Collaborative Care Model for Integrating Mental Health & SUD Treatment

Steve Daviss MD DFAPA
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@HITshrink
### Disclosures

<table>
<thead>
<tr>
<th>Commercial Interest</th>
<th>Nature of Relevant Financial Relationship (Include all those that apply)</th>
<th>What was received</th>
<th>For What Role?</th>
</tr>
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<tbody>
<tr>
<td>Example: Company ‘X’</td>
<td>Honorarium</td>
<td></td>
<td>Speaker</td>
</tr>
<tr>
<td>Fuse Health Strategies LLC</td>
<td>Ownership</td>
<td></td>
<td>Founding President &amp; Managing Member</td>
</tr>
<tr>
<td>Mindoula Health LLC</td>
<td>Consulting fees</td>
<td></td>
<td>Consultant</td>
</tr>
<tr>
<td>Kenneth Greene MD</td>
<td>Honorarium</td>
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<td>Speaker</td>
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Learning Objectives

1. Explain the Structure of Collaborative Care Services for Mental Health and Substance Use Disorders
2. Learn about the Evidence Base for Collaborative Care
3. List the CPT Codes for Collaborative Care
4. Identify Two Case Examples

- What is collaborative care?
- Evidence base for collaborative care
- Why do it?
- How to structure it
- How to get paid for it
What is collaborative care?

“A model of behavioral health integration that enhances ‘usual’ primary care by adding two key services: care management support for patients receiving behavioral health treatment; and regular psychiatric inter-specialty consultation to the primary care team, particularly regarding patients whose conditions are not improving.”

Source: SAMHSA/CMS [5]
5 Principles of Effective Collaborative Care

01 Patient-centered team care
- Team works and communicates together
- Shared care plan

02 Population-based care
- Proactively tracks all patients
- Use of a patient REGISTRY
- No one falls through the cracks

03 Measurement-based treatment to target
- Systematic use of clinical outcome measures (e.g., PHQ9, GAD7)
- Set target goals (e.g., PHQ9 <5)

04 Evidence-based care
- Use of evidence-based psychosocial and medication treatments (e.g., motivational interviewing, MAT)

05 Accountable care
- Team and organization responsible for individual patients AND populations
- Ongoing quality improvement

Source: Ratzliff [1]
## 2019 Medicare CPT Payment Summary

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
<th>Minimum Time/Month</th>
<th>$ per Month</th>
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<tbody>
<tr>
<td>99492</td>
<td>Initial psych care mgmt</td>
<td>70 minutes</td>
<td>$162</td>
</tr>
<tr>
<td>99493</td>
<td>Subsequent psych care mgmt</td>
<td>60 minutes</td>
<td>$129</td>
</tr>
<tr>
<td>99494</td>
<td>Additional psych care mgmt</td>
<td>30 minutes (max=2)</td>
<td>$67</td>
</tr>
<tr>
<td>99484</td>
<td>General BHI care mgmt</td>
<td>20 minutes</td>
<td>$49</td>
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</table>

- Actual payment rates may vary
- Time spent refers to BHCM time
- BHI code does not require BHCM or psychiatrist consultant

Source: CMS [6]
## Practice Example

<table>
<thead>
<tr>
<th>REVENUE</th>
<th>99492</th>
<th>99493</th>
<th>99494</th>
<th>Total</th>
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<tbody>
<tr>
<td></td>
<td>80</td>
<td>13 @$162</td>
<td>80 @$129</td>
<td>46 @$67</td>
</tr>
<tr>
<td>Total:</td>
<td>$2106</td>
<td>$10320</td>
<td>$3082</td>
<td>$15,508/mo</td>
</tr>
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</table>

* assumes average 6-month duration and average ⅓ of population requires a 99494 and half of those require two 99494’s.

<table>
<thead>
<tr>
<th>EXPENSES</th>
<th>99492</th>
<th>99493</th>
<th>99494</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>BHCM @$40/hr</td>
<td>15hr</td>
<td>80hr</td>
<td>23hr</td>
<td>118hr = $4720/mo</td>
</tr>
<tr>
<td>Psychiatrist @$250/hr</td>
<td>~3hr/wk</td>
<td></td>
<td></td>
<td>12hr = $3000/mo</td>
</tr>
<tr>
<td>Total:</td>
<td></td>
<td></td>
<td></td>
<td>$7,720/mo</td>
</tr>
</tbody>
</table>

* hourly rates are approximations.
Care Team Members

**Patient** – The patient is the most important member of the care team

**Treating (Billing) Practitioner** – A physician and/or non-physician practitioner (PA, NP, CNS, CNM); typically primary care, but may be of another specialty (e.g., cardiology, oncology)

