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## THE COLLABORATIVE MODELS OF MENTAL HEALTH CARE FOR OLDER IOWANS

### MODEL ADMINISTRATION





There are four distinct clinical skills required to successfully administer the collaborative care model.

The first is a capacity to conduct the clinical evaluation effectively; primary care staff must be able to implement the screening tool, conduct a mental status interview, and provide supportive counseling that facilitates a successful patient referral.

The second skill involves the ability to conduct a thorough psychiatric assessment consisting of four psychiatric tests and one health status survey, a diagnostic interview, and developing a treatment plan in coordination with the patient.

The third skill necessitates an understanding of pharmaceutical therapies targeting older persons with mental illnesses. These include anti-depressants and other medications appropriate for the treatment of anxiety, dementia, and substance abuse. This skill also requires ability to consider co-occurring effects of other prescription medications being used to treat other diagnoses.

The fourth skill requires an ability to perform brief, problem focused psychotherapy tailored for depression and other diagnoses. The therapy also must entail an evaluation of the patient's progress within a six month or ten session time frame.

A collaborative model of care requires between two and four dedicated staff members.

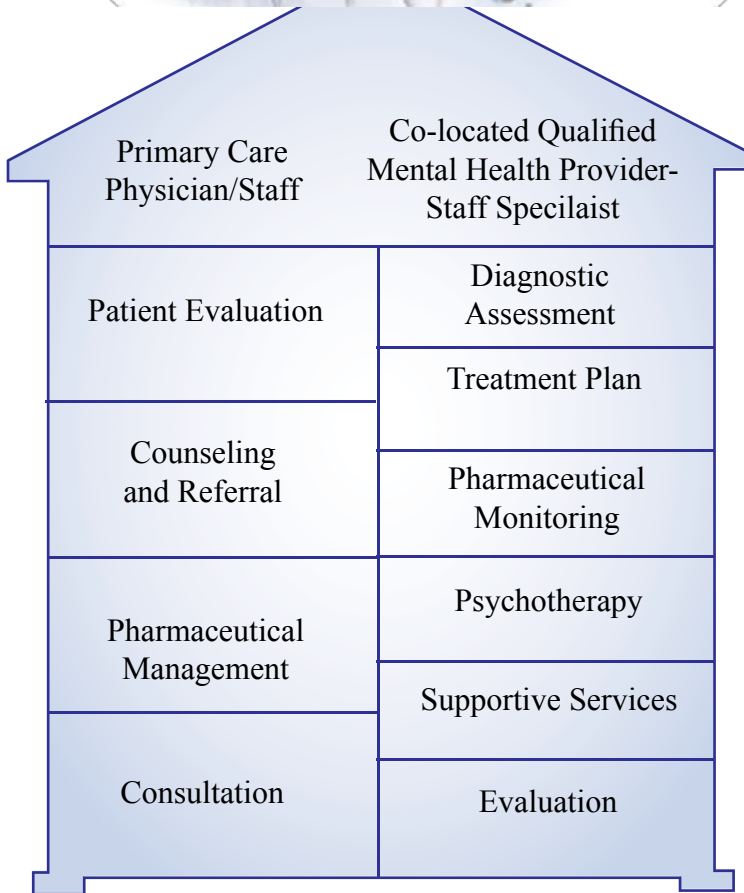
A qualified Medicare physician and mental health specialist should perform or directly supervise these four clinical procedures. In some collaborative models, the primary care physician conducts screening, counseling and referral and medication management and leaves the diagnostic assessment, treatment plan development and provision of problem solving therapy to a qualified mental health provider or a supervised and appropriately trained staff member. In other models, the physician or qualified mental health provider directly supervise staff who perform these procedures.

When a mental health provider works under contract with the primary care office and performs assessment, PST and other clinical procedures on site, these are called "carve-in" or "co-location" models. When a qualified mental health provider and his or her staff work independently and provide services outside of the primary care office, these are called "carve-out" or "referral" models.

