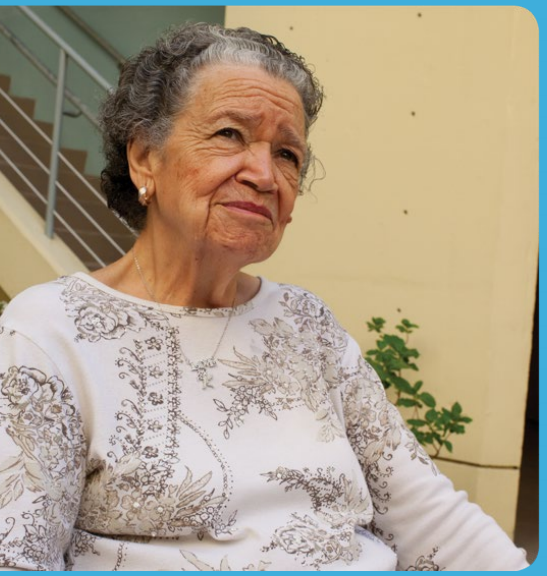

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Behavioral Health Town Hall

Introduction

Topics of discussion

- Assessments
- Value based purchasing
- Documentation
- Crisis intervention
- Discharge planning
- Psychological testing
- Billing, coding, and telehealth guidelines
- Behavioral health HEDIS® measures
- Behavioral health and physical health integration

Assessments

Biopsychosocial assessment vs. trauma assessment

- Assessments are done at intake and as needed during treatment for a member
  - Following the initial intake assessment, the frequency and length of assessments should be determined as clinically indicated by the diagnosed treatment needs of the member
  - Providers should conduct a Mental Health Assessment (H0031) when the purpose of the assessment is to render a provisional diagnosis

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Assessments (cont.)

- Trauma assessments must be completed within 15 days of the child entering or re-entering custody of the Division of Family and Child Services (DFCS)
  - Trauma assessments are appropriate for members who are 5 years of age or older when first brought into DFCS custody
  - Patients 4 years and younger should be given a developmental assessment as part of the EPSDT visit service that is given to all members when first brought into DFCS custody
  - Providers must submit medical records within three business days, bill the TJ modifier along with HCPCS code H0031 and submit the claim within 30 days of rendering the service to meet the criteria for a possible value-based purchasing incentive payment
  - The TJ modifier should be billed in addition to all relevant modifiers

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Trauma assessments are used to guide treatment

- Trauma impacts many aspects of a youth's life and may lead to secondary problems that negatively impact safety, permanency and well-being.
- In 2012, the Division of Family and Children Services (DFCS) implemented trauma-focused screening, assessment and treatment practices for youth entering custody.
- The trauma assessment became a required component of the Comprehensive Child and Family Assessment for all youth between the ages of 5 to 17 who are entering DFCS custody.
- The trauma assessment identifies all forms of traumatic events experienced directly or witnessed by the youth.
- The results of the trauma assessment are then used to identify the best treatment for the youth.
- Individualized care plans are developed with recommendations from the trauma assessment.

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Trauma assessment timelines

- The trauma assessment timelines are based on the Kenny A guidelines. For more information on Kenny A, please go to https://dfcs.georgia.gov/kenny-vs-sonny-perdue-consent-decree
- The trauma assessment must be completed by the provider within 15 days of the child or youth being taken in DFCS custody
- The provider has three business days from the services being rendered to submit the completed trauma assessment to Amerigroup Community Care.
- The completed trauma assessment should be faxed to **1-888-375-5064**.

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Trauma assessments: evidence-based practice

Trauma assessments are to be completed by an Amerigroup behavioral health provider who is equipped to assess and is capable of providing evidence-based treatment recommendations for trauma-related issues if needed.

The trauma assessment should include:

- A complete trauma history
- A Child and Adolescent Needs and Strengths (CANS) Assessment
- Completion and inclusion of results from one of the five identified standardized trauma screening tools:
  - Child Sexual Behavior Inventory
  - Child PTSD Symptom Scale
  - Trauma Symptom Checklist for Children
  - Trauma Symptom Checklist for Young Children
  - UCLA PTSD Index for DSM-V

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Trauma assessment report

The trauma assessment report should include information that will allow DFCS to coordinate services that will meet the child's needs.

