at the AMA and I'm going to start us off by talking a little bit about some of the CPT codes, procedural codes, that you may wish to consider when you're thinking about integrating behavioral health into your practice.

Now, we won't have time to get through all of them in deep detail in the time we have available, but I'll give you an overview and would strongly recommend that you consider taking a look at the latest CPT professional code book. As many of you know, those codes are finished at the end of August. Each year, we're updated. And so our new book effective for 2021 is just starting to hit the shelves. So everything that we talk about here, certainly make sure that you consult the full coding information and guidelines that's available to get a full sense of what works.

With that, I'll probably go to the next slide and we'll start talking about really the continuum and kind of

do a little level setting for everyone in the audience. As all of us know from the joint AMA and RAND study on integrating behavioral health, that really speaks to a lot of the opportunities to address behavioral health workforce shortages and the potential for integrating behavioral health into medical care. And certainly COVID has heightened everyone's awareness and quite likely the need for behavioral health services to be available in addition to addressing medical concerns. So they really are converging right about now.

The article noted two archetypes for behavioral health integration that you see here. From the co-located model where you've got onsite behavioral health clinicians providing enhanced services within physician services all the way over to a true collaborative care model where you're really working as a combined care team for the benefit of the patient. And I like to see these as bookends for a continuum of structures. When you think about how to structure your practices and what works best, there could be a number of variants within this depending on your capabilities and abilities within your practice to deliver this level of care to your patients.

And the good thing is that when we take a look on the next slide, we can start to see how CPT really has a variety of codes across the continuum. And in taking a look with many of our coding experts, these are the ones that came to top of mind. Certainly every patient has unique circumstances, but when you're taking a look here, we've really got codes that cover a wide swath. And as you go from left to right, from the co-located to the collaborative care model, you start to see an increasing volume and variety of providers starting out with our physicians and qualified health care professionals on the left-hand side, primarily with many of our E&M or evaluation and management codes.

And while they're there on the right hand side as well, in between we start getting a number of codes that are in what's called our medicine section of CPT. And that's important because in this case, codes that are in the evaluation and management section of CPT are available to be reported by physicians and those who we indicate are qualified health care professionals. The title is a little lengthy, but it's really defined as an individual who's qualified by education, training, licensure, regulation when applicable, and facility privileging when applicable, who performs the professional service within their scope of practice and independently reports that professional service.

The reason I noted that, it's in the CPT book. But it's important to note that when we get to some of the other codes, particularly in the middle sections, we're starting with the 90s, the 96s, the 97s, these are in our medicine section and the reporting requirements are a little bit different. It's important for this area because when it comes to behavioral health, that starts getting into, in some cases, the ability for individuals who may not meet those requirements of physician or qualified health care professional, but may still be able to have a way to report their services as well. And that's key with behavioral health as a matter of fact.

I wanted to call that out and probably in the subsequent so you can see you've got a variety of different types of codes and services that are available for reporting. I'm going to go through each one

of these in a little bit of detail on the subsequent slide so you can get a sense of how the codes, how the services can vary depending on the needs of your practice, and you'll probably start thinking about certain ones that will resonate well with you. And I know that when Jacob comes on, he'll be talking a little bit about how they've worked in his practice environment.

So let's go ahead and talk on the next slide and we'll start with those codes that are really on closer to the co-location side, more towards the left hand side. And these are services that are really designed to help engage patients early in the care continuum and they're also a little bit easier, I would think, to incorporate in a smaller setting. You don't necessarily need a broad range of providers and physicians and a broad team to affect them. And some of them can actually be conducted even before the patient has a particular issue or condition, particularly when it comes to preventative medicine, which I think is going to be extremely important right about now.

So when we take a look at the preventative medicine counseling codes, and these are used to report services provided face-to-face by a physician or another qualified health care professional for the purpose of promoting health and preventing illness or injury. And it's important for these types of items that some of them are for use before a patient has a specified illness. It's designed to be preventive in nature. So even before a patient has a set diagnosis, you have a chance to connect and work and intervene with that patient. Certainly in individual settings, the codes are defined by how much time is spent, increasing time increments, as well as in group settings.

The other set of codes that really comes in with the evaluation and management group is behavior change interventions. And these two, I bring out there for persons who have a behavior that's sometimes considered an illness itself, and these can be reported when they're part of the treatment of the condition related to or maybe exacerbated by this behavior, or when it's performed to change the harmful behavior, again, that has not yet resulted in illness. So you get a chance to connect with that patient before it gets to be a medical problem. And it's nice to note that there are facilities there, and depending on who's reporting this, this may be an option. Again, if you have a patient who maybe they haven't gotten to the stage where a full fledged behavioral health broad program is needed, you have the chance to intervene early. So the CPT gives you that option.