## Staffing Model #1 Carve-in (Co-location)

Because each primary care office is a unique environment, we have illustrated two general staffing models that could be used to administer a collaborative model.

### Model 1: Carve In (Co-location)



**Primary Care Office**



**Specialty Mental Health Clinic**

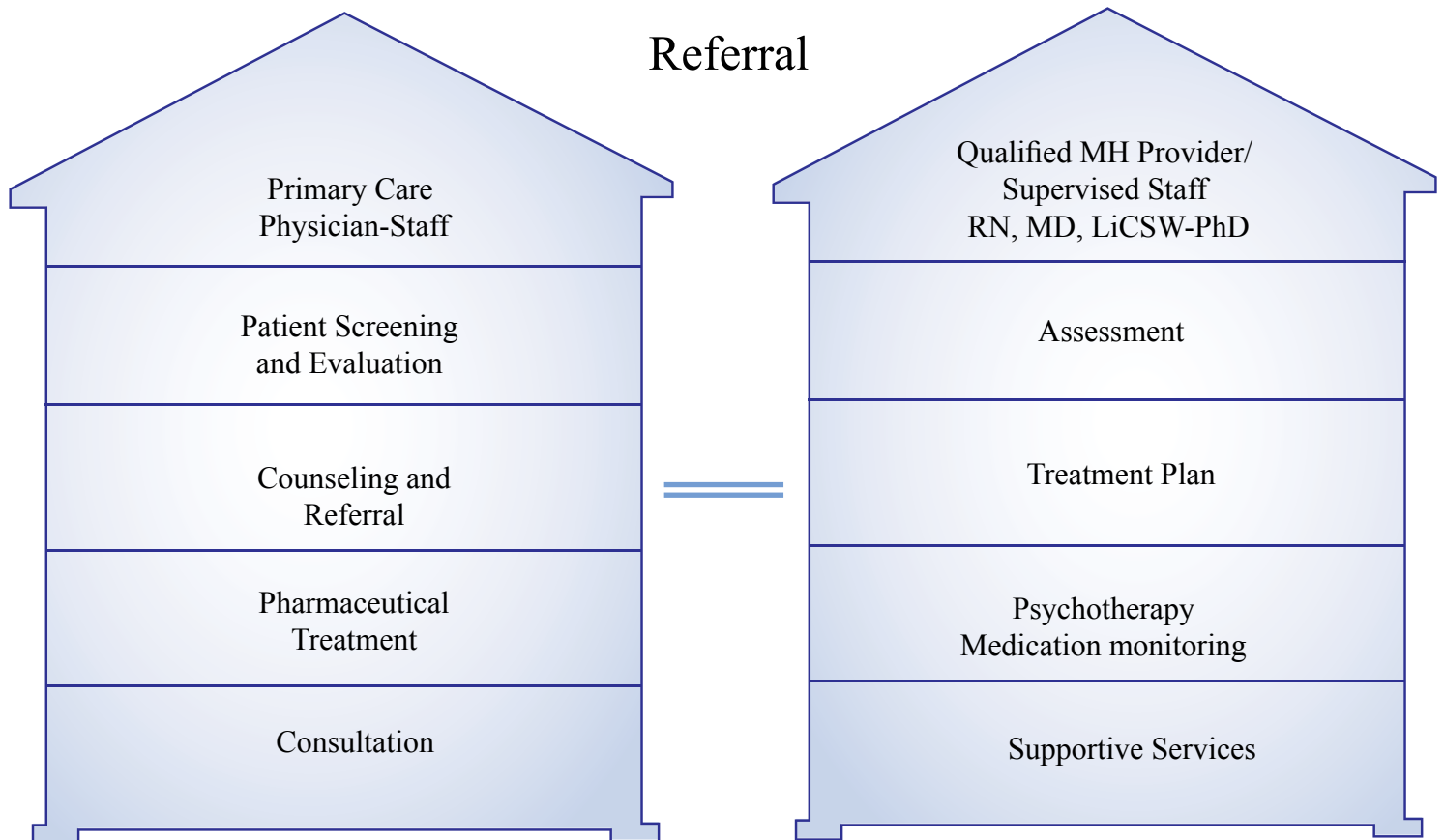




Model 2: Carve Out (Referral)