The results of these assessment or screening tools will be incorporated into a structured report that will include the following components:

- Demographic data (name, DOB, Amerigroup ID, etc.)
- Presenting history (a summary of the traumatic events that the member has experienced)
- Identification of the specific tool and its value as it relates to assessing trauma in youth
- Summary of the CANS assessment (action items from CANS)
- Summary of the assessment process (presented history, tool used and CANS)
- Recommendations based on the assessment process for ongoing needs for the member (what services would the member benefit from based on the assessment — for example, individual and family therapy, medication management, supportive services, etc.)

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Billing for a completed trauma assessment

Providers should code all **initial intake** trauma assessment examinations for **newly enrolling or re-enrolling** Georgia Families 360°$_{SM}$ foster care members ages 5 and older with the following code and modifiers: H0031 + provider descriptor (U3, U4 etc.) + TJ

- The procedure code and TJ modifier should not be used for the standard behavioral health assessment that is performed on members.
    - Only the actual number of units used to complete the face-to-face assessment should be billed.
- If providers do not submit claims within 30 days of the service date using the correct procedure code (H0031) with the modifier (TJ), then they will not be eligible to participate in the Amerigroup incentive program. Incorrect coding also impedes the accurate reporting of specific clinical services.
- Trauma assessments are to be completed for all youth between the ages of 5 to 17.
- Youth 4 years of age or younger should obtain a developmental evaluation.

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Trauma assessment quality

The Georgia Families 360°$_{SM}$ program completes quality reviews on completed trauma assessments.

Quality assessments are conducted to ensure that our members are receiving appropriate services and to ensure that treatment teams are receiving information that will improve treatment and overall health outcomes.

The quality reviews ensure that providers completing trauma assessments are using approved evidence-based assessment tools and including all the required information in the completed report.

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Value-based purchasing

Eligible participating providers may have the opportunity to earn an enhanced payment of $50 per encounter for each member on a quarterly basis when the following criteria are met:

- Service completed within the established time frame of 15 calendar days for an initial intake trauma assessment performed on any newly enrolling or re-enrolling foster care member
- Required assessment elements identified for the required code(s) must be addressed in the trauma assessment and corresponding medical documentation
- Established claims coding criteria met for billing of trauma assessment services under H0031 with the TJ modifier and appropriate practitioner level modifiers

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Value-based purchasing (cont.)

- Copy of visit records faxed to Amerigroup within three business days after service rendered.
- Members excluded from eligibility for the initial trauma assessment incentive payment are:
  - Members who are in secure placement such as residential youth detention centers or youth detention centers.
  - Members who have been taken into custody but have not had a 72-hour court hearing determination made regarding their case.

Training

Each trauma assessment tool and CANS have specific requirements associated with its usage to support the validity of the measurement process. Each provider must determine what tool and training technique best fits their particular clinical model and methods of practice.

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) sponsors trainings regarding the CANS tools. Details about the training dates/locations and how to register are included in the training announcements at the link below.

Registration is quick and easy online at https://tinyurl.com/yxhzrfxo.

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Training (cont.)

A link to the announcement will be posted on the DBHDD training website at http://dbhdd.georgia.gov/training-0.

Registration questions? Please email DBHDDLearning@dbhdd.ga.gov.

This training is for clinicians or practitioners and will not be sufficient for clinical supervisors.

Additional information regarding CANS can be found at www.praedfoundation.org.

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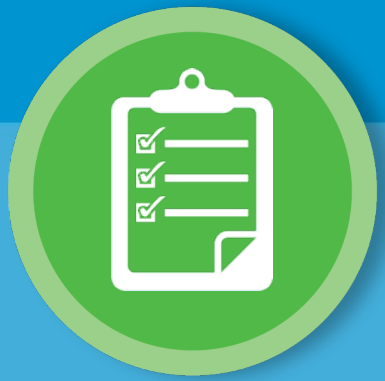
Additional information

The trauma assessment bulletin can be found online at https://providers.amerigroup.com/Public%20Documents/GAGA_CAID_PU_ComprTraumaAssessBltn.pdf.

If you have additional questions or need assistance, please reach out to the Community Outreach and Education team at ga360trng@amerigroup.com.



Documentation

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Prior authorization

- Medical necessity is defined as health care services that a medical practitioner provides to a covered individual for the purposes of preventing, evaluating, diagnosing and treating an illness, injury or disease, or symptoms of an illness, injury or disease.
- **Services rendered by medical practitioners are:**
  - Performed in accordance with generally accepted standards of medical practice
  - Clinically appropriate in terms of type, frequency, extent and duration
  - Considered effective for the member's conditions
  - Not primarily for the convenience of the member, physician or other health care providers
  - Not more costly than alternative services that produce similar or equivalent results for the member's diagnosis or treatment

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Prior authorization (cont.)