Now, when you're ready for a little bit more than that, we can talk about some of the items on the next slide where we start moving that yellow dot across our continuum here. So it's towards co-location but at this point there are a few more codes that are a little more focused on behavioral health. There, again, not requiring a large collaboration. So depending on the capabilities and abilities within your practice, this may be something that's a little bit easier to integrate. In particular with psychotherapy, I did want to call out that there's two ranges of codes there. Now, these are in our medicine section and so you may have people who are reporting simply psychotherapy, 30, 45, 60 minutes, pretty straightforward.

But then we also have the second range of codes. And these codes are important because they're

specifically for psychotherapy when they're performed with another evaluation and management service. So they're designed to add on to another service that you may be performing. Now, there are requirements that those services have to be separately identifiable, they have to be reported, obviously, using specific codes. And there are lots of guidelines in terms of what's determined to be separately identifiable, and what have you. But the idea is that the code set is designed so that if you have a patient who has a medical condition but may also require this type of service, there is a way for that physician or qualified health care professional to actually report both the medical and the psychotherapeutic components of the service when it applies.

It's also good to know that a separate diagnosis is not required if you're using that model reporting E&M and psychotherapy on the same date of service. So from CPT reporting guidelines, it's not needed. And so that could be a very useful avenue for areas where it may be applicable for a given patient. It may not be something where you're implementing it in a broad practice, but it is an option for those patients who may benefit from that.

The second one is with behavioral and developmental screening. There are a number of different screening codes in CPT, a number of different types of assessments. But I pointed this one out because it's focused on a brief emotional or a behavioral assessment with the examples that you see there with scoring and documentation, and it's designed to be a code that would be performed by clinical staff under the supervision of a physician or qualified health care professional. So, if you have a little more capacity within your practice, or again, this could be that sort of co-located area. You have someone who is able to perform those assessments and work within your practice. This may be one way to start bringing some of those behavioral health focus services in in a relatively low key way. Again, for patients who would benefit from it.

When we move on to the next group, we start getting into assessments, and these are ones, particularly with adaptive behavior and help behavior assessment and intervention where we're now starting to see a clear focus on behavioral health. So it's moving to the further side. There's also a broader range of roles that are included in here. So physicians, qualified health care professionals can report these, but also there are codes sometimes where perhaps say a technician is performing a particular assessment, again, under the guidance of the physician or QHP, but there are a lot of distinct codes that will allow for that.

I chose two to highlight here. The first one, adaptive behavior services. And these are really used to assess deficient adaptive behaviors. So for example impaired social, communication, self-care skills, maladaptive behaviors such as repetitive stereotypical behaviors, behaviors that risk physical harm to the patient, others or property, or some other impaired functioning. And there are a number of examples in the CPT that talk about that. So those sorts of services that are really behaviorally focused. And then the health behavior assessment and intervention codes, and these were just new for 2020. So these are new groups.

But this particular assessment is very interesting because again, it's a blend of the medical and the psychological issues. So with these codes, they're designed to identify and address psychological, behavioral, emotional, cognitive, interpersonal factors important to the assessment, treatment or management of physical health problems. Now, in this case, the patient's primary diagnosis is physical in nature, but the assessments are meant to address the psychological impacts on those particular disease states and amelioration. So you're starting to get really a blend of acknowledging that a behavioral health issue is...acknowledging that a behavioral health issue is not always an isolated case, and sometimes you need services that can run the gamut and actually address both of those. So I wanted to call that one out, and again, there are options. The different codes are for either an individual, you're working with a group, you're working with a family, or family settings. So there are a number of options that are available, but I didn't particularly want to call that one out, because again, it's a blend of medical and the psychological areas, and the codes are specifically designed to do that. The last one I'll call out is really on the far side, when we really good over to Collaborative Care. These are Care Management codes. They're probably the most comprehensive, and really are for an expansive coordination model. So, you have a physician or another QHP. They're guiding the work of a defined team, particularly when it comes to Behavioral Health Management.

Many of these are reported over extended periods, so many of our previous codes will be reported for a particular visit or an episode of service. These, you can tell you have a true ongoing relationship and a broader care management with the patient. Some of these are reported maybe once every 30 days. In the case of cognitive assessment and care plan services, that's reported once every 180 days. So there's a lot more work that goes on behind it. But the patient... The General Behavioral Health Integration Care Management is really where you're working with these patients and working with clinical staff, and it's important... I thought that this was interesting, is that when I looked back at how this particular code was developed, actually the literature with all the CPT Category 1 codes... There are literature requirements that the CPT editorial panel makes these codes go through as part of a broader process for getting approval for a code.

