Behavioral Health Toolkit

For Primary Care and Behavioral Health Providers

MOLINA® HEALTHCARE

Your Extended Family.

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WELCOME:

Thank you for being part of the Molina Healthcare network of providers.

We designed this Behavioral Health Toolkit for Primary Care Providers to provide tools and guidance around management of Behavioral Health (mental health and substance use) conditions commonly seen in the primary care and community setting. Included in the toolkit are chapters addressing:

- Assessment and Diagnosis of Mental Health Conditions in the Primary Care Setting including:
    - Depression
    - Substance Use Disorders (Alcohol and Other Drugs)
    - Attention Deficit Hyperactivity Disorder (ADHD)

- HEDIS Tips including:
    - Follow-up After Hospitalization for Mental Illness
    - Antidepressant Medication Management
    - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
    - Follow-Up Care for Children Prescribed ADHD Medication
    - Schizophrenia Management including:
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        - ❖ Antipsychotic Medication Adherence
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- Risk Adjustment Education Tools for:
    - Major Depression
    - Bipolar Disorder
    - Substance Use Disorders
    - Schizophrenia

We hope the information in this toolkit helps support your clinical practice.

Jayleen A. Harland, M.D., M.B.A.
Senior Medical Director, BH & SUD Programs
Molina Healthcare Inc.

Contact Molina Healthcare	
PROVIDER PORTAL	https://provider.molinahealthcare.com/
California	888-665-4621/option 1
Florida	855-322-4076
Idaho	844-239-4914
Illinois	855-866-5462
Michigan	855-322-4077
Mississippi	844-826-4335
New Mexico	800-377-9594/option 3
New York	877 872 4716
Ohio	855-322-4079
Puerto Rico	888-558-5501
South Carolina	855-237-6178
Texas	866-449-6849/option 1
Utah	888-483-0760/option 1
Washington	800-869-7165/option 1
Wisconsin	855-326-5059/option 1

Assessment and Diagnosis of Mental Health Conditions in the Primary Care Setting

If you suspect bipolar disorder, schizophrenia or other psychotic disorders, refer your patient to a Molina Healthcare-affiliated Behavioral Health or Substance Use Disorder Specialist.

Contact Molina Healthcare (see Contact Information at the beginning of this handbook) for referral assistance for these or any mental health conditions that require evaluation or treatment by a specialist.

Clinical Depression Screening & Follow-Up

The Centers for Medicare & Medicaid Services **REQUIRES** enrollees in Medicare Medicaid Plans (also known as Dual Eligible) to be screened for Depression on an annual basis using a standardized depression screening tool. This includes members age 18 and older who complete a physical or behavioral health outpatient visit must complete depression screening even in the absence of symptoms.

Molina Healthcare encourages annual screening for Depression for ALL of our members in each of our insurance plans. This provider education material is intended to ensure that Molina Member Care Providers are aware and using a standardized screening tool for depression, documenting a follow up plan, and correctly coding the service.

PHQ-9 (Standardized Depression Screening Tool)

Molina endorses the use of the PHQ-9 (Patient Health Questionnaire 9 Questions), a standardized depression screening tool with established clinical validity. The PHQ-9 screening tool, scoring instructions and description of depression risk levels (low/maintenance level; moderate; high/severe) can be found on the SAMHSA website at http://www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf

Codes for Documenting Clinical Depression Screen	
G8431	Screening for clinical depression is documented as being positive and a follow-up plan is documented.
G8510	Screening for clinical depression is documented as negative. A follow-up plan is not required as patient not eligible/appropriate for follow-up.

Documenting the Follow-Up Plan

The follow-up plan is the proposed outline of treatment to be conducted as a result of clinical depression screening. Follow-up for positive depression screening must include one (1) or more of the following:

o Additional evaluation

o Suicide risk assessment

o Referral to a practitioner who is qualified to diagnose and treat depression

o Pharmacological interventions

o Other interventions or follow-up for the diagnosis of depression

The documented follow-up plan must be related to positive depression screening, for example: "***Patient referred for psychiatric evaluation due to positive depression screening.***"

Documenting Exclusions

A patient is not eligible if one or more of the follow g conditions are *documented in the patient's medical record.*

- Patient has an active diagnosis of Depression or Bipolar Disorder.
- Patient refuses to participate.
- Patient is in an urgent or emergent situation where time is of the essence and to delay the patient's treatment would jeopardize the patient's health status.
- Situations where the patient's functional capacity or motivation to improve may impact the accuracy of the screening tool. For example, court-appointed cases or cases of delirium.

Codes for Documenting Exclusions	
G8433	Screening for clinical depression not documented. Medical record documents that the patient is not eligible/appropriate.
G8940	Screening for clinical depression is documented as positive. A follow-up plan is not documented. Medical record documents that the patient is not eligible/appropriate

Depression Screening – PHQ9
Patient Heath Questionnaire 9 Questions

Molina Healthcare endorses the use of the PHQ-9 (Patient Health Questionnaire 9 Questions), a standardized depression screening tool with established clinical validity.

- The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression.
- The tool is a diagnostic measure for Major Depression as well as for recognizing subthreshold depressive disorders.
- It can be administered repeatedly - reflecting improvement or worsening of depression in response to treatment.

Over the last 2 weeks, how often has the patient been bothered by the following problems?	**Not at All**	**Several Days**	**More than Half the Days**	**Nearly Every Day**
1. Little interest or pleasure in doing things	☐ 1	☐ 2	☐ 3	☐ 4
2. Feeling down, depressed, or hopeless	☐ 1	☐ 2	☐ 3	☐ 4
3. Trouble falling or staying asleep, or sleeping too much	☐ 1	☐ 2	☐ 3	☐ 4
4. Feeling tired or having little energy	☐ 1	☐ 2	☐ 3	☐ 4
5. Poor appetite or overeating	☐ 1	☐ 2	☐ 3	☐ 4
6. Feeling bad about yourself - or that you are a failure or have let yourself and/or your family down	☐ 1	☐ 2	☐ 3	☐ 4
7. Trouble concentrating on things such as reading the newspaper or watching television	☐ 1	☐ 2	☐ 3	☐ 4
8. Moving or speaking so slowly that other people have noticed, or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	☐ 1	☐ 2	☐ 3	☐ 4
9. Thoughts that you would be better off dead or thoughts of hurting yourself in some way	☐ 1	☐ 2	☐ 3	☐ 4
Scoring				

10. If the patient checked off any problems, how difficult have those problems made it for him/her to do work, take care of things at home, or get along with other people?

o Not difficult at all
o Somewhat difficult
o Very difficult
oExtremely difficult

☐ **Total Score**

Consider Total Score as possible indicator of level of depression. Circle the appropriate score/severity indicator.	
Score	**Depression Severity**
1-4	Minimal Depression
5-9	Mild Depression
10-14	Moderate Depression
15-19	Moderately to Severe Depression
20-17	Severe Depression
Q10 – a non-scored question used to assign weight to the degree to which depressive problems have affected the patient's level of function	

NOTE: The clinician should rule out physical causes of depression, normal bereavement and a history of manic/hypomanic episode.

Substance Screening – CAGE AID

Molina Healthcare recommends the use of the CAGE-AID to screen for alcohol and other drug abuse & dependence.

The CAGE-AID questionnaire is used to test for alcohol and other drug abuse and dependence in adults . The tool is not diagnostic, but is indicative of the existence of an alcohol or other drug problem.

Each item on the CAGE-AID are scored 0 or 1. A *total score of 2 or greater is considered clinically significant*, which then should lead the physician to ask more specific questions about frequency and quantity CAGE is derived from the four questions of the tool:

- *Cut down*
- *Annoyed*
- *Guilty*
- *Eye-open*
- AID refers to *"Adapted to Include Drug Use"*

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.	**YES**	**NO**
1. Have you felt you should **cut down** or stop drinking or using drug?		
2. Has anyone **annoyed** you or gotten on your nerves by telling you to cut down or stop drinking or using drugs?		
3. Have you felt **guilty** or bad about how much you drink or use drugs?		
4. Have you been waking up wanting to have an alcoholic drink or use drugs? ***(eye-opening)***		
TOTAL 'YES' SCORE		

SCORING	Regard one or more positive responses to the CAGE-AID as a positive screen.

***Screening tool available at the SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) website:*
http://www.integration.samhsa.gov/clinical-practice/screening-tools

Assessment and Diagnosis of Attention-Deficit/Hyperactivity Disorder

Attention deficit hyperactivity disorder (ADHD) is defined by a persistent pattern of inattention (for example, difficulty keeping focus) and/or hyperactivity-impulsivity (for example, difficulty controlling behavior, excessive and inappropriate motor activity). Children with ADHD have difficulty performing well in school, interacting with other children, and following through on tasks. There are three sub-types of the disorder:

- Predominantly hyperactive/impulsive
- Predominantly inattentive
- Combined inattention & hyperactive/impulsive

The three overarching features of ADHD include inattention, hyperactivity, and impulsivity. Inattentive children may have trouble paying close attention to details, make careless mistakes in schoolwork, are easily distracted, have difficulty following through on tasks, such as homework assignments, or quickly become bored with a task. Hyperactivity may be defined by fidgeting or squirming, excessive talking, running about, or difficulty sitting still. Finally, impulsive children may be impatient, may blurt out answers to questions prematurely, have trouble waiting their turn, may frequently interrupt conversations, or intrude on others' activities.