Referral



Primary Care Office

Specialty Mental Health Clinic

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The collaborative models can be supported financially by submitting claims for the clinical procedures performed. In this section, we align the clinical procedures of the collaborative model with CPT codes and practitioners that are qualified to perform those services. While Medicare is the primary payer for the majority of older persons who present in primary care clinics and engage in treatment, we will also outline the billing process for dual eligibles and waiver clients as well. The table on the following page depicts the steps in the collaborative model with respect to the billing process—in terms of provider involvement, treatment location, and the proper documentation of services rendered via CPT codes. The table on the next page is followed by a detailed explanation of the entire process.



## Clinical Procedures and Corresponding Billing Codes



Steps	Qualified Providers*	Treatment Location	CPT Code
1. Screening for mental health problem  Counseling and referral	-Primary Care Provider -Mental Health Specialist -Supervised staff	- Primary Care Office	- 99202, 99203, 99204 - 99212, 99213, 99214
2. Diagnostic Assessment	- Qualified Mental Health Specialist  - Supervised staff	- Primary Care Office/ Mental Health Provider  OR  - Home-based	- 90801 - 96150, 96151
3. Psychotherapeutic Treatment	- Qualified Mental Health Specialist  - Supervised staff	- Primary Care Office/ Mental Health Provider  OR  - Home-based	- 90804, 90805 - 90806, 90807 - 90808, 90809 - 90899 - 96152, 96153, 96154, 96155
4. Pharmacy Evaluation	-Primary Care Provider -Supervised Staff -Qualified Mental Health Specialist	- Primary Care Office/ Mental Health Provider  OR  - Home-based	- 90862 - M0064

\*For description of qualified providers and staff in the collaborative model, please see the section entitled 'Qualified Providers'

§ Home-based CPT codes reserved for physician and psychiatrist only

β Home-based CPT codes for qualified non-physicians

### **Clinical Procedures**

#### **Step One: Evaluation and Management**

##### *Screening for Mental Health Problems:*

Screening for mental health problems should be conducted during the initial office visit to the primary care physician. While the screening procedure is performed during the primary care visit, the state of Iowa does not require that the screen is conducted by the physician. Any staff member of the primary care physician's office can conduct the standardized screen for mental health problems. While the physician does not need to be present during the screening, the office visit should be coded to reflect the intensity of the primary care physician's effort and not the total time the patient was seen by other staff members.

##### *Counseling and Referral:*

Counseling and Referral should be performed by the primary care physician if the patient screens positively for mental health problems. This is the initial step in creating a treatment plan, and in order to bill incident to the physician's services in future visits, this step necessitates that the primary care physician interprets the results of the screening tool and refers the patient to the appropriate service.

#### **Step Two: Diagnostic Assessment**

According to the law in the state of Iowa, diagnostic assessment must be completed by a person who meets the criteria of a mental health professional as defined at the beginning of this section. Diagnostic assessment can also be completed by an individual with a master's degree who is license-eligible or an intern in a master's or doctorate program as long as they are supervised by a mental health professional. In order to bill incident to the physician's services, the individual diagnosing the patient must be a doctorate level clinical psychologist, master's or doctorate level LCSW, nurse practitioner, or a clinical nurse specialists. A physician assistant that qualifies as a mental health professional is able to conduct a psychiatric diagnosis (90801), but must bill under their own UPIN number.