And in this case, the literature for the efficacy of the collaborative care model was actually sufficient to help support the addition of this code and the code set. So it specifically had collaborative care in mind when it was created, which is wonderful. There's also, in this case, a number of new guidelines for use of that code in 2021. So if you've used this in the past, many of the older guidelines are still there, but there are some additions, and they clarify a little bit about reporting requirements, how often in a particular month treatment plans and are certain elements of service descriptions required for this. So if this is an area that you're using, I would definitely recommend taking a look at the updated guidelines. There will be some new items there. 99492 to 494 is Psychiatric Collaborative Care Management.

This one's a little bit different in that your care group, your caregiver groups, your provider groups, are typically physicians or QHPs, and in some cases they're directing the work of other physicians or

QHPs, behavioral consultants. It's where you really get a model that is focused on psychiatric care management versus medical management, and it's a very involved and kind of complex model. So those would be the ones that are probably on the farthest side, in terms of complexity, in terms of involvement of multiple roles in the care for the patient, and are really focused on behavioral health. Now, I noted in a box there are some other care management codes that we hear about relatively often. These are Chronic Care Management and Complex Chronic Care Management. And I've placed them in a box, because people will often take a look at those and say, "Well, couldn't those qualify?"

They are care management, but they're not necessarily behavioral health focused, so I didn't want to place too much emphasis on them in this presentation. And there also are some reporting requirements that are a little bit different, including if you looked at the guidelines, especially for 2021, there are some new guidelines in there for practice requirements in order for those codes to be used. Some of the requirements are much more stringent than they are with the Psychiatric Collaborative Care and Behavioral Health Integration codes. So those may be common, but I'd say take a look at the requirements for those codes before they're used, because they're not exactly one and the same. So that's an overview of some of the different types of codes that you may find beneficial as you think about integrating behavioral health into your practice. In the last couple of slides, I did want to go over a few things people often talk about. "Well, what about telemedicine? What can we do?"

And not every code is available in a telemedicine setting, but there are some, and I did highlight of the ones we went over here. Those that are in red are listed in one of the appendices in the CPT book, and that's that appendix is designed to specifically talk about codes that have been approved by the panel for use in a telemedicine setting. It requires real-time audio-visual, among other things, and there is a modifier 95 that can be reported with those codes. So, they are permanently available for use in telemedicine. Now, right now during the public health emergency, we all know that there are a number of waivers that CMS has enacted for additional services to be provided during the PHE in a telemedicine environment. In this case, the cognitive assessment and care plan services is actually one of those codes. So I wanted to highlight that certainly, and I understand, based on yesterday, that I think the PHE has been extended another 90 days. I'm not sure of the exact end date.

So, a few of these are going to be with us for a little while, but that's something that's kind of happening. But I wanted to make sure that people knew that... I'm sure, ideally, you'd like to have them all at least available. That's not quite the case, but you can see that there are some avenues in terms of being able to interact with patients if you're in a telemedicine environment in a situation that you can still connect with those patients. I think our last slide I will probably go through has to do with internet, or virtual visits and conducting those visits. And these are some that are from our evaluation and management series, our E/M sections.

And they're specifically designed... The reason they're not on the telehealth list, because they're designed to be virtual. So you have Interprofessional Telephone, Internet, EHR Referral Services that

may be an area of use. There's a code for the referral and sort of the referee, if you think of it that way, and then some additional codes that I wanted to highlight, particularly for telephone and virtual visits. So they're designed for telephone calls. Most of these are designed for use with established patients in most situations. During the PHE, some of these have been waived so that they can be reported for established or new patients. That's a temporary one, but there have been some waivers made there. And in this case, again, because the E/M section is designed for physicians and qualified health care professionals to report, in this case, we have two parallel sets of codes.

One is for physicians and qualified health care professionals, and the second set is for groups that we term of qualified non-physicians. they may not report the E/M set, but sometimes your therapists or psychologists or others who don't meet that definition of physician or QHP, there is an option for them to report as well. So that would be my overview of some of the CPT codes that are available for use. Again, certainly going through the CPT book, there may be a number of additional ones that are relevant for your particular situation, and I always recommend people take a look through the guidelines and the full descriptions to make sure that you're accurately reporting the service that you give. But this is a good overview, and with that, I would say, Megan, I think I'd like to hand it over to Jacob to talk a little bit about how this collaborative care service has worked in his organization. So, Jacob, over to you.

**Atlas:** Thank you, Leslie. That was a great framework for what services are available and the corresponding billing opportunities. For the next part of this webinar, we're going to discuss the implementation of collaborative care management billing processes at Northwestern Medicine, and to provide a little bit of context on Northwestern Medicine's situation and kind of what we were facing when we started this process. Northwestern is a health system in the Chicagoland area. We have a few different regions, and we have more than a quarter million primary care patients just in Chicago alone. So our experience, while there might be some takeaways for you as you go back to your practice, a lot of what we did really focused on building it for a large system. And to be a little more specific before we dive in, these are the services... Collaborative care is the service covered by CPT codes 99492 through 99494 from Leslie's presentation earlier. This was the far right of the continuum.