The following clinical practice guidelines may be helpful in the assessment, diagnosis, and treatment of ADHD:

- ❑ American Academy of Pediatrics. Clinical Practice Guideline: ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents. Pediatrics 2011 Oct; 128:5 1007-1022; doi:10.1542/peds.2011-2654. http://pediatrics.aappublications.org/content/128/5/1007.full
- ❑ The Centers for Disease Control and Prevention - https://www.cdc.gov/ncbddd/adhd/guidelines.html
- ❑ American Academy of Family Physicians - https://www.aafp.org/patient-care/clinical-recommendations/all/ADHD.html

HEDIS® Tips

HEDIS® Tips:
Follow-up After Hospitalization for Mental Illness

MEASURE DESCRIPTION

Patients 6 years of age and older who were hospitalized for treatment of selected mental health diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7- and 30- days of discharge. Visits must occur after the date of discharge.

USING CORRECT BILLING CODES

Codes to Identify Follow-up Visits *(must be with mental health practitioner)*

Description	Codes
Follow-up Visits	**CPT:** 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99411, 99412, 99510 **Transitional Care Management Visits:** 99496 (only for 7-day indicator), 99495 (only for 30-day follow-up indicator) **Telehealth Modifier:** 95, GT **HCPCS:** G0155, G0176, G0177, G0409-G0411, G0463, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485, T1015 **UB Rev (visit in a behavioral health setting):** 0513, 0900-0905, 0907, 0911-0917, 0919 **UB Rev (visit in a non-behavioral health setting):** 0510, 0515-0517, 0519-0523, 0526-0529, 0982, 0983

Description	Codes		
Follow-up Visits	**CPT:** 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90867-90870, 90875, 90876 **Telehealth Modifier:** 95, GT	***WITH***	**POS:** 03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72
	CPT: 99221-99223, 99231-99233, 99238, 99239, 99251-99255 **Telehealth Modifier:** 95, GT	***WITH***	**POS:** 52, 53

HOW TO IMPROVE HEDIS® SCORES

- ❑ The literature indicates that during the first 7 days post-discharge the patient is at greater risk for rehospitalization and, within the first 3 weeks post-discharge the risk of self-harm is high.
- ❑ Ensure that the follow-up appointment is made before the patient leaves the hospital and is scheduled within 7 days of discharge. Contact Molina case management if assistance is needed to obtain follow-up appointment.
- ❑ Assist the patient with navigation of barriers, such as using their transportation benefit to get to their follow-up appointment. Ensure your patient has an understanding of the local community support resources and what to do in an event of a crisis.
- ❑ Review medications with patients to ensure they understand the purpose and appropriate frequency and method of administration.
- ❑ Ensure accurate discharge dates and document not just appointments scheduled, but appointments kept. Visits must be with a *mental health practitioner.*
- ❑ Provide information about the importance of monitoring their emotional well-being and following up with their mental health practitioner.
- ❑ Follow-up visits must be supported by a claim, encounter or note from the mental health practitioner's medical chart.

Updated 1/5/18

Antidepressant Medication Management

Successful treatment of patients with major depressive disorder is promoted by a thorough assessment of the patient and close adherence to treatment plans. Treatment consists of an *acute phase,* during which remission is induced; a *continuation phase,* during which remission is preserved; and a *maintenance phase,* during which the susceptible patient is protected against the recurrence of a subsequent major depressive episode.

Molina Healthcare has been working on a variety of initiatives to raise awareness about the objectives of the National Committee for Quality Assurance (NCQA) HEDIS® *Antidepressant Medication Management* measures (AMM), which guide our efforts in measuring the quality and effectiveness of the care provided. The AMM measures specifically focus on promoting adequate and continuous medication therapy and adherence for patients diagnosed with Major Depression.

What are the HEDIS® AMM measures?

This two-part measure looks at:

- The percentage of patients 18 years of age and older with major depression who were initiated on an antidepressant drug and who received an adequate acute-phase trial of medications (three months).
- The percentage of patients with major depression who were initiated on an antidepressant drug and who completed a period of continuous medication treatment (six months).

What are the best practices regarding these HEDIS® measures?

- Regularly monitor patients to assess response to therapy as well as emergence of side effects, clinical condition and safety.
- Educate patients that it usually takes from one to six weeks to start feeling better. In many cases, sleep and appetite improve first while improvement in mood, energy, and negative thinking may take longer.
- Inform patients that once they begin to feel better it's important to stay on the medication for another six months to prevent a relapse.
- Develop a plan with the patient in the event of a crisis or thoughts of self-harm.

What is the relevance of these measures?

- Major depression can lead to serious impairment in daily functioning, including change in sleep patterns, appetite, concentration, energy and self-esteem, and can lead to suicide, the 11th leading cause of death in the United States (U.S.) each year (National Alliance on Mental Illness [NAMI], 2013; Centers for Disease Control and Prevention [CDC], 2012). Clinical guidelines for depression emphasize the importance of effective clinical management in increasing patients' medication compliance, monitoring treatment effectiveness and identifying and managing side effects (Birnbaum et al., 2010).
- In a given year, major depression affects 6.7 percent of the U.S. adult population (approximately 14.8 million American adults) (National Institute of Mental Health [NIMH], 2012).
- Severity of major depression is significantly associated with poor work performance (Birnbaum et al., 2010). Lost work productivity costs the U.S. up to $2 billion monthly (Birnbaum et al., 2010).
- Effective medication treatment of major depression can improve a person's daily functioning and well-being, and can reduce the risk of suicide. With proper management of depression, the overall economic burden on society can be alleviated, as well.

- Birnbaum HG, Kessler RC, Kelley D, Ben-Hamadi R, Joish VN, Greenberg PE. Employer burden of mild, moderate, and severe major depressive disorder: mental health services utilization and costs, and work performance. Depress Anxiety. 2010;27(1):78-89.
- Centers for Disease Control and Prevention (CDC). Suicide facts at a glance 2012. [internet]. Atlanta (GA): Centers for Disease Control and Prevention (CDC); 2012 [accessed 2014 Jun 20].
- National Alliance on Mental Illness (NAMI). Major depression fact sheet: what is major depression?. [internet]. Arlington (VA): National Alliance on Mental Illness (NAMI); 2013 [accessed 2014 Jun 20].
- National Committee for Quality Assurance (NCQA). The state of health care quality 2014. Washington (DC): National Committee for Quality Assurance (NCQA); 2014 Oct. 182 p.
- National Institute of Mental Health (NIMH). The numbers count: mental disorders in America. [internet]. Bethesda (MD): National Institutes of Health (NIH); 2013 [accessed 2014 Jun 20].

HEDIS® Tips:
Antidepressant Medication Management

MEASURE DESCRIPTION

The percentage of adults 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remain on an antidepressant medication treatment. Two rates are reported:

Effective Acute Phase Treatment: The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks). (Continuous treatment allows gaps in treatment up to a total of 30 days during the *Acute Phase*).

Effective Continuation Phase Treatment: The percentage members who remained on an antidepressant medication for at least 180 days (6 months). (Continuous treatment allows gaps in treatment up to a total of 51 days during the *Acute and Continuation Phases* combined).

USING CORRECT BILLING CODES

Codes to Identify Major Depression

Description	ICD-9 Codes	*ICD-10 Codes
Major Depression	296.20-296.25, 296.30-296.35, 298.0, 311	F32.0-F32.4, F32.9, F33.0-F33.3. F33.41, F33.9

*ICD-9 codes are included for historical purposes only and can no longer be used for billing.

ANTIDEPRESSANT MEDICATIONS

Description	Generic Name	Brand Name
Miscellaneous antidepressants	Buproprion Vilazodone Vortioxetine	Wellbutrin®; Zyban® Viibryd® Brintellix®
Phenylpiperazine antidepressants	Nefazodone Trazodone	Serzone® Desyrel®
Psycho-therapeutic combinations	Amitriptyline-chlordiazepoxide; Amitriptyline-perphenazine; Fluoxetine-olanzapine	Limbitrol® Triavil®; Etrafon® Symbax®
SNRI antidepressants	Desvenlafaxine Levomilnacipran Duloxetine Venlafaxine	Pristiq® Cymbalta® Effexor®
SSRI antidepressants	Citalopram Escitalopram Fluoxetine Fluvoxamine Paroxetine Sertraline	Celexa® Lexapro® Prozac® Luvox® Paxil® Zoloft®
Tetracyclic antidepressants	Maprotiline Mirtazapine	Ludiomil® Remeron®
Tricyclic antidepressants	Amitriptyline Amoxapine Clomipramine Desipramine Doxepin (>6mg) Imipramine Nortriptyline Protriptyline Trimipramine	Elavil® Asendin® Anafranil® Norpramin® Sinequan® Tofranil® Pamelor® Vivactil® Surmontil®
Monoamine oxidase inhibitors	Isocarboxazid Phenelzine Selegiline Tranylcypromine	Marplan® Nardil® Anipryl®; Emsam® Parnate®

HOW TO IMPROVE HEDIS® SCORES

- ❑ Educate patients on the following:
  - o Depression is common and impacts 15.8 million adults in the United States.
  - o Depression can be treated. Most antidepressants take 1-6 weeks to work before the patient starts to feel better.
  - o In many cases, sleep and appetite improve first while improvement in mood, energy and negative thinking may take longer.
  - o The importance of staying on the antidepressant for a minimum of 6 months.
  - o Strategies for remembering to take the antidepressant on a daily basis.
  - o The connection between taking an antidepressant and signs and symptoms of improvement.
  - o Common side effects, how long the side effects may last and how to manage them.
  - o What to do if the patient has a crisis or has thoughts of self-harm.
  - o What to do if there are questions or concerns.
- ❑ Contact Health Care Services at your affiliated Molina Healthcare State plan for additional information about Medication Therapy Management criteria and to request a referral for patients with at least six (6) chronic medications and at least three (3) qualifying diagnoses. They may be eligible for MTM sessions

Updated 1/5/18

Initiation and Engagement of Alcohol and Other Drug Treatment

The *Initiation and Engagement of Alcohol and Other Drug Treatment* measure assesses the degree to which patients with a need for alcohol and other drug (AOD) dependence services are engaged in initiating and continuing treatment once the need for care has been identified. Identifying patients with alcohol and other drug dependence disorders is an important first step in the process of care but identification often does not lead to initiation of care. The patient may not initiate treatment because of the social stigma associated with AOD disorder, denial of the problem or lack of immediately available treatment services.