**Behavioral Health Care Manager (BHCM)** – A designated individual with formal education or specialized training in behavioral health (including social work, nursing, or psychology), working under the oversight and direction of the billing practitioner

**Psychiatrist Consultant** – A medical professional trained in psychiatry and qualified to prescribe the full range of medications

Source: SAMHSA/CMS [5]
Care Team Roles: Patient

- Any mental, behavioral, psychiatric, or substance use condition is eligible
- Works directly with PCP and BHCM
- Reports changes in health, symptoms, meds, function, psychosocial
- Completes patient-reported outcome measures
- Establishes goals
- Asks questions and discusses concerns
- Understands treatment plan, goals, medication instructions

Source: Ratzliff [1]
Care Team Roles: Treating Practitioner

- Explains model to patient; obtains and documents consent (may be verbal) for attribution
- Directs and provides general supervision to the BH Care Manager
- Establishes and adjusts diagnoses in collaboration with care team
- Prescribes and adjusts medications, with input from patient and collaborating psychiatrist
- Oversees care, orders tests, makes referrals when needed
- Provides ongoing oversight, management, collaboration, and reassessment

Source: SAMHSA/CMS [5]
Care Team Roles: BH Care Manager

- Has formal education or specialized training in behavioral health, including nurse, social worker, psychologist, or counselor
- Works under oversight and direction of treating practitioner
- Can be remote or off-site, but must be able to provide face-to-face service if needed
- Provides assessment and care management services of caseload, including administration or facilitation of validated rating scales; care planning and revision, including for those not improving or with status changes; provides brief psychosocial interventions; ongoing collaboration with treating practitioner and psychiatrist; maintains registry; facilitates referrals as needed
- Supports medication management by treating practitioner, including monitoring for side effects and adherence
- Engages patients outside of routine office hours as necessary (nights, weekends)
- Does not necessarily require state licensure or meet CMS billing requirements
- Cannot include times spent on strictly admin/clerical duties to bill the threshold

Source: SAMHSA/CMS [5]
Care Team Roles: Psychiatrist Consultant

- Must be expert in psychiatry and psychopharmacology (does not need to be Medicare provider or in-network)
- Participates in regular (weekly and as needed) review of clinical status of patients with BHCM, and with treating practitioner as needed
- Advises care team regarding diagnosis
- Focuses on patients who are not improving or who need adjustments to care plan, including resolving issues with adherence and tolerance of treatment
- Manages negative interactions between patients’ behavioral health and their medical conditions and treatments
- Can be remotely located, and is generally not expected to have direct contact with patient nor prescribe medications or furnish other direct treatment
- Can and should facilitate referral for direct provision of psychiatric care when clinically indicated

Source: SAMHSA/CMS [5]
Case Example: Bill

56yo man c/o 18 month h/o feelings of depression and anxiety attributed to dissatisfaction with his new job responsibilities after obtaining a long-sought promotion at work in a state government regulatory body. Has been on fluoxetine (caused anorgasmia) and mirtazapine (caused weight gain) in the past for depression, nothing in past couple years.

Main sx are loss of interest in things, decreases social activities, reduced appetite but no change in weight (BMI=32), mildly depressed mood, low energy, and irritability. PCP does a PHQ9, which is 11. No thoughts of self-harm. No prior psych hospitalizations. Has 2-3 drinks per night, most nights. No DUIs or hx of problem drinking.

PMH: HTN, hyperlipidemia, erectile dysfunction, obesity

Meds: sildenafil, lisinopril, pravastatin

PCP says she’d like to have him see a therapist, but pt not interested in being referred to a mental health specialist. Is willing to talk to PCP’s nurse, Edgar, who used to work in a psych unit. Also willing to participate in collaborative care to have regular check-ins and assessments with Edgar. PCP explains that a psychiatrist will review his history with Edgar and offer suggestions about treatment. She also orders some lab work. A follow-up appointment is scheduled for 1 month.

Dx: Adjustment disorder with depressed mood
Evidence Base for CoCM

- 2012 Cochrane review of 79 RCTs, including over 24,000 patients worldwide comparing collaborative care with routine care or alternative treatments for depression and anxiety disorders. Most studies focused on depression, while some addressed anxiety. The review found that:
  - collaborative care was superior to routine care for depression and anxiety
  - the impact was present for up to two years
  - the percent of patients using medications in line with current guidance was increased
  - mental health-related quality of life improved
  - patient satisfaction with collaborative care was higher than with usual care

Evidence Base for CoCM: DIAMOND Trial

A Stepped-Wedge Evaluation of an Initiative to Spread the Collaborative Care Model for Depression in Primary Care

Leif I. Solberg, MD
A. Lauren Crain, PhD
Michael V. Maciosek, PhD
Jürgen Unützer, MD, MPH
Kris A. Olmstrom, RN, MPH

ABSTRACT

PURPOSE Scale-up and spread of evidence-based practices is one of the most important challenges facing health care. We tested whether a statewide initiative, Depression Improvement Across Minnesota–Offering a New Direction (DIAMOND), to implement the collaborative care model for depression in 75 primary care clinics resulted in patient outcome improvements corresponding to those reported in randomized controlled trials.