Slide, please. So, this slide is just a quick overview of the Collaborative Care Management model, and I just want to take a minute to take a step back and explain what this model is and how it differs from the traditional fee-for-service outpatient care structure, because I think that sets important context for understanding the rest of this presentation. So currently what we see in a lot of primary care practices is that the primary care provider is delivering behavioral health interventions to the patient directly. Collaborative care adds two care team members to supplement the existing PCP-patient relationship, and those two care team members are the behavioral care manager and the consulting psychiatrist.

The behavioral care manager works closely with the patient and the primary care provider to coordinate that patient's care, to follow up on treatment adherence, and to really own the care plan.



But the behavioral care manager has a key role working with a consulting psychiatrist who is often a third-party contracted psychiatrist who works off-site to coordinate care recommendations between the behavioral care manager, the PCP, and the patient. Now, one more thing that really makes this very different than what you're used to is that the majority of this is done over the phone, and that was even before COVID.

And to make this even more unique, every encounter that you see on this diagram is actually billable. So that includes the time that behavioral care manager spends with the primary care provider, spends with the consulting psychiatrist, and also spends with the patient. Basically, anything that that can be described as the provision of behavioral health care is technically allowable as a billable service. In addition, the billing for collaborative care is accumulated and billed monthly for participation in the program at the end of the month, rather than billing for encounters as we complete them. So this could mean potentially eight or more five-minute or two-minute encounters over the course of the month being accumulated and billed as one charge. And then in addition, this is technically a medical service for all billing purposes. And now, before I dive in any further, I want to emphasize that NM chose this model because it best met our patients' and organization's needs. So the remainder of this presentation is not a recommendation for collaborative care, but instead an example of a successful implementation and some key takeaways.

Next slide, please. So, when we looked at implementing collaborative care, of course we had to focus on the clinical component and ensuring clinical efficacy and best practices. However, for the purposes of today, we're going to focus on how we set and achieved our operational and financial goals, and specifically the obstacles that we faced as we look to implement this. Next slide, please.

So, some of the key challenges that we saw as we started implementing this were the challenges of adoption and expansion. When we looked at adoption, we focused on integrating the clinical and financial and operational goals to ensure that we saw widespread adoption across all of our primary care practices. And then when we looked at expansion, as I mentioned, we're a large health system and we wanted to make sure that this could grow efficiently, so we focused on automating as many of the processes as possible.

Slide, please. And when we did start to implement this, which was... We started working on this in the middle of 2018. We were fortunate in that we had peers and other organizations that had tried to do this previously with what were then called G-codes, which are temporary Medicare codes. So we were able to learn from their experiences and what did and didn't work, and specifically the challenges that they faced in getting primary care providers to adopt the service. So I think the biggest lessons that we took away from them are that we should avoid manual, time-intensive, and non-value adding billing workflows. So, when I mention this, some examples of what we saw were that some of our peers were recording patient activity and paper registries or third-party tools. They were manually adding up the time spent on care at the end of the month, and selecting charges based on what they were able to add up using a calculator.

So, this really took the clinicians away from providing behavioral health care, which is not a great use of our already limited behavioral health resources. So, we took their experiences and really focused on simplifying and integrating the necessary billing features. So the key takeaway here is that we focused on integrating the time capture feature into a clinically value-adding tool. So, to do this, we focus on first building a tool that added clinical value. So whenever our clinicians are recording collaborative care work or collaborative care encounters, they fill out a form. And that form has about six clicks that they need to fill out, and it's all clicks that determine the patient's progress through the program, their status, their PHQ-9 scores, et cetera.

And in filling out that form, the provider gets one thing. They got a patient registry integrated into the electronic health record that helps them track their patients, and the full population of the patients that they're supporting. Secondly, the organization benefits by taking this data from the tool and driving it into outcome reporting, so we actually measure the clinical performance of the program using data from this tool. And then finally, because the providers are now looking at this tool as a value-adding tool, we know that they're using it. So we now added in a time capture feature at the bottom where the clinician only has to do one additional click to enter in the time spent on each encounter. Now-

... enter in the time spent on each encounter. Now, our focus here again was let's not let billing get in the way of providing excellent clinical care. And then we also took this opportunity, this necessity for billing, to enhance our clinical and outcome measurement.

The next challenge that we saw was the challenge of expansion, as mentioned earlier. So we focused on automating this billing process. A lot of the feedback we've received from other providers is this idea of burnout and focusing too much on the doing things just for billing purposes or organizational purposes, and these activities get in the way of providing care. So we focused on removing the human element from the charge capture process. We did this by automating the time accumulation process, and then also by removing any action that the PCP needs to do to drop a charge. So everything happens automatically without the PCP doing anything.