Treatment engagement is an intermediate step between initially accessing care (the first visit) and completing a full course of treatment. This measure is an important intermediate indicator, closely related to outcome. In fact, studies have tied frequency and intensity of engagement as important in treatment outcome and in reducing drug-related illnesses. (Batten et al., 1992; McLellan et al., 1997).

Molina Healthcare has been working on a variety of initiatives to raise awareness about the objectives of the National Committee for Quality Assurance (NCQA) HEDIS® *Initiation and Engagement of Alcohol and Other Drug Treatment* (IET) measures, which guide our efforts in measuring the quality and effectiveness of the care provided. The IET measures specifically focus on improving the degree to which members initiate and continue treatment.

What are the HEDIS® IET measures?

This two-part measure looks at:

- *Initiation Phase*. The percentage of adolescent and adult patients age 13 years and older with a new diagnosis of alcohol or other drug dependency who complete a first treatment visit (initiation) within 14 days of the date of the initial diagnosis.
- *Engagement Phase.* The percentage of patients who completed the first treatment visit (initiation) and who had *two or more additional visits* with an AOD diagnosis within 30 days of the first visit.
- Following the date of the initial diagnosis*, a total of at least three visits* are required over both phases of the measure.

What are the best practices regarding these HEDIS® measures?

- Annually assess each patient for alcohol and other drug use, or whenever the possibility of substance abuse having an impact on a patient's presenting issues is suspected.
- Document the diagnosis of a suspected substance abuse issue. Often, practitioners are reluctant to use a substance abuse diagnosis for fear of stigmatizing a patient who has discussed his or her struggles with substances. Lack of labeling a diagnosis, however, prevents other clinicians from working with a patient in a coordinated manner, ultimately resulting in less effective care for the patient.
- Follow up with the patient. Schedule a follow-up appointment, or schedule appointments with a qualified behavioral health clinician. Ensure that a substance abuse diagnosis is included in each follow-up visit.
- Patients may want to minimize their substance abuse, so persistence is required in raising the topic and keeping it at the forefront of a patient's treatment.

What is the relevance of these measures?

- There are more deaths, illnesses and disabilities from substance abuse than from any other preventable health condition. Treatment of medical problems caused by substance abuse places a huge burden on the health care system. (Schneider Institute for Health Policy & Brandeis University, 2001).
- Numerous studies indicate that individuals who remain in treatment for a longer duration of time have improved outcome, but the 1990 Drug Service Research Survey suggested that many clients (52 percent) with AOD disorders leave treatment prematurely. (Institute of Medicine [IOM], 1990).
- Alcohol and other drug (AOD) dependence is common across many age groups and a cause of morbidity, mortality and decreased productivity.
- In 2012, an estimated 23.1 million Americans (8.9 percent) needed treatment for a problem related to drugs or alcohol, but only about 2.5 million people (1 percent) received treatment (National Institute on Drug Abuse [NIDA], "Nationwide," 2014).
- Abuse of alcohol and illicit drugs totals more than $700 billion annually in costs related to crime, lost work productivity and health care (NIDA, "Drugs, brain," 2014).
- Abuse of alcohol, illicit and prescription drugs contributes to the death of more than 90,000 Americans each year (NIDA, "Drugs, brain," 2014).
- There is strong evidence that treatment for AOD dependence can improve health, productivity and social outcomes, and can save millions of dollars on health care and related costs.

- Barten, H., et. al. 1992. Drug Service Research Survey. *Final Report: Phase II*. Submitted by the Bigel Institute for Health Policy, Brandeis University to the National Institute on Drug Abuse. Waltham, Massachusetts.
- McCorry, F., Garnick, D., Bartlett, J., Cotter, F., Chalk, M. Nov. 2000. Developing Performance Measures for Alcohol and Other Drug Services in Managed Care Plans. *Joint Commission Journal on Quality Improvement.* 26 (11): 633–43.
- McLellan, A., et. al. 1997. Evaluating effectiveness of addiction treatments: Reasonable expectations, appropriate comparisons. In Egertson, A., D. Fox, A. Leshner (eds): *Treating Drug Abusers Effectively*. Malden, MA: Blackwell Publishers.
- Schneider Institute for Health Policy, Brandeis University. 2001. *Substance Abuse: The Nation's Number One Health Problem,* for The Robert Wood Johnson Foundation, Princeton, New Jersey.
- Institute of Medicine (IOM). 1990a. *Broadening the Base of Treatment for Alcohol Problems.* Washington, DC: National Academy Press.

HEDIS® Tips:

Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment

MEASURE DESCRIPTION

The percentage of adolescent and adult patients 13 years of age and older with a new episode of alcohol or other drug (AOD) abuse or dependence with the following:

- *Initiation of AOD Treatment.* Initiate treatment through inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication assisted treatment (MAT) within 14 days of diagnosis.
- *Engagement of AOD Treatment.* Initiated treatment and had two or more additional AOD services or MAT within 34 days of the initiation visit.

USING CORRECT BILLING CODES

Codes to Identify AOD Dependence

ICD-10-CM Diagnosis
F10.10 F10.120, F10.121, F10.129, F10.14, F10.150, F10.151, F10.159, F10.180-F10.182, F10.188,F10.19-F10.20, F10.220, F10.221, F10.229-F10.232, F10.239, F10.24, F10.250-F10.251, F10.259, F10.26, F10.27, F10.280-F10.282, F10.288, F10.29, F11.10, F11.120-F11.122, F11.129, F11.14, F11.150, F11.151, F11.159, F11.181, F11.182, F11.188, F11.19, F11.20, F11-220-F11.222, F11.229, F11.23, F11.24, F11.250, F11.251, F11.259, F11.281, F11.282, F11.288, F11.29, F12.10, F12.120-F12.122, F12.129, F12.150, F12.151, F12.159, F12.180, F12.188, F12.19, F12.20, F12.220-F12.222, F12.229, F12.250, F12.251, F12.259, F12.280, F12.288, F12.29, F13.10, F131.20, F13.121, F13.129, F13.14, F13.150, F13.151, F13.159, F13.180- F13.182, F13.188, F13.19, F13.20, F13.220, F13.221, F13.229-F13.232, F13.239, F13.24, F13.250, F13.251, F13.259, F13.26, F13.27, F13.280-F13.282, F13.288, F13.29, F14.10, F14.120-F14.122, F14.129, F14.14, F14.150, F14.151, F14.159, F14.180-F14.182, F14.188, F14.19, F14.20, F14.220-F14.222, F14.229, F14.23, F14.24, F14.250, F14.251, F14.259, F14.280-F14.282, F14.288, F14.29, F15.10, F15.120-F15.122, F15.129, F15.14, F15.150, F15.151, F15.159, F15.180- F15.182, F15.188, F15.19, F15.20, F15.220-F15.222, F15.229, F15.23, F15.24, F15.250, F15.251, F15.259, F15.280-F15.282, F15.288, F15.29, F16.10, F16.120-F16.122, F16.129, F16.14, F16.150, F16.151, F16.159, F16.180, F16.183, F16.188, F16.19, F16.20, F16.221, F16.229, F16.24, 16.250, F16.251, F16.259, F16.280, F16.283, F16.288, F16.29, F18.10, F18.120, F18.121, F18.129, F18.14, F18.150, F18.151, F18.159, F18.17, F18.180, F18.188, F18.19, F18.20, F18.220, F18.221, F18.229, F18.24, F18.250, F18.251, F18.259, F18.27, F18.280, F18.288, F18.29, F19.10, F19.120-F19.122, F19.129, F19.14, F19.150, F19.151, F19.159, F19.16, F19.17, F19.180, F19.181, F19.182, F19.188, F19.19, F19.20, F19.220-F19.222, F19.229-F19.232, F19.239, F19.24, F19.250, F19.251, F19.259, F19.26, F19.27, F19.280-F19.282, F19.288, F19.29

Codes to Identify Outpatient, Intensive Outpatient, Partial Hospitalization, Telehealth, and Medication Assisted Treatment (MAT) Visits (*use these visit codes along with the one of the diagnosis codes above to capture initiation and engagement of AOD treatment*)