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## Step Three: Psychotherapeutic Treatment

Outpatient psychotherapy and counseling services must be performed by a mental health professional, as defined in the previous section, or by an individual with a master's degree in a mental health field who is directly supervised by a mental health professional. With regard to billing incident to a physician's services, the following practitioners can bill the corresponding CPT codes (which will be expanded upon in the next section) incident to a physician's services:

Doctorate level psychologists: 90804, 90806, 90908, 90899

Doctorate of Masters Level Social Workers: 90804, 90806, 90808, 90899

Nurse Practitioners: 90804, 90806, 90808, 90899 (90805, 90807, 90809 can be billed incident to if the NP has prescribing privileges)

Clinical Nurse Specialist: 90804, 90806, 90808, 90899 (90805, 90807, 90809 can be billed incident to if the CNS has prescribing privileges)

Physician's Assistant: 90804, 90806, 90808, 90899 (90805, 90807, 90809 can be billed incident to if the PA has prescribing privileges)

Note that psychologists and LCSW are able to conduct psychotherapeutic treatment, but cannot bill for services relating to medication evaluation and management. Likewise, other non-physician providers cannot bill for medication services if they do not have the ability to write prescriptions.

## Step Four: Pharmacy Evaluation

Pharmacy evaluation (90862, M0064) can only be performed by a physician, and should be performed by the prescribing physician or the physician supervising the prescriptions written by their PA, NP, or CNS. The specific CPT codes, and the distinction between the two, will be discussed in the next section.

### **Step One: Evaluation and Management**

#### *Screening for Mental Health Problems:*

When conducting an initial evaluation, primary care providers should use Current Procedural Terminology (CPT) Evaluation and Management codes. These codes are numbered as 99201 – 99204 (for new patients) and 99211 – 99215 (for established patients). The increasing numbers reflect the intensity and complexity of the evaluation such that 99201 or 99211 are brief evaluations lasting approximately 10 minutes while 99205 and 99215 are for intensive evaluations which last approximately 60 to 40 minutes respectively. More specifically, there are three principal components used to determine which code should be used for billing an evaluation and management session: historical information, system evaluation, and complexity of the decision making that occurs. Further information about these codes can be found in the American Medical Association CPT Manual.

The collaborative model requires the primary care staff to complete a diagnostic screen and a mental status examination as part of the evaluation. When such procedures (psychiatric system evaluation and historical information collection) are documented, CPT codes that can be submitted include 99202 – 99204, and 99212 – 99214. As previously mentioned, the CPT codes 99201 and 99211 are reserved for brief evaluations while CPT Codes 99205 and 99215 are typically reserved for intensive evaluation pertaining to a specific problem. These codes are not likely to be applicable to the diagnostic assessment phase of the model as 99201 and 99211 are too short a time span to complete the assessment, and 99205 and 99215 pertain to a specific problem. The CPT manual indicates that when psychiatric system evaluation and historical information are collected in addition to other information, then CPT codes 99204 and 99214 are applicable. However, the primary care office should determine the level of billing based on historical precedent. For example, if the office routinely bills evaluation and management services using the 99202 or the 99212 codes, then the addition of psychiatric systems evaluation and historical information may constitute only a single step up in resource use, and should then be billed as 99203 or 99213.

#### *Counseling and Referral:*

The collaborative care model requires brief counseling and referral for those individuals who may be experiencing a mental health problem. Since this is considered part of the evaluation and management session, there is no separate claim to file.





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## Step Two: Diagnostic Assessment