Next, we use algorithms to determine the CPT code, as Leslie was looking at earlier, 99492, 99493,

or 99494. And we have algorithms built into the system that automatically determine what we're going to need to charge, and that the algorithm runs the day after each month completes. And doing these two things allows our clinicians to spend more time on clinical work, which is excellent for our patients and excellent for our primary care providers because they get more support. But it also ensures that our organization is spending ... is reducing the overhead spent on supporting this type of a service.

And then there are, of course, additional considerations that we face as we look to implement this. One of these included managed care obstacles. So we, of course, had to negotiate contracts for these services with each of our payers. And that was a little touchy at times, but overall it was a fine experience. Fortunately, this is a medical service. And for those of you who are not very familiar with behavioral health insurance issues, a lot of patients' behavioral health coverage is actually carved out. So by virtue of this being a medical service, we have far more patients covered for the service than they would have been covered for behavioral health services in the same organization. But we still face issues with payers understanding and recognizing that this is medical and not behavioral health. And this, of course, can be a patient dissatisfier at times when they receive insurance denials.

And then secondly, there is an impact on the patient in regards to enrolling in this program. Medicare or CMS requires that we obtain advanced consent from the patient, because this is a billed service for non-face-to-face time, which is a key difference from what patients are used in an outpatient setting. For example, if a primary care provider were to refer a patient to an orthopedic surgeon, there would be no mention of the anticipation of a charge. You would assume that you're going to be charged. But because we need to now mention that this will be a billed service, the patient's natural reaction is "Well, how much?" So we had to get creative with finding ... Not creative. We had to find ways to equip our clinicians and the patient-facing users with information to provide the patients to address these questions.

And looking back, we had a few takeaways that I think could be applied to almost any iteration of collaborative care management services. So for starters, collaborative care management or any integrated behavioral health solution needs to be tailored to fit an organization's needs. A lot of what we did at Northwestern that worked really well for us would be too time intensive and costly for a smaller organization or a single practice to implement.

Secondly, removing the burnout factor ensured that everybody was really focused on providing clinical care and did not feel that this was a burdensome process that only served to inflate the bottom line.

Third, integration is key. Integration of the electronic health record billed to support both clinical and administrative functions was essential to adding value. And this opportunity to integrate offers a really unique opportunity to simultaneously capture program and clinical outcomes data. So take advantage of that whenever you can.

And then finally, recognize and embrace the unique components of behavioral health integration. This

is different than the health care that we're used to seeing in outpatient settings. Coordinated care is a newer and complex area to navigate, but it allows us to offer our patients so much additional clinical benefit. And you really need to embrace that benefit and really stay true to the fact that this is different and that we need to make certain accommodations to allow for these services to actually take place and come to fruition.

And thank you so much for tuning in and joining us today. I think we're ready for our Q&A.

**Host:** All right. Well, thank you both, Leslie and Jacob. So we did have a few questions come in, and I would encourage folks to continue to submit questions into the chat box while I go through what we've got here. So the first question I'll start with, I'm going to go backwards because it's the first one I see. This is for you, Jacob. Was the program that you used in the EHR or was it built in or added, or is it standard, or can tell us a little bit more about that?

**Atlas:** Sure. So I will do my best. I'm not an Epic architect. I'm just a business guy. But we use Epic at Northwestern, and our focus was on integrating everything within Epic. So everything we did is an available function in Epic. Having said that, we did have our Epic architects adapt certain Epic functionality to support our specific needs. So for those of you that are more familiar with the backend of Epic, we used a tool called Healthy Planet, which is Epic's population registry system. And we used Healthy Planet to determine which patients are in collaborative care and to aggregate, accumulate, and apply algorithms to determine the CPTs to be dropped for each patient.

And then we use ... And then we similarly built assessment tools. We adapted assessment tools to build the form that we have our clinicians enter clinical information into. So it's all within the EHR and it's all doable, but it's going to require a really strong partnership with an EHR architect to build solutions that work specifically for collaborative care.

Having said all that, we built this before integrated services and collaborative coordinated services were really becoming commonplace. And Epic, from my understanding, and other EHRs are working to provide tools that actually support these going forward.

**Host:** And I'm going to keep you on your toes, Jacob. I have another question for you.

**Atlas:** Sure.

**Host:** Can you clarify what you mean by the payers paying for medical, but not the carve-out behavioral health coverage?

**Atlas:** Yeah, sure. So I'll give just a simple example. A patient John Doe might come to Northwestern Medicine and they have their primary care provider here who they're in network with. Let's say that ... And I might mismatch the combinations here, but let's say the patient has Cigna. Okay? So the patient has Cigna and they're in network to see their primary care provider and they pay \$25 every

visit.