CPT	HCPCS	UB Revenue
98960-98962, 98966-98969, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99281-99285, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99408, 99409, 99411, 99412, 99441-99444, 99510, HZ2ZZZZ	G0155, G0176, G0177, G0396, G0397, G0409-G0411, G0443, G0463, H0001, H0002, H0004, H0005, H0007, H0008-H0016, H0020, H0022, H0031, H0034-H0037, H0039, H0040, H0047, H2000, H2001, H2010-H2020, H2035, H2036, M0064,S0201, S9480, S9484, S9485, T1006, T1012, T1015	0100, 0101, 0110-0154, 0156-0160, 0164, 0617, 0169-0174, 0179, 0190-0194, 0199-0204, 0206-0214, 0219, 0450-0452, 0456, 0459, 0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0902-0907, 0911-0917, 0919, 0944, 0945, 0982, 0981, 0983, 1000-1002
CPT		**POS**
90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876	WITH	02, 03, 05, 07, 09, 11, 12, 13, 14, 15,16,17,18,19, 20, 22, 33, 49, 50, 52, 53, 57, 71, 72
99221-99223, 99231-99233, 99238, 99239, 99251-99255	WITH	02, 52, 53

HOW TO IMPROVE HEDIS® SCORES

- ❒ Consider using screening tools or questions to identify substance abuse issues in patients.
- ❒ Document identified substance abuse in the patient chart and submit a claim with the appropriate codes, as described above.
- ❒ Avoid inappropriate use of diagnosis codes that are the result of alcohol or drug dependency (ex. Cirrhosis) as these also qualify patients for the measures.
- ❒ Schedule a follow-up visit within 14 days and at least two additional visits within 30 days, or refer immediately to a behavioral health provider when giving a diagnosis of alcohol or other drug dependence.
- ❒ Involve family members or others who the patient desires for support and invite their help in intervening with the patient diagnosed with AOD dependence.
- ❒ Provide patient educational materials and resources that include information on the treatment process and options.
- ❒ Work collaboratively with the Molina Care Manager if they contact you about a recent encounter with a patient for substance dependency to motivate the patient to initiate treatment.
- ❒ Continue ongoing discussions with patients about treatment to help increase their willingness to commit to the process as the timeframe for initiating treatment is 14 days.
- ❒ Ensure your patient has an understanding of the local community support resources and what to do in an event of a crisis.

Updated 1/5/18

Follow-Up Care for Children Prescribed ADHD Medication

Attention deficit/hyperactivity disorder (ADHD) is one of the more common chronic conditions of childhood. Children with ADHD may experience significant functional problems, such as school difficulties; academic underachievement; troublesome relationships with family members and peers; and behavioral problems (American Academy of Pediatrics [AAP], 2000). Given the high prevalence of ADHD among school-aged children (4 to 12 percent), primary care clinicians will regularly encounter children with ADHD and should have a strategy for diagnosing and long-term management of this condition (AAP, 2001).

Practitioners can convey the efficacy of pharmacotherapy to their patients. AAP guidelines (2000) recommend that once a child is stable, an office visit every 3 to 6 months allows assessment of learning and behavior. Follow-up appointments should be made at least monthly until the child's symptoms have been stabilized.

Molina Healthcare has been working on a variety of initiatives to raise awareness about the objectives of the National Committee for Quality Assurance (NCQA) HEDIS® *Follow-Up Care for Children Prescribed ADHD Medication* (ADD) measures, which guide our efforts in measuring the quality and effectiveness of the care provided. The ADHD measures focus on promoting appropriate follow-up care to monitor clinical symptoms and potential adverse events for patients with ADHD.

What are the HEDIS® ADHD measures?
This two-part measure looks at:

- *Initiation Phase.* The percentage of patients 6 to 12 years of age prescribed an ADHD medication who had *one follow-up visit* with a prescribing practitioner within 30 days of the initial prescription.
- *Continuation and Maintenance Phase.* The percentage of patients who remain on ADHD medication for 6 or more months and who complete at least *two additional follow-up visits* within a 9 month period.
- *A total of at least three visits* are required over both phases of the measure.

What are the best practices regarding these HEDIS® measures?

- When prescribing a new medication to your patient, be sure to schedule a follow-up visit within 30 days to assess how the medication is working. Schedule this visit while your patient is still in the office.
- Schedule two more visits in the 9 months after the first 30 days, to continue to monitor your patient's progress.
- Use a **phone visit** for one of the visits after the first 30 days. This may help you and your patients if getting to an office visit is difficult.
- NEVER continue these controlled substances without at least 2 visits per year to evaluate a child's progress. If nothing else, you need to monitor the child's growth to make sure they are on the correct dosage.

What is the relevance of these measures?

- Attention-deficit/hyperactivity disorder (ADHD) is one of the most common mental disorders affecting children. Ten percent of American children have been diagnosed with ADHD, whose main features are hyperactivity, impulsiveness and an inability to sustain attention or concentration (Bloom, Jones, & Freeman, 2013; American Psychiatric Association [APA], 2012).
- Children with ADHD add a high annual cost to the United States (U.S.) education system–on average, $5,000 each year for each student with ADHD (Robb et al., 2011).
- Studies suggest that there is increased risk for drug use disorders in adolescents with untreated ADHD (National Institute on Drug Abuse [NIDA], 2011).
- When managed appropriately, medication for ADHD can control symptoms of hyperactivity, impulsiveness and inability to sustain concentration. To ensure that medication is prescribed and managed correctly, it is important that children be monitored by a pediatrician with prescribing authority.

- American Academy of Pediatrics. Clinical practice guideline: diagnosis and evaluation of the child with attention-deficit/hyperactivity disorder. Pediatrics. 2000 May;105(5):1158-70. [60 references]
- American Academy of Pediatrics. Clinical practice guideline: treatment of the school-aged child with attention-deficit/hyperactivity disorder. Pediatrics. 2001 Oct;108(4):1033-44. PubMed
- American Psychiatric Association (APA). Children's mental health. [internet]. Arlington (VA): American Psychiatric Association (APA); 2012 [accessed 2014 Jun 01].
- Bloom B, Jones LI, Freeman G. Summary health statistics for U.S. children: National Health Interview Survey, 2012. Vital Health Stat 10. 2013 Dec;(258):1-81. PubMed
- National Committee for Quality Assurance (NCQA). The state of health care quality 2014. Washington (DC): National Committee for Quality Assurance (NCQA); 2014 Oct. 182 p.
- National Institute on Drug Abuse (NIDA). Comorbidity: addiction and other mental illnesses. [internet]. Bethesda (MD): National Institutes of Health (NIH); 2011 [accessed 2010 Sep 06].
- Robb JA, Sibley MH, Pelham WE, Foster ME, Molina BS, Gnagy EM, Kuriyan AB. The estimated annual cost of ADHD to the US education system. School Mental Health. 2011;3:167-77.

HEDIS® Tips:
Follow-up Care for Children Prescribed ADHD Medication

MEASURE DESCRIPTION

Patients 6-12 years old, with a new prescription for an attention-deficit/hyperactivity disorder (ADHD) medication who had:

- At least one follow-up visit with practitioner with prescribing authority during the first 30 days of when the ADHD medication was dispensed. (Initiation Phase)
- At least two follow-up visits within 270 days (9 months) after the end of the initiation phase. One of these visits may be a telephone call. (Continuation and Maintenance Phase)

USING CORRECT BILLING CODES

Codes to Identify Follow-up Visits

Description	Codes
Follow-up Visits	**CPT:** 96150-96154, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99381-99384, 99391-99394, 99401-99404, 99411, 99412, 99510 **HCPCS:** G0155, G0176, G0177, G0409-G0411, G0463, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485, T1015 **UB Revenue:** 0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0902-0905, 0907, 0911-0917, 0919, 0982, 0983
Telephone Visits	**CPT:** 98966-98968, 99441-99443 (Can use for one Continuation and Maintenance Phase visit)

Description	Codes		
Follow-up Visits	**CPT:** 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876	***WITH***	**POS:** 03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 52, 53, 71, 72
	CPT: 99221-99223, 99231-99233, 99238, 99239, 99251-99255	***WITH***	**POS:** 52, 53

HOW TO IMPROVE HEDIS® SCORES

- ❑ Schedule a follow-up visit within 30 days to assess how the medication is working when prescribing a new medication to your patient. Schedule this visit while your patient is still in the office.
- ❑ Schedule two more visits in the 9 months after the first 30 days to continue to monitor your patient's progress. Visits must be on different dates of service.
- ❑ Use a **phone visit** for one of the visits after the first 30 days. This may help you and your patients if getting to an office visit is difficult **(codes: 98966-98968, 99441-99443).** Only one phone visit is allowed during the Continuation and Maintenance Phase. If a phone visit is done, at least one face-to-face visit should also be completed.
- ❑ Do not continue these controlled substances without at least 2 visits per year to evaluate a child's progress. If nothing else, you need to monitor the child's growth to make sure they are on the correct dosage.
- ❑ Refer patients for Health Management interventions and coaching by contacting Health Care Services at your affiliated Molina Healthcare State plan.
- ❑ Ensure the parents/guardians have an understanding of the local community support resources and what to do in an event of a crisis.