No differences in depression remission rates were found between CoCM and usual care, though patient satisfaction was better.

“At least 10 systematic reviews and/or meta-analyses ... have almost all concluded that the [CoCM] model produces better outcomes, but the following reports have tried to identify the individual components of the model that were most important:

- staff assistance with case management and mental health specialist involvement;
- revision of professional roles and provision of a care manager who delivers psychotherapy (not part of this initiative);
- patient education and self-management, symptom monitoring, decision support for treatment adherence, patient registries, and mental health supervision of care managers;
- professional background and method of supervision of care managers;
- systematic follow-up and service restructuring; and
- ensuring adequate doses of antidepressants.”

Evidence Base for CoCM: IMPACT Trial

IMPACT doubles effectiveness of care for depression

- n=1801
- 45% vs 19% responded (OR 2.7-4.4)
- better depression treatment rate (OR 2.3-3.8)
- better pt satisfaction (OR 2.7-4.3)
- lower depression severity & functional impairment
- higher quality of life

50% or greater improvement in depression at 12 months

Figure 2. Mean SCL-20 Depression Score
Evidence base for CoCM

- 8-year follow-up study of 235 primary care pts age 60+ w/depression who were randomized to CoCM or usual care (from IMPACT trial)
- CoCM patients without baseline CVD had 48% lower risk of a hard CVD event.

Evidence base for CoCM: SUMMIT Trial (AUD/OUD)

Conclusions: Among adults with OAUD in primary care, the SUMMIT collaborative care intervention resulted in significantly more access to treatment and abstinence from alcohol and drugs at 6 months, than usual care.

- n=377 across 2 FQHCs randomized to CoCM or UC
- Interventions included 6-session brief therapy, sublingual BUP/NX for OUD, XR-NTX for AUD
- UC was a phone number to schedule an appt to receive tx and a list of community referrals
- Pharmacotherapy consultation was provided by a board-certified addiction medicine physician affiliated with a local academic medical center

<table>
<thead>
<tr>
<th>Table 2. Effects of Collaborative Care on OAUD Treatment Utilization and Patient Outcomes</th>
</tr>
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<tbody>
<tr>
<td>Treatment Utilization Outcomes</td>
</tr>
<tr>
<td>--------------------------------</td>
</tr>
<tr>
<td>Primary outcome</td>
</tr>
<tr>
<td>Patient received any evidence-based treatment (BT or MAT)</td>
</tr>
<tr>
<td>Secondary outcomes</td>
</tr>
<tr>
<td>Patient received any BT</td>
</tr>
<tr>
<td>Patient received any medication assisted treatment</td>
</tr>
<tr>
<td>HEDIS Initiation</td>
</tr>
<tr>
<td>HEDIS Engagement</td>
</tr>
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</table>

Table 3. Participant Outcomes

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Baseline, %</th>
<th>6-Month Follow-up, %</th>
<th>Effect Estimate (95% CI)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstinence from all opioids or any alcohol, past 30 days</td>
<td>NA</td>
<td>32.8</td>
<td>0.12 (0.01 to 0.23)</td>
<td>.03</td>
</tr>
</tbody>
</table>

Evidence Base for CoCM: OUD & Pregnancy

Feasibility of collaborative care treatment of opioid use disorders with buprenorphine during pregnancy

Leena Mittal, MD\textsuperscript{a,b} and Joji Suzuki, MD\textsuperscript{a,b}
\textsuperscript{a}Brigham and Women's Hospital, Boston, Massachusetts, USA; \textsuperscript{b}Harvard Medical School, Boston, Massachusetts, USA

- 16 pregnancies in 2 OB clinics in Boston using OBOT buprenorphine
- used a psychiatrist consultant
- they found the collaborative care approach to be feasible

Source: https://www.ncbi.nlm.nih.gov/pubmed/26672650
Evidence base for CoCM: OUD

*A Budget Impact Analysis of the Collaborative Care Model for Treating Opioid Use Disorder in Primary Care*

Chuan Mei Lee, MD, MA, Claudia Scheuter, MD, Danielle Rochlin, MD, Terry Platchek, MD, and Robert M. Kaplan, PhD

1Clinical Excellence Research Center, Stanford University, Stanford, CA, USA; 2Division of General Internal Medicine, Inselspital Bern University Hospital, Bern, Switzerland.