- **Generally accepted standards of medical practice:**
  - Accepted standards are based on credible scientific evidence published in peer-reviewed medical literature that are generally recognized by the relevant medical community.
  - These include recommendations by the National Physician Specialty Society and the views of medical practitioners practicing in relevant clinical areas.

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Prior authorization (cont.)

- Services are justified through comprehensive, person-centered, service-related assessments and treatment plans or based on medical necessity
- Reflect interventions (consistent with the level of service) designed to achieve objectives listed in the treatment plan
- The clinical information provided should describe symptoms, behaviors, or skill deficits
- The clinical information should properly quantify behavior, progress, and demonstrate interventions consistent with the level of service being requested

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Treatment planning (cont.)

Treatment plans should be:

- Client-centered.
- Individualized to the specific care needs of each member.
- Driven by the individual.
- Focused on outcomes the individual wishes to achieve.
- Updated as clinically appropriate.

- The treatment plan should be fully explained to the individual using language he or she can understand and to which he or she can agree and execute.
- A treatment plan must be created within 30 days of initiating treatment and following the initial behavioral health assessment.

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Treatment planning (cont.)

- A treatment plan must identify the duration of services and the target dates for reaching each identified objective under each goal in the plan.
- Every session in which a treatment plan is created or updated must have dated signatures from all parties involved, as appropriate.
  - For example: provider, member, family/guardian
- There must be a face-to-face session of treatment plan development that includes the member to be an appropriate service for billing H0032.

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Medical records or progress notes

- Evidence-based interventions referenced in the notes must include documentation regarding how the modality was used to address specific treatment goals.
- Documentation for each intervention must also include why it was appropriate for the member.
- For a group therapy session, the medical records for each member who participated in the session must include individualized progress notes specific to their response to the intervention in that session.
- For a family therapy session, the focus of the intervention should be tied to the treatment plan, and the notes should specify the manner of treatment, whether the session was held with or without the client present.

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Medical records or progress notes (cont.)

- A fully licensed supervisor must sign off on any services rendered by a practitioner at a master's level or lower.
- The procedure code appropriate for the rendered service must be documented in the progress note.
- For all services (for example, assessments, skills-based services, therapy, treatment planning, evaluation and management E&M, etc.), the start and end time of the service must be documented in the progress note.

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Medical records or progress notes (cont.)

Providers must use an industry-recognized format (for example, behavior intervention response plan; data assessment plan; subjective, objective, assessment and plan) for documenting each session.

- **Other supportive documentation should be included in the member's medical record, such as:**
  - Release of information
  - Evidence of coordination of care among the member's providers
  - Previously completed assessments
  - Guardianship documentation
- Each progress note must indicate the specific intervention being addressed in the session, which should also have been identified in the most current treatment plan.

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Medical records or progress notes (cont.)

- Each progress note should contain a legible handwritten or electronic medical record-generated signature, along with a printed version of the:
  - Signing provider name and credentials.
  - Date of signature.
- Changes to previously finalized documents should be done according to industry standards, to include the following next to each change:
  - A strikethrough
  - The person's initials
  - The date

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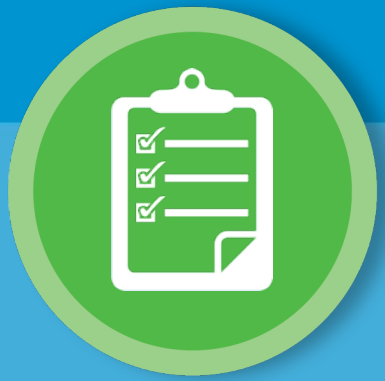

Crisis intervention

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Crisis intervention

- Develop crisis or safety planning at enrollment/admission and then implement and update as necessary throughout treatment.
- The member should be a full participant in the safety planning and all crisis stabilization steps should be clearly identified.
- Providers are required to be available for crisis services 24/7 with a crisis response time of two hours.
- The individual recovery plan (IRP) may indicate that the crisis intervention service is provided as needed.
- If crisis intervention is a part of the services outlined in the IRP, it is expected that a crisis plan be developed and in place to direct the crisis service.