Updated 1/5/18

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

People with schizophrenia are at a greater risk of metabolic syndrome due to their serious mental illness (Cohn et al., 2004).Diabetes screening is important for anyone with schizophrenia or bipolar disorder, and the added risk associated with antipsychotic medications contributes to the need to screen people with schizophrenia for diabetes. Diabetes screening for individuals with schizophrenia or bipolar disorder who are prescribed an antipsychotic medication may lead to earlier identification and treatment of diabetes.

Molina Healthcare has been working on a variety of initiatives to raise awareness about the objectives of the National Committee for Quality Assurance (NCQA) HEDIS® *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)* measure, which guide our efforts in measuring the quality and effectiveness of the care provided. This measure focuses on promoting recommended diabetes screening for schizophrenic and bipolar patients prescribed antipsychotic medications.

What is the HEDIS® Diabetes Screening measure?

- The percentage of patients 18-64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.
- A glucose test or an HbA1c test is required by the measure.

What are the best practices regarding this HEDIS® measure?

- Continue educating patients about appropriate health screenings related to certain medication therapies.
- Do not rely on the patient to follow through with scheduling prescribed appointments. Routinely arrange the lab appointment when the patient is in the office.
- Confirm that the billing code related to the selected service is a HEDIS appropriate code.

What is the relevance of this measure?

- In 2010, heart disease and diabetes were the leading causes of death in the United States (U.S.) (Murphy, Xu, & Kochanek, 2013). Because persons with serious mental illness who use antipsychotics are at increased risk of cardiovascular diseases and diabetes, screening and monitoring of these conditions is important.
- In 2007, diabetes was estimated to cost the U.S. economy $174 billion. Of this, $116 billion was attributed to medical care and $58 billion to disability, work loss and premature death (Roger et al., 2011).
- People with diabetes and schizophrenia or bipolar disorder have a 50 percent higher risk of death than diabetics without a mental illness (Vinogradova et al., 2010).
- Lack of appropriate care for diabetes and cardiovascular disease for people with schizophrenia or bipolar disorder who use antipsychotic medications can lead to worsening health and death. Addressing these physical health needs is an important way to improve health and economic outcomes downstream.

- Cohn T, Prud'homme D, Streiner D, Kameh H, Remington G. Characterizing coronary heart disease risk in chronic schizophrenia: high prevalence of the metabolic syndrome. Can J Psychiatry. 2004 Nov;49(11):753-60.
- Murphy SL, Xu J, Kochanek KD. Deaths: final data for 2010. Natl Vital Stat Rep. 2013 May 8;61(4):1-117.
- Roger VL, Go AS, Lloyd-Jones DM, Adams RJ, Berry JD, Brown TM, Carnethon MR, Dai S, de Simone G, Ford ES, Fox CS, Fullerton HJ, Gillespie C, Greenlund KJ, Hailpern SM, Heit JA, Ho PM, Howard VJ, Kissela BM, Kittner SJ, Lackland DT, Lichtman JH, Lisabeth LD, Makuc DM, Marcus GM, Marelli A, Matchar DB, McDermott MM, Meigs JB, Moy CS, Mozaffarian D, Mussolino ME, Nichol G, Paynter NP, Rosamond WD, Sorlie PD, Stafford RS, Turan TN, Turner MB, Wong ND, Wylie-Rosett J. Heart disease and stroke statistics--2011 update: a report from the American Heart Association. Circulation. 2011 Feb 1;123(4):e18-209.
- Vinogradova Y, Coupland C, Hippisley-Cox J, Whyte S, Penny C. Effects of severe mental illness on survival of people with diabetes. Br J Psychiatry. 2010 Oct;197(4):272-7.

HEDIS® Tips:

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications

MEASURE DESCRIPTION

Adults 18-64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test (glucose test or HbA1c test) during the measurement year.

USE CORRECT BILLING CODES

Codes to Identify Diabetes Screening

Description	Codes
Codes to Identify Glucose Tests	**CPT:** 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951
Codes to Identify HbA1c Tests	**CPT:** 83036, 83037 **CPT II:** 3044F (if HbA1c<7%), 3045F (if HbA1c 7%-9%), 3046F (if HbA1c>9%)

Antipsychotic Medications

Description	Generic Name	Brand Name
Miscellaneous antipsychotic agents	Aripiprazole, Asenapine, Brexpiprazole, Cariprazine, Clozapine, Haloperidol, Iloperidone, Loxapine, Lurisadone, Molindone, Olanzapine, Paliperidone, Pimozide, Quetiapine, Quetiapine fumarate, Risperidone, Ziprasidone	Abilify, Saphris, Rexulti, Vraylar, Clozaril, Haldol, Fanapt, Loxipac/Loxitane, Latuda, Moban, Zyprexa, Invega, Orap, Seroquel, Seroquel XR, Risperdal, Geodon
Phenothiazine antipsychotics	Chlorpromazine, Fluphenazine, Perphenazine, Prochlorperazine, Thioridazine, Trifluperazine	Thorazine, Prolixin,, Etrafon, Compazine, Mellaril, Stelazine
Psychotherapeutic combinations	Fluoxetine-olanzapine Perphenazine-amitriptyline,	Symbyax Trilafon
Thioxanthenes	Thiothixene	Navane
Long-acting injections	Aripiprazole, Fluphenazine decanoate, Haloperidol decanoate, Olanzapine, Paliperidone palmitate, Risperidone	Abilify Maintena, Prolixin, Haldol Decanoate INJ, Zyprexa Relprew, Invega Sustenna, Risperdal Consta

HOW TO IMPROVE HEDIS® SCORES

- ❑ Help patients with scheduling a follow-up appointment in 1-3 months with their PCP to screen for diabetes. If the patient is not ready to schedule appointment, make note or flag chart to contact the patient with a reminder to schedule an appointment.
- ❑ Ensure patient (and/or caregiver) is aware of the risk of diabetes and have awareness of the symptoms of new onset of diabetes while taking antipsychotic medication.
- ❑ Schedule lab screening tests through PCP prior to next appointment.
- ❑ The BH provider can order diabetic lab tests for patients who do not have regular contact with their PCP but who regularly see the BH provider. The BH provider can then coordinate medical management with the PCP.
- ❑ Patients can be referred for Health Management interventions and coaching by contacting Health Care Services at your affiliated Molina Healthcare State plan.
- ❑ Ensure your patient has an understanding of the local community support resources and what to do in an event of a crisis.

Updated 12/28/17

Diabetes Monitoring for People with Diabetes and Schizophrenia

Prevalence rates of metabolic syndrome in people with schizophrenia is 42.6 percent for males and 48.5 percent for females, compared with rates in the general population (24 percent for males, 23 percent for females) (Cohn et al., 2004).

Among patients with co-occurring schizophrenia and metabolic disorders, the non-treatment rate for diabetes is approximately 32 percent (Nasrallah et al., 2006). In addition to general diabetes risk factors, diabetes is promoted in patients with schizophrenia by initial and current treatment with olanzapine and mid-potency first-generation antipsychotics (FGA), as well as by current treatment with low-potency FGAs and clozapine (Nielsen, Skadhede, & Correll, 2010).

Improving blood sugar control has shown to lead to lower use of health care services and better overall satisfaction with diabetes treatment (Asche, LaFleur, & Conner, 2011). People who control their diabetes also report improved quality of life and emotional well - being (Saatci et al., 2011).

Molina Healthcare has been working on a variety of initiatives to raise awareness about the objectives of the National Committee for Quality Assurance (NCQA) HEDIS® *Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)* measure, which guide our efforts in measuring the quality and effectiveness of the care provided. This measure focuses on promoting appropriate diabetes monitoring for patients diagnosed with *both* diabetes and schizophrenia.

What is the HEDIS® Diabetes Monitoring measure?

- This measure is used to assess the percentage of patients 18 to 64 years of age with schizophrenia and diabetes who had *both* an LDL-C test and an HbA1c test during the measurement year.

What are the best practices regarding this HEDIS® measure?

- Continue educating patients about appropriate health screenings related to certain medication therapies.
- Do not rely on the patient to follow through with scheduling prescribed appointments. Routinely arrange the lab appointment when the patient is in the office.
- Confirm that the billing code related to the selected service is a HEDIS appropriate code.

What is the relevance of this measure?

- In 2010, heart disease and diabetes were the leading causes of death in the United States (U.S.) (Murphy, Xu, & Kochanek, 2013). Because persons with serious mental illness who use antipsychotics are at increased risk of cardiovascular diseases and diabetes, screening and monitoring of these conditions is important.
- In 2007, diabetes was estimated to cost the U.S. economy $174 billion. Of this, $116 billion was attributed to medical care and $58 billion to disability, work loss and premature death (Roger et al., 2011).
- People with diabetes and schizophrenia or bipolar disorder have a 50 percent higher risk of death than diabetics without a mental illness (Vinogradova et al., 2010).
- Lack of appropriate care for diabetes and cardiovascular disease for people with schizophrenia or bipolar disorder who use antipsychotic medications can lead to worsening health and death. Addressing these physical health needs is an important way to improve health and economic outcomes downstream.