The CPT code 90801 should be used when submitting a claim pertaining to the initial psychiatric assessment. The psychiatric system evaluation (i.e., four tests) and collection of historical information (i.e., health screen and diagnostic interview schedule) should be documented when filing the claim. The 90801 assessment should be supported by the initial primary care evaluation and can occur with or without an established psychiatric diagnosis. Note there are two other CPT codes 96101 (testing) and 90889 (report preparation) that appear to pertain to initial assessment. However, 96101 is generally reserved for a comprehensive neuropsychological evaluation while creation of a treatment plan is considered to be a part of the initial assessment (i.e. 90801). If treatment is being directed towards a health or behavioral problem with a mental health component, then Health and Behavior assessment claim (96150) can be filed. It should be noted that the Health and Behavior assessment codes (96150-96155) cannot be billed on the same date as other psychiatric services (90801-90899). Medicare pays 80% of the allowable charge for an initial psychiatric evaluation. For all other outpatient psychiatric services provided to persons with a psychiatric diagnosis, Medicare pays 62.5% of the allowable charge. CPT code 90801 can only be used once during the initial visit, but can be used again if the patient experiences a new episode of mental illness (i.e. new diagnosis) or if the patient is admitted to an inpatient facility due to complications from their underlying mental health condition. If, after completing the diagnostic assessment, the mental health professional concludes that no mental illness is present, the visit should not be coded as 90801. Instead be coded under the ICD-9 code V71.09 (Observation for suspected mental condition – Other suspected mental condition).

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## Step Three: Psychotherapeutic Treatment

Regardless of where the treatment phase takes place, the treatment plan should consist of pharmaceutical therapy and/or psychotherapy, and should be approved in consultation with the primary care provider, the mental health specialist, and the patient. Many supportive services are offered at minimal or no charge, especially to Medicaid waiver participants. An older client can also purchase these services separately. Medicare covers a minimal amount of medically necessary supportive services.

### *Outpatient:*

The non-pharmaceutical aspect of an individual's treatment should be defined and monitored by the qualified mental health specialist (or staff). This would involve conducting regularly scheduled therapeutic sessions, conducting treatment outcomes evaluation and determining continued course of treatment. Psychiatric care can be billed by using CPT codes 90804 (30 minutes), 90806 (50 minutes), or 90808 (75 minutes). When the psychotherapy sessions include evaluation and management of psychiatric medications, the complementary CPT codes 90805, 90807, and 90809 can be used. Note that the CPT code 90862 (pharmacologic management) cannot be used on the same day as 90805, 90807, and 90809. If the session lasts longer than 90 minutes, providers should use 90899 (unlisted psychiatric service) and document the service provided in Item 19 of the CMS 1500. When treatment is tailored to a health or behavioral problem and there is no primary psychiatric diagnosis, then Health and Behavior treatment codes 96152 or 96154 can be submitted. The complete list of ICD-9 codes that are accepted for psychotherapeutic treatment services provided under these CPT codes is attached in the appendix. Note that dementia (ICD-9-CM codes 290.0, 290.20-290.9, 331.0-331.2) is not covered under these CPT codes.





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## Step Four: Pharmacy Evaluation

### *Outpatient:*

The management of psychiatric medication can be billed on its own as 90862 or M0064; pharmacologic management. This includes pharmacologic management of prescription drugs with minimal medical psychotherapy. Again, when there is a combination of psychotherapy sessions and evaluation and management of psychiatric medications, the CPT codes 90805, 90807, and 90809 should be used. When a mental health diagnosis is not present and the Health and Behavioral Codes (96150-96155) are being used, Medicare will not reimburse for any of the 90801-90899 series on that date—including 90862; pharmacologic management. M0064 should be used instead of 90862 if the sole purpose of the office visit is for monitoring or changing drug prescriptions and the visit is brief. Examples of such a visit would be to re-order drugs with or without lab orders, or a simple dosage adjustment of a long-term medication. 90862 refers to an assessment and management of psychopharmacological agents. This assessment includes prescribing medication, monitoring the effect of medication, and side effects as well as adjustments to the dosage.





### **Medicare:**

Medicare beneficiaries who present in primary care clinics should have their claims billed to Medicare as the primary payer, leaving their Medi-Gap plans, Medicaid, or the individual patient as the co-payer. In cases where services are provided to individuals qualified for the Medicaid Elderly waiver program, or if services are rendered in a Federally Qualified Health Center (FQHC), service claims will be billed and reimbursed differently, though the same CPT coding mechanisms will need to be documented.