Now, when that primary care provider ... This is before collaborative care was a thing, right? Now, let's say that primary care provider says, "You screen positive. You're depressed. I want to send you to our psychiatry department, same health system, same CEO, same everything here, right? Same system." Patient gets referred to us, and we then have to verify their insurance again because Cigna actually carves out, for example, their behavioral health to a third party called Optum, right? And we don't have a contract with Optum.

Now, this is just an example. I'm definitely mixing up the names and what is true at Northwestern, but that's an example that might happen with a patient. So now, they're out of network here at Northwestern and they are going to have a hard time finding behavioral health care anywhere, because that third party mental health carve out does not offer the same benefits that the medical component offers. Behavioral health, from my understanding, is one of the ... it's one of, if not the only specialty that is often carved out of insurance plans.

So now, in collaborative care, we don't face that problem because this is not billed as a behavioral health service. It's billed as medical. So because it's medical and it's billed by the primary care provider, we already know the patient's in network. So the insurance barrier to treatment is basically zero.

Megan:

Wonderful. Thank you. So another question, and Leslie, this is probably going to go to you, can 99406, 99407, can they be used for vaping, for other substances that are inhaled like marijuana or things like that? Do you know?

Leslie Prellwitz:

Good question. I'll probably want to do a little bit of research on that. I know we did have some items, particularly around smoking cessation, and we actually have a service where individuals can actually send queries, particular coding queries to us. I know we answered this. So I want to go back and research that just before responding. And that's actually one of the things I will note. Oftentimes, we'll get a lot of the questions, just like what you've posed here, and what we typically will refer people to is what's called our CPT network and our knowledge base. And it's a group of coding experts that I actually managed here at the AMA to handle specific coding queries, because as we all know, sometimes the nuances come in the documentation and the details. And so we want to make sure we have all of those.

Leslie Prellwitz:

I'll try to research this and see if we've gotten this question in our knowledge base recently before the

end of this session, if I can. And if not, I'll make sure, Megan, that I get that answer to you.

Megan:

Perfect. Thank you.

Leslie Prellwitz:

You're welcome.

Megan:

Another question, this may be again for you, Leslie. If someone is conducting telehealth from home, do I document it in the note as a point of service, and is there a difference in reimbursement for phone versus video versus in office? I think you addressed that a little bit, but if you could expand possibly.

Leslie Prellwitz:

Sure. So there are a couple of limitations or actually exemptions that are in place during the PHE, and specifically provisions ... And I'll go with what CMS has given in their waivers. Certainly, they're not the only payer in town, but they're a major payer in town. So but when it comes to that and the waivers that they've given, with the advice that they've given for telemedicine visits in particular or visits that would normally be conducted in an office, but for various reasons you're doing them in a telemedicine setting during the PHE ... And one thing to remember is we only went over a few codes here that were eligible for telemedicine. It's important to note when we did a webinar back in May, I think we had about 70 codes that were in the CPT, CPT codes that were designated as telemedicine eligible specifically.

Leslie Prellwitz:

When we looked at the impact of both CMS waivers, the March and April waivers, and really added up the number of codes that they had temporarily added to that list, it increased by a factor of four. So there are a lot of services that at least for the time being are telemedicine eligible that weren't normally.

Leslie Prellwitz:

But the last information that we have, the most recent information we have, is when you're performing a service, and perhaps it's performed in a telemedicine environment, that the preferred reporting is to report that code with the place of service that you would normally use if you weren't in a telemedicine environment. So let's say if you see the patient typically in your office, I believe it's place of service 11, if I remember my place of service codes correctly. So you would report it with a place of service of 11, but add a modifier 95 to the code to indicate that it was delivered using a telemedicine

functionality. So that's the distinction that I know of in terms of how to report telemedicine services during the PHE. That's the preferred reporting path.

Leslie Prellwitz:

And you had a subsequent question of whether or not there's a difference in the reimbursement for phone versus video versus in office visits. There has been some evolution on that. When the PHE started, we do have telephone codes specifically, and it was a little bit of a bump for a lot of people because, even though the codes were active, they didn't always get universal reimbursement from all payers. So I know that the AMA and others worked quite a bit, first to have those telephone codes established with payment, and then there was a concern, is there any chance for some level of payment parity, particularly where you may not have an audio visual setup for someone who's living in isolation and your patient, maybe they don't have an iPad or an iPhone. They don't have the audio and visual at the same time. And maybe all they have is a telephone. So what can I do if all they have is audio? What's possible?

Leslie Prellwitz:

So it went from no coverage for those codes to getting paid for codes. And then in the latest waiver, the April updates for those, I believe that there was some parity established with the telephone or the audio only codes to actually the CMS changed the status of the telephone evaluation management services from non-covered to active. They also permitted it to be used for new or established patients. Again, it was typically established, but they expanded that. And particularly for the codes, it can be reported by physicians or QHPs, the 99441 through 443 series. The payments for those visits were adjusted to be similar to CPT codes 99212 to 214, which would be your established patient visit codes, office visit codes during the public health emergency.