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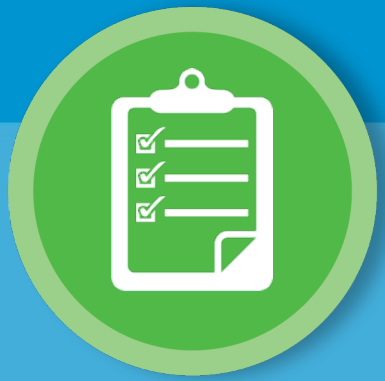

Discharge planning

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Discharge planning

- Planning for the member's discharge from treatment should be discussed as part of the initial treatment plan.
- At the time of discharge, a summary should be shared with the member/guardian to indicate services and treatment provided as well as necessary plans for referral.
- Progress notes should outline how interventions help the member progress toward reaching the goal or outcomes targeted for discharge.

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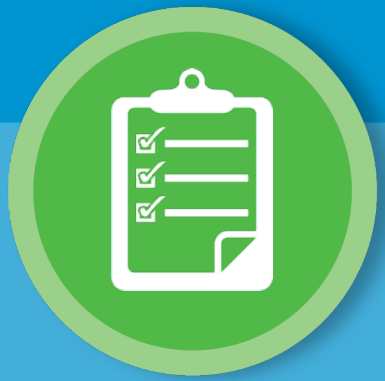

Psychological testing

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Psychological testing

- Licensed clinical providers must request a prior authorization (PA) and receive approval before a psychologist renders psychological testing services.
- Determination of medical necessity and PA for psychological testing is made using InterQual® criteria, effective on January, 2, 2020.
- A peer-to-peer review is available to the provider as part of the PA process.

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Psychological testing (cont.)

- When billing for psychological testing, providers should bill the appropriate code that pertains to the testing component administered for the corresponding time on the date of service. For example:
  - Test evaluation services by a psychologist — 96130, 96131
  - Test administration and scoring by a psychologist — 96136, 96137
  - Test administration and scoring by a technician — 96138, 96139
  - Test administration and scoring via electronic platform — 96146
- Providers should bill the codes and units specific to each date of service over the span of testing, not billing all codes and units on the last date of testing.

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Psychological testing (cont.)

Psychological testing is not considered medically necessary when it is being used:

- For educational or vocational services.
- As part of annual or regular checkups.
- To determine placement or admission to nonmedical programs.
- As part of a nonmedical, court-ordered test.

Psychological testing is not considered medically necessary when:

- Diagnosis, symptoms or behaviors do not suggest the need for testing.
- Testing is being used to evaluate suspected attention deficit and/or hyperactivity disorder.
- Similar testing has been performed in the last 12 months, subject to individual case consideration.

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Psychological testing (cont.)

Examples of applicable uses of psychological testing:

- When a member has been treated for a condition, but has not made improvements and there is a need for additional diagnostic clarification.
- Differentiating between organic and psychogenic conditions.
- Clarifying a diagnosis after the provider has completed a thorough clinical assessment, obtained data from other sources (for example, family, collateral contacts and medical records), and administered questionnaires or rating scales.

Psychological testing (cont.)

Example: In a child with a primary diagnosis of ADHD and disturbances in mood and behavior:

- Learning disorders have been ruled out by testing at school
- Behavior rating scales conducted by provider have mixed or unclear findings
- Child has been treated with various medications and behavioral treatment without improvement
- PCP requests testing to aid in clarifying diagnosis and to shape treatment planning

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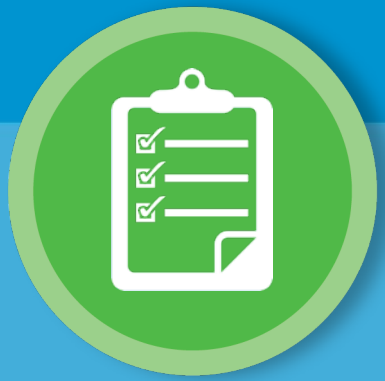

Billing, coding, and telehealth guidelines

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Billing code reminders

Individual practitioners

- Providers should only bill for services they have directly rendered, and may not bill for any services rendered by another provider or by an unlicensed individual under their supervision
- Coding and billing of each service rendered should be done in conjunction with the appropriate modifier specific to provider licensure:

  - **M.D.: no modifier**
  - **NP and APRN: SA**
  - **Ph.D. and Psy.D.: HP**
  - **LCSW, LMFT and LPC: HO**

Billing code reminders (cont.)