### **Medicaid:**

Medicaid beneficiaries that are ineligible for Medicare who present in a primary care clinic should have their claims billed to Medicaid as the primary payer, leaving counties (if applicable) or the individual patient as the co-payer. Again, in cases where services are provided to individuals qualified for the Medicaid Elderly waiver program, or if services are rendered in a FQHC, service claims will be billed and reimbursed differently, though the same CPT coding mechanisms will need to be documented.

### **Waiver:**

The Medicaid Elderly Waiver was purposefully designed for older adults to receive care within their own home. Eligibility for the waiver program extends beyond the minimum requirements for Medicaid, but the services provided must meet the definition of 'mental health outreach.' The home-based services provided in the proceeding chapters meet this definition and claims should be billed using those home-based codes.

### **Federally Qualified Health Center:**

If the patient presenting at an FQHC is a Medicaid enrollee, the center is reimbursed for its services based on 100 percent of the reasonable costs which are determined by Iowa Medicaid based on the FQHC Cost Report Form. The FQHC Cost Report Form cannot exceed the reasonable costs as determined by the applicable Medicare cost reimbursement principals. Until the FQHC submits the Cost Report Form, Medicaid will make interim payments that are based on a budgeted or projected average cost per visit. At the end of the year, Iowa Medicaid will make additional payments to the center if the reported annual Medicaid costs exceed the sum of the interim payments.

## KEY POINTS OF CLARIFICATION

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### **'Incident To' Billing:**

Understanding how to properly bill incident to a physician's service is a key component when implementing a collaborative mental healthcare model. Under Medicare and Medicaid rules, a nonphysician is allowed to bill for services incident to a physician's service. Incident to billing is paid at 100% of the physician fee schedule while qualified, nonphysician practitioners submitting claims under their own billing numbers are paid at 85% of the physician fee schedule. There are, however, requirements when billing incident to a physician's service that should be followed to obtain 100% of the payment in the physician fee schedule from Medicare.

### **Qualified Practitioners able to bill incident to a physician's service:**

- Physician Assistants (PAs)
- Nurse Practitioners (NPs)
- Clinical Nurse Specialists (CNSs)
- Clinical Psychologists (CPs)
- Licensed Clinical Social Workers (LCSWs)

While these nonphysician practitioners are able to bill incident to the physician's services under Medicare rules, the State of Iowa has additional requirements as to the extent that each of these practitioners can provide services within the collaborative model. Those additional requirements, as well as the services each of the above practitioners can provide under the model, will be discussed in the section entitled 'Qualified Providers'.

### **'Incident To' Billing Criteria:**

- 1) The patient must be an established patient and cannot be a new patient.** This means that an established office visit (CPT codes 99212-99214) must be billed for in order for a qualified nonphysician practitioner to bill incident to the physician's services.
- 2) The physician must have seen the patient first and initiated the plan of care before any nonphysician can bill incident to the physician's services.** This requirement aligns very well with the collaborative model as the primary care physician is the patient's first contact. The patient is then screened and then referred to the proper mental health specialist.
- 3) Services provided and billed 'incident to' must be for office or home services and must be part of the physician's documented treatment plan.** Incident to billing does not apply to hospital inpatient, hospital outpatient, or Skilled Nursing Facility (SNF) services.