Leslie Prellwitz:

So there is a difference in some of those. The nice thing is that at least it's gone from no coverage to some coverage and some level of the payment parity. So there are differences, but you also want to make sure that you report that place of service and the modifier 95 appropriately when you're using the other codes.

Megan:

Fantastic. Thank you. So we definitely have a very engaged audience, so we've got a couple more questions for both of you. I do want to just share a clarifying comment from one of our collaborative members at APA. Just she noted that the collaborative care management codes and other care management codes are like the internet codes. They won't appear on the telehealth list because the code itself is designed to be both virtual and face-to-face. So she just wanted to provide that extra bit of context for folks in the audience, I think, Leslie, to add onto what something-

PART 3 OF 4 ENDS [00:48:04]

Megan:

Folks in the audience. I think Leslie, to add onto what something that you had said in your presentation, just a little bit of extra context there. So next question, I'm not sure who would be best to answer this, maybe Jacob, but do you have any suggestions on how to contract with insurance companies for small groups to get their mental health clinicians to provide integrated care in the practice without joining the mental health IPA's like Beacon or Magellan?

Jacob Atlas:

Sorry, is this question contracting for behavioral health or contracting for collaborative care?

Megan:

It doesn't specify, just says, mental health clinicians to provide integrated care in the practice.

Jacob Atlas:

Yeah. So I'll admit I don't have much experience working with managed care. I've been fortunate to be isolated. We have a great managed care team that handles all that, but I would encourage anybody just to start by calling the insurance providers the same way that they would have set up any other credentialing.

Megan:

Okay. Perfect. And then next question, possibly, I mean, Jacob, you're a part of a larger health system, but either one of you, any thoughts on how making the billing and coding work in a small practice setting? Any thoughts on how you might be able to address that?

Jacob Atlas:



I guess I'd look for a little more specificity on what their question is specifically around. Is it around billing in general or billing for collaborative care type service at a smaller practice?

**Host:** Okay. All right. Let's see if we'll get some additional clarification on that and I'll move us to our next question. This is specifically for Leslie, how does 99452 differ from other digital evaluation codes, 99421 to two, three?

**Prellwitz:** Sorry. I was on mute there. So 99452 is the internet consultation code. And that is specifically designed, if I remember correctly, I'll go through, for use between two physicians or qualified health care providers when they're discussing a patient. So if you think you actually, set up a telephone or an internet consultation as a transfer of data, transfer of information about the patient. One physician is preparing the request for a consult, the other physician is evaluating the information and sending their consultation back, usually through an internet portal. But the thing is that's between physician to physician, or physician to QHP. So it's really those two connecting. It's not with a physician and a patient. Now, the 421 codes, and I will go back to my presentation briefly here. You don't need to bring it up, that's okay...

I've got a separate set here, but the 421 visits, these are online visits. So if you think the 421 through 423 series, these are when you are interacting with the patient, say through a computer portal. Okay. So it's not physician to physician, it's physician to patient or QHP to patient. And so you're connecting via EHR portal. It allows for digital communications to go back and forth. Usually they're rather brief, maybe brief assessments, but that's probably the difference between the two. 452 is between physician to discuss a patient. But the patient's not in that interaction. And 421 to 423 is physician to patient.

**Host:** Perfect. And Jacob, we did get some clarification in terms of the small practice setting question, it is billing for collaborative care in the small practice setting.

**Atlas:** Yeah. So the benefit here is that the behavioral care manager is not the one billing. All the billing is done under the primary care provider. So no additional contracting for those mental health workers and with the mental health insurance companies is required. So a little bit of a simpler answer than I think might've been expected, but it's truly one of the benefits of this service.

**Host:** Perfect. Thank you. And then the last question that's come through thus far is how, and at what rate does a collaborative psychiatrist get paid? And then just other noted that obviously the psychiatrists in the area are all very busy. So they're just trying to get some extra context around that particular aspect of it.

**Atlas:** Sure. So you mentioned one of the key reasons why we found collaborative care to be so attractive at our organization. Our psychiatrists are swamped, and more patients need psychiatric support than we have psychiatrists. So the university of Washington AIMS Center is really the

godfather of collaborative care management. And they have excellent resources online regarding collaborative care implementation and ratios of behavioral care managers to patients, to psychiatry support. The model that we're using is one behavioral care manager is paired with 0.1 FTE of a psychiatrist. So basically four hours per week to support a 40 hour full-time behavioral care manager. And that care manager can support between 60 and 100 patients at our organization based on patient acuity. So we focus more on the patients in the program than the clinics that they're supporting, but either way. At what rate do they get paid? So we're a large organization.