Community providers (CORE, IFI, CSB)

- Providers must use the appropriate POS code applicable to the location of the service rendered
  - POS 99 is only to be used in instances where there is no other appropriate code that applies to the rendering location.
  - Coding and billing of each service rendered should be done in conjunction with the appropriate practitioner level modifier specific to the provider's level of licensure
  - E&M services should only be billed by providers who hold a medical licensure (e.g., M.D., N.P., P.A., APRN), and can only be billed for sessions that are medically focused; nonmedical sessions provided by a lower level provider should not be billed as an E&M service
  - POS 53 should not be used by community providers as this is a facility place of service code specific to Community Mental Health Centers

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Telehealth

Originating site

- An **originating site** is the **location of the eligible Medicaid member** at the time the service is delivered via a ***HIPAA-compliant*** telecommunications system.
  - Originating sites are paid an originating site facility fee for telehealth services as described by HCPCS® code Q3014.

Distant site

- A **distant site** is the site where **the physician or practitioner providing the professional service is located** at the time the service is delivered via a telecommunications system.
  - Telemedicine services provided by the **distant site** provider must be billed with the appropriate CPT® and/or HCPCS® codes, GT modifier, and with the point of service (POS) code 02 to indicate telehealth services.

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Telehealth

- Providers must use an interactive audio and video telecommunications system that permits real time communication between the provider, at the distant site, and the member, at the originating site.
- All interactive video telecommunications must comply with HIPAA patient privacy regulations at the site where the member is located, the site where the consulting provider is located and in the transmission process.
- Use of the GT modifier indicates real-time telehealth services are provided by audio and video systems, not by telephone unless the code description or regulatory guidelines support the service can be provided by phone.

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Common billing practices

- Family therapy is billable once per member per day
  - 90846 and 90847 are not separately reimbursable for the same member on the same date of service.
- Interactive complexity should be used appropriately according to standard guidelines
  - Billed only in conjunction with appropriate psychiatric services.
  - Used only with respect to difficulties experienced rendering services — not time.
  - Documented in the medical record specifying the difficulties that led to the utilization of the code.
  - Interactive complexity is not to be used in conjunction with all psychiatric services.

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Common billing practices

- Psychotherapy add-on with E&M
  - The psychotherapy add-on codes with E&M are:
    - 90833 — 30 minutes.
    - 90836 — 45 minutes.
  - These add-on codes are to be used to bill for distinct psychotherapy services provided by a medical provider (MD) in conjunction with an E&M visit.
  - Providers must document a distinct start and stop time for the psychotherapy service.
  - The time billed for the psychotherapy service does not include the time spent providing the E&M service.

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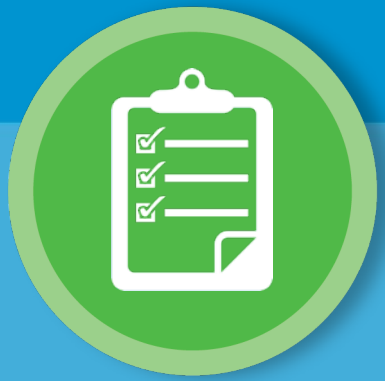

Behavioral health HEDIS measures

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Behavioral health HEDIS measures — follow-up care

- Follow-up after hospitalization for mental illness (FUH)
  - Seven days
  - 30 days
- Follow-up after emergency department (ED) visit for Mental Illness (FUM)
  - Seven days
  - 30 days
- Follow-up after emergency department (ED) visit for Alcohol and Other Drug Abuse/Dependence (FUA)
  - Seven days
  - 30 days
- Follow-up care for children prescribed ADHD medication (ADD)
  - Initiation
  - Continuation and maintenance
- Antidepressant Medication Management (AMM)
  - Acute Phase
  - Continuation Phase

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Behavioral health HEDIS measures — monitoring and screening

- Use of first-line psychosocial care for children and adolescents on antipsychotics (APP)
- Diabetes screening for people with schizophrenia or bipolar disorder who use antipsychotic medications (SSD)
- Adherence to antipsychotic medications for individuals with schizophrenia (SAA)

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Follow-up after hospitalization for mental illness

- Members 6 years and older who were discharged from an hospitalization of mental illness or intentional self-harm (FUH)
- Follow-up must occur within seven days of discharge and no later than 30 days after discharge.
- Members must have a follow-up visit with a mental health practitioner.