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- 4) **The physician must be present on site, either in the office suite or in the patient's home.** Supervision necessitates that the physician is available to provide immediate assistance and direction while the qualified practitioner is performing services. For home health visits, the physician should perform services, or the qualified mental health practitioner should bill using their own Medicare UPIN number.
  - 5) **The physician must remain actively involved in the patient's care and must periodically see the patient for the ongoing disease or illness.** Medicare does not specify how often the physician must check up on the patient, but the collaboration between the mental health specialist and the primary care physician should satisfy this requirement to bill incident to the physician's services. Also, it is recommended that the physician review the qualified mental health practitioner's chart notes in order to monitor treatment progress.
  - 6) **A qualified practitioner cannot bill incident to the physician's services for a new illness or problem that the physician has not previously seen the patient for.** There must be an established treatment plan that is followed by the qualified mental health practitioner. Any deviation from the treatment plan requires patient contact with the physician.
  - 7) **When billing incident to a physician's services, the billing number used must be the supervising physician's UPIN number.** A common mistake when billing 'incident to' is using the UPIN number of the physician who first saw the patient. Medicare requires documentation of the supervising physician via their UPIN number to ensure that there is someone in the office suite that is available to assist the nonphysician practitioner should the need arise.
  - 8) **The qualified practitioner must be acting under the supervision of a physician and must be an employee, leased employee, or independent contractor of the physician, or of the legal entity that employs or contracts with the physician.** The supervision requirements are mentioned above and require that the physician is in the same office suite. Also, the requirements pertaining to employment of a qualified practitioner are fairly wide and conducive for 'incident to' billing in the collaborative model.

## Qualified Providers

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In addition to the Medicare requirements regarding billing incident to physician's services, the State of Iowa requires that nonphysicians meet a minimum standard of training in order to provide certain mental health services. In this section, we identify those individuals that are able to perform the various steps within the collaborative mental healthcare model.

### Definitions of Providers:

- *Mental Health Professional*
  - Must hold at least a master's degree in a mental health field, including but not limited to, psychology, counseling and guidance, psychiatric nursing and social work; or is a doctor of medicine or osteopathic medicine; AND
  - Must hold a current Iowa License when required by the Iowa professional licensure laws (e.g. psychiatrist, psychologist, mental health counselor, ARNP, LCSW, etc.); AND
  - Has at least two years of post-degree experience supervised by a mental health professional in assessing mental health problems, mental illness, service needs, and in providing mental health services.
  
- *Staff*
  - Any individual paid by a healthcare organization to perform duties and responsibilities as defined in the organization's policies and procedures.
  
- *Physician Assistants (PAs)*
  - Must be a physician assistant who is licensed to practice by the Iowa Bureau of Professional Licensure.
  - Must have graduated from a physician assistant education program accredited by the Commission on Accreditation of Allied Health Education programs OR must have passed the national certification examination administered by the National Commission on Certification of Physician Assistants.
  
- *Nurse Practitioners (NPs)*
  - Must be a registered professional nurse who is authorized to practice as a nurse practitioner delivering mental health services pursuant to Iowa Board of Nursing Rules.
  - Must fulfill ONE of the following criteria:
    - Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners; OR
    - A registered professional nurse who is authorized to practice as a nurse practitioner by Iowa law in which the services are furnished, and has been granted a Medicare billing number as a nurse practitioner by December 31, 2000; OR
    - A nurse practitioner who meets the above standards and applies for a Medicare billing number for the first time on or after January 1, 2001; OR





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-A nurse practitioner who meets the above standards and applies for a Medicare billing number for the first time on or after January 1, 2003, and possesses a master's degree in nursing.

- *Clinical Nurse Specialists (CNSs)*

- Must be a registered nurse who is currently licensed to practice in Iowa and is authorized to performed the services of a clinical nurse specialist in accordance with Iowa Law.

- Must have a master's degree in a defined clinical area of nursing from an accredited educational institution.

- Must be certified as a clinical nurse specialist by the American Nurses Credentialing Center.

- *Clinical Psychologists (CPs)*

- Must hold a doctoral degree in psychology

- Must be licensed or eligible for licensure to practice psychology in the state of Iowa or who is certified by the Iowa Department of Education as a school psychologist, or who meets the requirements for eligibility for a license to practice psychology in the State of Iowa as defined in Iowa Code chapter 154B.

- *Licensed Clinical Social Workers (LCSWs)*

- Must possess a master's or doctoral degree in social work

- After completion of degree, the LCSW must have performed at least two years of supervised clinical social work.

- Must be licensed or certified as a clinical social worker by the State of Iowa Bureau of Professional Licensure.