We just put it into their paycheck and it's a funded effort. It takes away their clinical activity. But what other organizations are doing is entering into contracts where they pay a predetermined rate, and that's going to differ by region, by psychiatrist, by experience of the psychiatrist. But essentially it's a four hour per week contract and the rates will have to be determined separately. But one thing to specify here, the psychiatrist is not billing. We have to actually purchase their time. Their contribution to this model is essentially twofold. They review all cases with the behavioral care manager and review medications with a behavioral care manager, and then also make advice to the primary care provider who continues to prescribe the medications. And then the psychiatrist is also available to the primary care providers for ad hoc consultation for an hour or two throughout the week.

**Host:** All right. Well, I thank you for that very helpful answer, Jacob. And we are coming to the end of our time. So before I move us onto my last few thoughts in terms of housekeeping, I'd like to ask both of you, if you have any parting thoughts or anything that you'd like folks to take away from this presentation. And Jacob, I'm going to start with you because you were the last one to speak. So I'm going to have you give your thoughts here and then Leslie, I'll turn to you.

**Atlas:** Sure. Yeah. I'd say be open to the opportunities. Leslie shared a lot of great opportunities, and I think we need to focus less on finding the perfect opportunity and more on finding a good opportunity for helping our patients access behavioral health care, where they otherwise could not have. This is a really tremendous opportunity to reduce by integrating behavioral health care. We have a tremendous opportunity to reduce the stigma around behavioral health care and improve the likelihood that patients actually integrate or sorry, engage in treatment. And it's an excellent opportunity that I don't think anybody could have expected 10 years ago. So it's really exciting stuff.

**Prellwitz:** And this is Leslie, probably my parting comments would be definitely to echo what Jacob has said in terms of certainly the opportunity to be able to care for patients in new ways, with new venues you may not have thought of. Certainly worthwhile to explore. Certainly in these difficult times, behavioral health is becoming so much more of an emphasis, even on patient populations that may not have traditionally looked or needed for that venue. I could certainly see the need is growing from a CPT perspective. It's certainly all about making sure that we've got services available to take care and get the patients the care they need when they need it.

And to be able to report that work of the physicians and the QHPs, and our non-physicians as well, in

many cases. I would say probably, especially with regards to the CPT, there's been quite a growth, not only in many of the surgical areas of CPT, but particularly in the medicine sections with a lot of the assessments, a lot of the evaluations, particularly behavioral health in the last few years. So if it's something that you haven't looked at lately, I would strongly encourage you to get reacquainted with that area of CPT, because there's a lot of changes going on and there may be options there you had not considered. And Megan, I did just want to share one last question. Someone had a question about the vaping, whether 99406 or seven could be used for vaping.

**Host:** Yes.

**Prellwitz:** We actually did have this question come through in our knowledge base. Now, this was an isolated question. So I always say the response is based on the information supplied in the query. So we don't know if other services were being provided or not. But the question that was posed was if a physician provides smoking cessation counseling for e-cigarette vaping for eight minutes, may CPT code 99406 be reported? And the answer for that particular scenario that was given was yes, it could be. That would be 406 smoking and tobacco use cessation counseling visit, intermediate between three and 10 minutes is as part of the code descriptor. Now, obviously that may change if other services are provided during that encounter. We don't know, but if that were solely what was done, that could be a reporting option. I don't know if it extends to marijuana or not. I would have to research that one.

**Host:** Okay. Well, thank you for... What a quick turnaround on that research there. Thank you.

So we are at the end of our time, just about, and so I want to thank you both for joining us this evening, spending part of your evening with us and our participants. We are, as I mentioned, putting on this webinar series. And so our upcoming webinar is scheduled for Thursday, October 22nd. And our physician experts will be talking about strategies for virtual health or excuse me, virtual behavioral health integration. If you were unable to attend any of our previous webinars, which at this point has only just been one, but which was focused on the importance of shared culture and collaboration and behavioral health integration, we will be sharing a link to the location of the recording and the slides. We can put that in the chat box, and we can also make sure that that's included our follow-up email as well. So once again, I would like to thank everybody for spending part of their evening with us. And we hope that you enjoy the rest of your night. Leslie and Jacob, thank you again. And everybody take care.

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**Disclaimer:** The viewpoints expressed in this video are those of the participants and/or do not necessarily reflect the views and policies of the AMA.

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## About the BHI Collaborative

The American Medical Association along with seven leading medical associations have established the BHI Collaborative, a group dedicated to catalyzing effective and sustainable integration of behavioral and mental health care into physician practices.

With a focus on primary care, the Collaborative is committed to ensuring a professionally satisfying, sustainable physician practice experience and will act as a trusted partner to help them overcome the obstacles that stand in the way of meeting their patients' mental and behavioral health needs.

The medical associations include: the American Medical Association, American Academy of Child & Adolescent Psychiatry, American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, American Osteopathic Association, and the American Psychiatric Association.