- Asche C, LaFleur J, Conner C. A review of diabetes treatment adherence and the association with clinical and economic outcomes. Clin Ther. 2011 Jan;33(1):74-109.
- Cohn T, Prud'homme D, Streiner D, Kameh H, Remington G. Characterizing coronary heart disease risk in chronic schizophrenia: high prevalence of the metabolic syndrome. Can J Psychiatry. 2004 Nov;49(11):753-60.
- Murphy SL, Xu J, Kochanek KD. Deaths: final data for 2010. Natl Vital Stat Rep. 2013 May 8;61(4):1-117.
- Nasrallah HA, Meyer JM, Goff DC, McEvoy JP, Davis SM, Stroup TS, Lieberman JA. Low rates of treatment for hypertension, dyslipidemia and diabetes in schizophrenia: data from the CATIE schizophrenia trial sample at baseline. Schizophr Res. 2006 Sep;86(1-3):15-22.
- Nielsen J, Skadhede S, Correll CU. Antipsychotics associated with the development of type 2 diabetes in antipsychotic-naive schizophrenia patients. Neuropsychopharmacology. 2010 Aug;35(9):1997-2004.
- Roger VL, Go AS, Lloyd-Jones DM, Adams RJ, Berry JD, Brown TM, Carnethon MR, Dai S, de Simone G, Ford ES, Fox CS, Fullerton HJ, Gillespie C, Greenlund KJ, Hailpern SM, Heit JA, Ho PM, Howard VJ, Kissela BM, Kittner SJ, Lackland DT, Lichtman JH, Lisabeth LD, Makuc DM, Marcus GM, Marelli A, Matchar DB, McDermott MM, Meigs JB, Moy CS, Mozaffarian D, Mussolino ME, Nichol G, Paynter NP, Rosamond WD, Sorlie PD, Stafford RS, Turan TN, Turner MB, Wong ND, Wylie-Rosett J. Heart disease and stroke statistics--2011 update: a report from the American Heart Association. Circulation. 2011 Feb 1;123(4):e18-209.
- Saatci E, Tahmiscioglu G, Bozdemir N, Akpinar E, Ozcan S, Kurdak H. The well-being and treatment satisfaction of diabetic patients in primary care. Health Qual Life Outcomes. 2010;8:67.
- Vinogradova Y, Coupland C, Hippisley-Cox J, Whyte S, Penny C. Effects of severe mental illness on survival of people with diabetes. Br J Psychiatry. 2010 Oct;197(4):272-7.

HEDIS® Tips:
Diabetes Monitoring for People with Diabetes and Schizophrenia

MEASURE DESCRIPTION

Adults 18-64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.

USE CORRECT BILLING CODES

Description	Codes
Codes to Identify HbA1c Tests	**CPT:** 83036, 83037 **CPT II:** 3044F (if HbA1c<7%), 3045F (if HbA1c 7%-9%, 3046F (if HbA1c>9%)
Codes to Identify LDL-C Tests	**CPT:** 80061, 83700, 83701, 83704, 83721 **CPT II:** 3048F, 3049F, 3050F
Codes to Identify Schizophrenia	***ICD-9 CM:** 295.00-295.05, 295.10-295.15, 295.20-295.25, 295.30-295.35, 295.40-295.45, 295.50-295.55, 295.60-295.65, 295.70-295.75, 295.80-295.85, 295.90-295.95 **ICD-10 CM:** F20.0-F20.3, F20.5, F20.81, F20.89, F20.9, F25.0, F25.1, F25.8, F25.9
Codes to Identify Diabetes	***ICD-9 CM:** 250.00-250.93, 357.2, 362.01, 362.07, 366.41, 648.00-648.04 **ICD-10 CM:** E10, E11, E13, 024

*ICD-9 codes are included for historical purposes only and can no longer be used for billing.

HOW TO IMPROVE HEDIS® SCORES

- ❑ Review diabetes services needed at each office visit.
- ❑ Order labs prior to patient appointments. PCP should notify the BH professional of forthcoming labs.
- ❑ Order a direct LDL if patient is not fasting to avoid a missed opportunity. Some lab order forms have conditional orders – if fasting, LDL-C; if not fasting, direct LDL.
- ❑ BH providers (MD, NP or other professional with lab ordering ability) should order diabetic tests for patients who do not have regular contact with their PCP. The BH provider then coordinates medical management with the PCP.
- ❑ Bill for point of care HbA1c tests if completed in office. Ensure HbA1c result and date are documented in the chart.
- ❑ Adjust therapy to improve HbA1c, LDL, and BP levels; follow-up with patients to monitor changes.
- ❑ Give any patient caregiver instructions on the course of treatment, labs or future appointment dates.
- ❑ Monitor body mass index, plasma glucose level, lipid profiles and signs of prolactin elevation at each appointment.
- ❑ Educate patients about appropriate health screenings with some medication therapies.
- ❑ Refer patients for Health Management interventions and coaching by contacting Health Care Services at your affiliated Molina Healthcare State plan.
- ❑ Care Coordination with the patient's behavioral health provider is a key component in the development of a comprehensive treatment plan.
- ❑ Ensure your patient has an understanding of the local community support resources and what to do in an event of a crisis.
- ❑ Provide information about the importance of monitoring their emotional well-being and following up with their BH provider.

Updated 12/28/17

MOLINA HEALTHCARE

Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia

Patients with schizophrenia are likely to have higher levels of blood cholesterol and are more likely to receive less treatment. Patients with schizophrenia and elevated blood cholesterol levels are prescribed statins at approximately a quarter of the rate of the general population. Furthermore, certain atypical antipsychotic drugs increase total and low-density lipoprotein (LDL) cholesterol and triglycerides, and decrease high-density lipoprotein (HDL) cholesterol, which increases the risk of coronary heart disease (Hennekens et al., 2005).

Among patients with co-occurring schizophrenia and metabolic disorders, rates of non-treatment for hyperlipidemia and hypertension were 62.4 percent for hypertension and 88.0 percent for hyperlipidemia (Nasrallah et al., 2006). Atypical antipsychotic medications elevate the risk of metabolic conditions, relative to typical antipsychotic medications (Nasrallah, 2008).

Molina Healthcare has been working on a variety of initiatives to raise awareness about the objectives of the National Committee for Quality Assurance (NCQA) HEDIS® *Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)* measure, which guide our efforts in measuring the quality and effectiveness of the care provided. This measure focuses on promoting appropriate cardiovascular monitoring for patients diagnosed with *both* cardiovascular disease and schizophrenia.

What is the HEDIS® Cardiovascular Monitoring measure?

- This measure is used to assess the percentage of patients 18 to 64 years of age with schizophrenia and cardiovascular disease who had an LDL-C test during the measurement year.

What are the best practices regarding this HEDIS® measure?

- Continue educating patients about appropriate health screenings related to certain medication therapies.
- Do not rely on the patient to follow through with scheduling prescribed appointments. Routinely arrange the lab appointment when the patient is in the office.
- Confirm that the billing code related to the selected service is a HEDIS appropriate code.

What is the relevance of this measure?

- In 2010, heart disease and diabetes were the leading causes of death in the United States (U.S.) (Murphy, Xu, & Kochanek, 2013). Because persons with serious mental illness who use antipsychotics are at increased risk of cardiovascular diseases and diabetes, screening and monitoring of these conditions is important.
- The total cost of cardiovascular disease in 2010 was estimated to be $315.4 billion (Go et al., 2014).
- Cardiovascular disease is the greatest contributor to death in patients with schizophrenia (Capasso et al., 2008).
- Lack of appropriate care for diabetes and cardiovascular disease for people with schizophrenia or bipolar disorder who use antipsychotic medications can lead to worsening health and death. Addressing these physical health needs is an important way to improve health and economic outcomes downstream.

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HEDIS® Tips:

Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia

MEASURE DESCRIPTION

Adults 18-64 years of age with schizophrenia and cardiovascular disease who had an LDL-C test during the measurement year.

Patients who have cardiovascular disease are defined as having any of the following:

- Discharged from an inpatient setting with an Acute Myocardial Infarction (AMI) or any setting with a Coronary Artery Bypass Graft (CABG) during the year prior to the measurement year,
- Patients who had a Percutaneous Coronary Intervention (PCI) during the year prior to the measurement year, or
- Patients diagnosed with Ischemic Vascular Disease (IVD) during both the measurement year and the year prior to measurement year.

USE CORRECT BILLING CODES

Description	Codes
Codes to Identify LDL–C Tests	**CPT:** 80061, 83700, 83701, 83704, 83721 **CPT II:** 3048F, 3049F, 3050F

HOW TO IMPROVE HEDIS® SCORES

- ❑ Order labs prior to patient appointments. PCP should notify the BH professional of forthcoming labs.
- ❑ BH providers (MD, NP or other professional with lab ordering ability) should order diabetic tests for patients who do not have regular contact with their PCP but who regularly see the BH provider. The BH provider can then coordinate medical management with the PCP.
- ❑ Review cardiovascular services needed at each office visit and ensure lipid levels, blood pressure and glucose are monitored at every appointment.
- ❑ Educate patient (and caregiver) about the risks associated with antipsychotic medications and cardiovascular disease and the importance of a healthy lifestyle. This includes nutrition, exercise and smoking cessation.
- ❑ For LDLs, if patient is not fasting, order direct LDL to avoid a missed opportunity.
- ❑ Adjust therapy to improve HbA1c, LDL, and BP levels; follow-up with patients to monitor changes.
- ❑ Refer patients for Health Management interventions and coaching by contacting Health Care Services at your affiliated Molina Healthcare State plan.
- ❑ Ensure your patient has an understanding of the local community support resources and what to do in an event of a crisis.
- ❑ Provide information about the importance of monitoring their emotional well-being and following up with their BH provider.