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Follow-up after emergency department visit for mental illness and alcohol or drug use or dependence

- Members ages 6 years or older with an ED visit with a principal diagnosis of mental illness or intentional self-harm (FUM)
- Members ages 13 years or older with an ED visit with a principal diagnosis of alcohol and other drug use or dependence (FUA)
- Members must receive a follow-up visit within seven days of the ED visit and within 30 days of the ED visit
- The follow-up visit may be an outpatient visit, an intensive outpatient encounter, or a partial hospitalization

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Follow-up care for children prescribed ADHD medication

- Children ages 6 to 12 years newly prescribed ADHD medication (ADD)
- Members must have three follow-up visits within the 10 month period. Two phases:
  - Initiation phase — initial follow-up visit must occur within 30 days of ADHD medication dispense date
  - Continuation and maintenance phase — at least two additional follow-up visits within nine months following initiation phase

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Antidepressant medication management

- Members aged 18 and older who had a diagnosis of major depression and remained on antidepressant medication treatment
- Members who were treated with antidepressant medications and remained on the medication for at least (two phases):
  - Acute phase — 84 days (12 weeks)
  - Continuation phase — 180 days (six months)

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Use of first-line psychosocial care for children and adolescents on antipsychotics

- Members age 1 to 17 years who had a new prescription for an antipsychotic medication
- Member must have documentation of psychosocial care as a first-line treatment
- Psychosocial care, which may include behavioral interventions, psychological therapies, and skills training, among other services, is the recommended first-line treatment option for children and adolescents diagnosed with nonpsychotic conditions such as attention-deficit disorder and disruptive behaviors
- Measurement period is 90 days prior to dispense of new prescription through 30 days after

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Diabetes screening for members with schizophrenia or bipolar disorder who use antipsychotic medications

- Members age 18 to 64 years, newly diagnosed with schizophrenia, schizoaffective disorder, or bipolar disorder who were dispensed an antipsychotic medication (SSD)
- A glucose test of hemoglobin A1c (HbA1c) test must be performed during the measurement year
- If the screening indicates the member is diabetic, the member should be monitored for diabetes.
- Members already diagnosed with schizophrenia and diabetes are excluded and fall into the monitoring measure on the next slide.

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Diabetes monitoring for people with diabetes and schizophrenia

- Members age 18 to 64 previously diagnosed with schizophrenia or schizoaffective disorder, and diabetes
- Members should have:
  - An HbA1c test at least once a year
  - An LDL-C test at least once a year

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Monitoring of cardiovascular disease in members with schizophrenia

- Members 18 to 64 years with schizophrenia or schizoaffective disorder and cardiovascular disease.
- Members must have an LDL-C test during the measurement year.

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Adherence to antipsychotic medications for individuals with schizophrenia

- Members 18 to 64 years of age with a diagnosis of schizophrenia or schizoaffective disorder who were dispensed and antipsychotic medication. (SAA)
- Members must continue and remain on the medication for 80% of the treatment period (dispense date through end of the measurement year).

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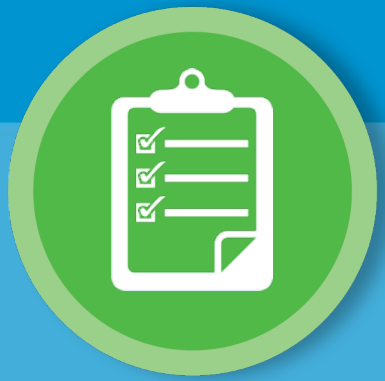

Behavioral health and physical health integration

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Provider responsibilities

- Identification of high-risk or high-need members for referral
- Communication of inappropriate ER usage
- Communication of hospital discharge upon notification
- Documentation and sharing of care coordination documents
- Communication of barriers and roadblocks between providers to ensure efficient and effective care coordination

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Co-management

- Establishing treatment responsibilities for each provider
- Medication management collaboration and communication
  - Consults
  - EMR sharing
- Referrals to each other and to outside providers
- Sharing of crisis and safety plans
- Identification and addressing of care gaps
  - Diabetes management
  - High blood pressure
  - Dental
  - Pediatric and adolescent wellness

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Provider communication

- Items that will be communicated between the providers
  - Intake and assessment integrated summary
  - Life transition
  - Crisis
  - Medication
- Methods of communication
  - Care coordination forms
  - EMR interface
  - Dedication referral coordinators
- Frequency of communication
- Response time

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Member communication

- Clarification of the roles each provider will play in their care
- Appointment scheduling assistance
- Relevant test results
- Self-management skills
- Member consent

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Questions?

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