Introduction: We performed a budget impact analysis on the expected increases in the expenditure of a health care system after the adoption CoCM to address OUD.

Discussion: Adopting Medicare reimbursement rates by Medicaid and private payers would result in net positive revenue potential for primary care practices. We believe CoCM is likely to result in lower costs through decreased utilization of emergency department and inpatient hospital services.
Comorbidity: Md Medicaid 2011

Relative risk of medical admission with & without MH and SU comorbidity

Diabetes

-- Maryland Medicaid Adults, 2011

Source: Hilltop Institute, 2012
Why bother with CoCM?
Relative risk of medical admission with & without MH and SU comorbidity

- COPD
- Asthma
- Pneumonia NOS
- Bronchitis

Source: Hilltop Institute, 2012

-- Maryland Medicaid Adults, 2011
Comorbidity: Md Medicaid 2011

Relative risk of medical admission with & without MH and SU comorbidity

Cellulitis
Septicemia

-- Maryland Medicaid Adults, 2011

Source: Hilltop Institute, 2012
NSDUH 2017: Need SUD Tx vs Receive Any SUD Tx

Need SUD Tx
- 12 or Older: 7.6%
- 12 to 17: 4.1%
- 18 to 25: 15.1%
- 26 or Older: 6.8%

Receive Any SUD Tx
- 12 or Older: 1.5%
- 12 to 17: 0.7%
- 18 to 25: 1.9%
- 26 or Older: 1.5%

Source: SAMHSA 2018
Past Year SUD and Mental Illness among Adults: 2017

Source: SAMHSA 2018
Receipt of MH & Specialty SUD Tx in the Past Year among Adults with Past Year MI+SUD: 2017

8.5 Million Adults with Co-Occurring Mental Illness and Substance Use Disorders

Source: SAMHSA 2018
CoCM variants for SUD
Classic CoCM Model
CoCM Model: SUD+MH

- Addiction Medicine
- SUD+MH Patient
- Registry
- Psychiatrist
- BHCM (CAC)
Leadership and infrastructure may be the most overlooked core element of the CCM; they will be crucial for its successful uptake in ‘real-world’ settings.

A systematic review of the literature suggests a lack of 1) continuing professional and faculty development, 2) team-based training of all relevant disciplines together, and 3) quality improvement of the clinical training environment.

In conclusion, the CCM is a critical strategy to closing the current access and quality gaps in mental health care across the life span. However, the overwhelming evidence supporting its efficacy is not sufficient to ensure its success. We need to understand how to successfully implement it across Canada. Health care policy and financing are key enablers to the spread of CCM, but so too are clinician innovators.

Discussion
FAQs

- Can CoCM codes and CCM codes be used in the same month? 
  Yes, but read the details.
- Can the general BHI code and the CoCM codes be used in the same month? No.
- Do the BHCM and psychiatrist need to be in the same practice as the billing practitioner? No.
- Must the BHCM services be face-to-face? No, but the BHCM must be available to provide face-to-face services if needed.
- Can the BHCM separately bill for psychotherapy? Yes, if they are eligible to bill Medicare separately, but that time cannot be used in the time applied to CoCM codes.
- Can CoCM codes be billed by specialists other than “traditional” primary care specialties? Yes, anyone who can bill Medicare for E&M services, except for psychiatrists.
- Can addiction specialists serve as the consulting physician in CoCM? Yes, if and SUD is being treated and they are qualified to prescribe the full range of medications.

Source: CMS [7]
Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements:

- Outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional;
- Initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan;
- Review by the psychiatric consultant with modifications of the plan if recommended;
- Entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.

Source: SAMHSA/CMS [5]
CMS Descriptor: 99493

Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements:

- Tracking patient follow-up and progress using the registry, with appropriate documentation;
- Participation in weekly caseload consultation with the psychiatric consultant;
- Ongoing collaboration with and coordination of the patient’s mental health care with the treating physician or other qualified health care professional and any other treating mental health providers;
- Additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant;
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies; and
- Monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.

Source: SAMHSA/CMS [5]
CMS Descriptor: 99494

Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional.

- List separately and use in conjunction with 99492 or 99493
- Limit of 2 add-ons per month

Source: SAMHSA/CMS [5]
Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements:

- Initial assessment or follow-up monitoring, including the use of applicable validated rating scales;
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and
- Continuity of care with a designated member of the care team.

Source: SAMHSA/CMS [5]
3. AIMS Center (aims.uw.edu) - Advancing Integrated Mental Health Solutions
4. APA - Implement the collaborative care model (https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/implement)
5. SAMHSA/CMS (https://integration.samhsa.gov/BehavioralHealthIntegration.pdf)
7. FAQs from CMS (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Behavioral-Health-Integration-FAQs.pdf)

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