Reviewed 01/4/18

Adherence to Antipsychotic Medications for Individuals with Schizophrenia

For people with schizophrenia, nonadherence to treatment with antipsychotics is common, and medication nonadherence is a significant cause of relapse (Olfson, Hansell, & Boyer, 1997; Ascher-Svanum et al., 2010). Measuring antipsychotic medication adherence may lead to less relapse and fewer hospitalizations. Additionally, there is potential to lead to interventions to improve adherence and help close the gap in care between people with schizophrenia and the general population.

Molina Healthcare has been working on a variety of initiatives to raise awareness about the objectives of the National Committee for Quality Assurance (NCQA) HEDIS® *Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)* measure, which guide our efforts in measuring the quality and effectiveness of the care provided. This measure focuses on promoting medication adherence and compliance for patients diagnosed with schizophrenia.

What is the HEDIS® Adherence to Antipsychotic Medications measure?

- This measure is used to assess the percentage of patients 19 to 64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.

What are the best practices regarding this HEDIS® measure?

- Schedule appropriate follow-up with the patient to assess if medication is taken as prescribed.
- Continue educating patients about the importance of adhering to their medication therapy and follow-up visits with their provider(s).
- Do not rely on the patient to follow through with scheduling subsequent appointments. Routinely arrange the next appointment when the patient is in the office. If the patient misses a scheduled appointment, office staff should contact the patient to:
    - Assess why the appointment was missed
    - Reschedule the appointment and assess the possibility of a relapse
- Confirm that the billing code related to the selected service is a HEDIS appropriate code.

What is the relevance of this measure?

- Schizophrenia is a chronic and disabling psychiatric disorder that requires ongoing treatment and monitoring. Symptoms include hallucinations, illogical thinking, memory impairment and incoherent speech (American Psychiatric Association [APA], n.d.). Medication nonadherence is common and a major concern in the treatment of schizophrenia. Using antipsychotic medications as prescribed reduces the risk of relapse or hospitalization (Busch et al., 2009).
- In 2002, the overall economic burden of schizophrenia was estimated to be $62.7 billion (Wu et al., 2005).
- The cost of care for people with schizophrenia and a history of prior relapse is three times higher than it is for people without a history of prior relapse (Ascher-Svanum et al., 2010).
- 1.1 percent of adults in the United States have schizophrenia (Wu et al., 2005).
- Approximately 40 percent of hospital readmissions for patients with schizophrenia are attributed to nonadherence to antipsychotic medications (Weiden & Olfson, 1995).
- Nearly half of people with schizophrenia take less than 70 percent of prescribed medication doses (Goff, Hill, & Freudenreich, 2010).
- People with schizophrenia who discontinue their medications are twice as likely to experience a relapse in symptoms than those who continue their prescribed doses (Wunderink et al., 2007).
- Schizophrenia is a life-long mental illness that can be tough to treat and manage. Continuation of medication is important to reduce the number of relapse episodes and the need for hospitalization.

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HEDIS® Tips:

Adherence to Antipsychotic Medications for Individuals with Schizophrenia

MEASURE DESCRIPTION

The percentage of patients 19 to 64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

USE CORRECT BILLING CODES

Codes to Identify Schizophrenia

Description	Codes
Schizophrenia	***ICD-9CM:** 295.00-295.05, 295.10-295.15, 295.20-295.25, 295.30-295.35, 295.40-295.45, 295.50-295.55, 295.60-295.65, 295.70-295.75, 295.80-295.85, 295.90-295.95 **ICD-10CM:** F20.0, F20.1, F20.2, F20.3, F20.5, F20.81, F20.89, F20.9, F25.0, F25.1, F25.8, F25.9

*ICD-9 codes are included for historical purposes only and can no longer be used for billing.

Codes to Identify Long-Acting Injections

Description	Codes
Long-Acting Injections	**HCPCS:** J2794, J0401, J1631, J2358, J2426, J2680

ANTIPSYCHOTIC MEDICATIONS

Description	Generic Name	Brand Name
Miscellaneous antipsychotic agents	Aripiprazole, Asenapine, Brexpiprazole, Cariprazine, Clozapine, Haloperidol, Iloperidone, Loxapine, Lurisadone, Molindone, Olanzapine, Paliperidone, Pimozide, Quetiapine, Quetiapine fumarate, Risperidone, Ziprasidone	Abilify, Saphris, Vraylar, Clozaril, Haldol, Fanapt, Loxipac/Loxitane, Latuda, Moban, Zyprexa, Invega, Orap, Seroquel, Seroquel XR, Risperdal, Geodon
Phenothiazine antipsychotics	Chlorpromazine, Fluphenazine, Perphenazine, Perphenazine-amitriptyline, Prochlorperazine, Thioridazine, Trifluperazine	Thorazine, Prolixin, Trilafon, Etrafon, Compazine, Mellaril, Stelazine
Psychotherapeutic combinations	Fluoxetine-olanzapine	Symbyax
Thioxanthenes	Thiothixene	Navane
Long-acting injections	***28 days supply***: Aripiprazole, Fluphenazine decanoate, Haloperidol decanoate, Olanzapine, Paliperidone palmitate ***14 days supply***: Risperidone	Abilify Maintena, Prolixin, Haldol Decanoate INJ, Zyprexa Relprew, Invega Sustenna, Risperdal Consta

HOW TO IMPROVE HEDIS® SCORES

- ❑ Schedule appropriate follow-up with the patients to access if medication is taken as prescribed.
- ❑ Educate patients about the importance of adhering to their medication therapy and follow-up visits with their provider(s).
- ❑ Contact Health Care Services at your affiliated Molina Healthcare State plan for additional information about MTM criteria and to request a referral, for patients with at least six (6) chronic medications and at least three (3) qualifying diagnoses. They may be eligible for Medication Therapy Management (MTM) sessions.
- ❑ Do not rely on the patient to follow through with scheduling subsequent appointments. Routinely arrange the next appointment when the patient is in the office. If the patient misses a scheduled appointment, office staff should contact the patient to:
  - o Assess why the appointment was missed
  - o Reschedule the appointment and assess the possibility of a relapse
- ❑ Refer patients for Health Management interventions and coaching by contacting Health Care Services at your affiliated Molina Healthcare State plan.
- ❑ Ensure your patient has an understanding of the local community support resources and what to do in an event of a crisis.
- ❑ Provide information about the importance of monitoring their emotional well-being and following up with their BH provider.

HEDIS® Tips:

Use of Multiple Concurrent Antipsychotics in Children and Adolescents

MEASURE DESCRIPTION

The percentage of children and adolescents 1 to 17 years of age who were on two or more different antipsychotic medications concurrently for at least 90 consecutive days during the measurement year. A lower rate indicates better performance.

ANTIPSYCHOTIC MEDICATIONS

Description	Generic Name	Brand Name
First Generation Antipsychotic Medications	Chlorpromazine HCL, Fluphenazine HCL, Fluphenazine decanoate, Haloperidol, Haloperidol decanoate, Haloperidol lactate, Loxapine HCL, Loxapine succinate, Molindone HCL, Perphenazine, Pimozide, Thioridazine HCL, Thiothixene, Trifluoperazine HCL	Thorazine HCL , Prolixin HCL, Prolixin decanoate, Haldol, Haldol intramuscular, Haldol intravenous, Loxitane HCL, Loxitane succinate, Moban HCL, Trilaphon, Orap, Mellaril HCL, Navane, Stelazine HCL
Second Generation Antipsychotic Medications	Aripiprazole, Asenapine, Brexpiprazole, Cariprazine, Clozapine, Iloperidone, Lurasidone, Olanzapine, Olanzapine pamoate, Paliperidone, Paliperidone palmitate, Quetiapine fumarate, Risperidone, Risperidone microspheres, Ziprasidone HCL, Ziprasidone mesylate	Abilify, Saphris, Rexulti, Vraylar, Clozaril, Fanapt, Latuda, Zyprexa, Zyprexa Relprevv, Invega, Invega Sustenna, Seroquel, Risperdal, Risperdal Consta, Geodon, Geodon for injection

HOW TO IMPROVE HEDIS® SCORES

- ❑ Avoid the simultaneous use of multiple antipsychotic medications for children and adolescents per The American Academy of Child and Adolescent Psychiatry.
- ❑ Consider monotherapy as the preferred treatment option as it poses a reduced health risk burden for patients associated with multiple concurrent antipsychotics
- ❑ Monitor children and adolescents prescribed antipsychotics closely as they are more at risk for serious health concerns, including weight gain, extrapyramidal side effects, hyperprolactinemia and some metabolic effects.
- ❑ Monitor girls treated with certain antipsychotics closely as they may also be at increased risk for gynecological problems.
- ❑ Inform parents/guardians of the increased side effect burden of multiple concurrent antipsychotics on children's health has implications for future physical health concerns including obesity and diabetes.
- ❑ Ensure the parents/guardians have an understanding of the local community support resources and what to do in an event of a crisis.

Updated 1/5/18

HEDIS® Tips:

Metabolic Monitoring for Children and Adolescents on Antipsychotics

MEASURE DESCRIPTION

The percentage of children and adolescents 1 to 17 years of age who had at least two antipsychotic prescriptions of the same or different medications, on different dates of service during the measurement year, and had metabolic testing (one diabetes screening test and one cholesterol screening test).

USE CORRECT BILLING CODES

Codes to Identify Diabetes Screening		
	Description	**Codes**
Complete at least ONE Diabetes Screening test during the measurement year	Codes to Identify Glucose Tests	**CPT:** 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951
	Codes to Identify HbA1c Tests	**CPT:** 83036, 83037 **CPT II:** 3044F (if HbA1c<7%), 3045F (if HbA1c 7%-9%), 3046F (if HbA1c>9%)

Codes to Identify Cholesterol Screening		
	Description	**Codes**
--AND-- ***Complete at least ONE Cholesterol Screening test during the measurement year***	Codes to Identify LDL-C Tests	**CPT:** 80061, 83700, 83701, 83704, 83721 **CPT II:** 3048F (if less than 100 mg/dL), 3049F (if 100-129 mg/dL), 3050F (if greater than or equal to 103 mg/dL)
	Codes to Identify Cholesterol Tests (other than LDL)	**CPT:** 82465, 83718, 84478

ANTIPSYCHOTIC MEDICATIONS

Description	Generic Name	Brand Name
First Generation Antipsychotic Medications	Chlorpromazine HCL, Fluphenazine HCL, Fluphenazine decanoate, Haloperidol, Haloperidol decanoate, Haloperidol lactate, Loxapine HCL, Loxapine succinate, Molindone HCL, Perphenazine, Prochlorperazine, Pimozide, Thioridazine HCL, Thiothixene, Trifluoperazine HCL	Thorazine HCL , Prolixin HCL, Prolixin decanoate, Haldol, Haldol intramuscular, Haldol intravenous, Loxitane HCL, Loxitane succinate, Moban HCL, Trilaphon, Orap, Mellaril HCL, Navane, Stelazine HCL
Second Generation Antipsychotic Medications	Aripiprazole, Asenapine, Brexpiprazole, Cariprazine, Clozapine, Iloperidone, Lurasidone, Olanzapine, Olanzapine pamoate, Paliperidone, Paliperidone palmitate, Quetiapine fumarate, Risperidone, Risperidone microspheres, Ziprasidone HCL, Ziprasidone mesylate	Abilify, Saphris, Rexulti, Vraylar, Clozaril, Fanapt, Latuda, Zyprexa, Zyprexa Relprevv, Invega, Invega Sustenna, Seroquel, Risperdal, Risperdal Consta, Geodon, Geodon for injection
Combinations	Olanzapine-fluoxetine HCL, Perphenazine-amitriptyline HCL	Symbyax; Etrafon, Triavil

HOW TO IMPROVE HEDIS® SCORES

- ❑ Monitor glucose and cholesterol levels, for children and adolescents on antipsychotic medications as metabolic monitoring is recommended by The American Academy of Child and Adolescent Psychiatry.
- ❑ Monitor children on antipsychotic medications to help to avoid metabolic health complications such as weight gain and diabetes.
- ❑ Inform parents/guardians of metabolic problems in childhood and adolescence are associated with poor cardiometabolic outcomes in adulthood.
- ❑ Inform parents/guardians of the long-term consequences of pediatric obesity and other metabolic disturbances include higher risk of heart disease in adulthood.
- ❑ Establish a baseline and continuously monitor metabolic indices to ensure appropriate management of side-effects of antipsychotic medication therapy.

Updated 1/5/18

Risk Adjustment

The following pages provide a one page educational tool for the mental disorders that are risk adjustable as well as the codes that can be used for each mental disorder for risk adjustment purposes. Such risk adjustment codes represent a subset of all diagnostic codes for mental disorders. For a complete list of all diagnostic codes, refer to the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition). Providers should only use a risk adjustable code if it represents a condition that the Provider believes the Member has.

Risk Adjustment - Overview

Disclaimer

- Risk Adjustment is the process by which the *Centers for Medicare and Medicaid Services* (CMS) uses health status and demographic information gathered from providers and health plans to stratify patients by risk.
- This information is used to determine Medicare Advantage Plan premiums.
- Some State Medicaid programs use risk adjustment to determine premium revenue as well.
- Accurate Risk Adjustment submissions allow a complete picture of a patient's health status with resulting benefits to CMS, State Medicaid programs, health plans, providers and the beneficiary.

Risk Adjustment Diagnostic Code Sets & Documentation

CMS requires the use of specific ***diagnostic codes*** as well as accurate ***medical record documentation*** to support the diagnostic code.

Diagnostic Codes

Acceptable Risk Adjustment diagnostic codes for the behavioral health conditions listed below can be found in this document:

- Major Depressive Disorder
- Alcohol and Other Drug Dependencies
- Bipolar Disorder
- Schizophrenia

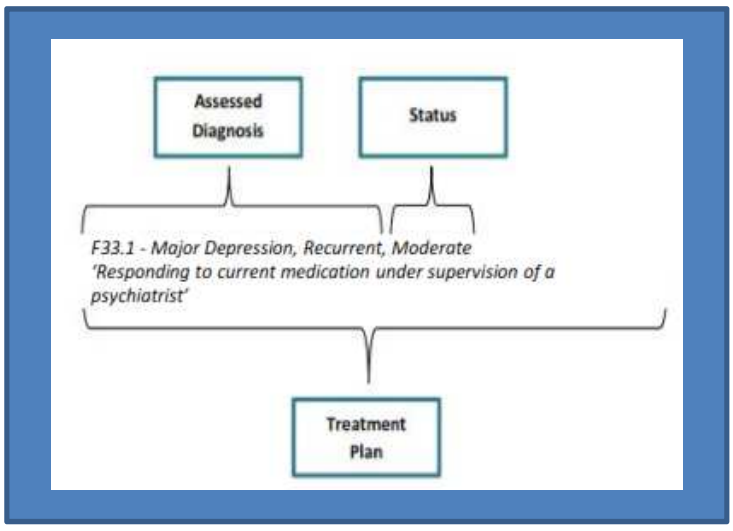
Required Medical Record Documentation

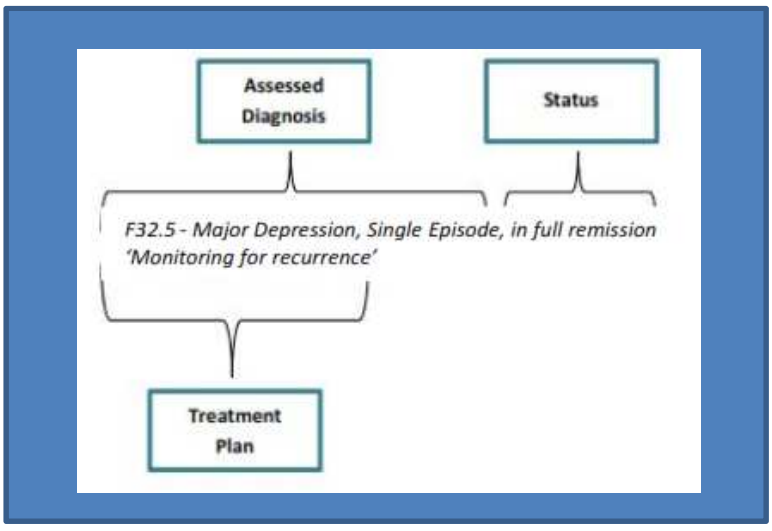
Documentation must include:

- Assessed Diagnosis - **Evidence** in chart the condition is present
- Status - **Evaluation** of the condition in the note
- Treatment Plan - Linked **plan** of action in the note

A **plan** can include:

- Description of a procedure
- Referral to a specialist
- Medication change
- Lab orders
- Monitoring, planning to follow-up





Molina Healthcare Education Tool for Major Depression (MDD)

Depression is common and impacts 15.8 million adults in the United States. Your patient's symptoms may manifest in various ways including increase in anxiety, feeling sad most of the time, or even a change in the amount of food or substances taken. Major depression affects your patient's life in multiple settings (for example, school, work, relationships).

***ICD codes capture current symptoms severity AND onset**

MDD, Single Episode Mild	MDD, Recurrent Episode Mild
ICD 10: F32.0	ICD 10: F33.0

You are able to refer your patient to Molina Healthcare's Case Management services for additional assistance.

Refer: If applicable, refer your patient to a Mental Health Professional.

73 year old female with many known episodes of Major Depression now complaining of worsening symptoms including increased loss of interest in activities, hypersomnia, increased tearfulness and sadness. Denies thoughts of self-harm.

Assessment/Diagnosis: Patient diagnosed with Major Depression, recurrent, unspecified; currently symptoms not controlled (**F33.9*, Major Depressive Disorder, recurrent, unspecified)**
Plan: Increase SSRI dosage and follow-up in 14 days with mental health counselor .

Coding & Documentation: Appropriate coding assist the patient in determining treatment options.

Diagnose: The patient's diagnosis reflects the clinical documentation.

Assess: Use a standard tool to assess the severity your patient's depressed mood.

The Patient Health Questionnaire-9 (PHQ-9) . The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression. It's a recognizing sub-threshold depressive disorders. It can be administered repeatedly, reflecting improvement or worsening of depression in response to treatment.

**For specific Risk Adjustable codes related to Major Depression, contact RAMP.Operations@MolinaHealthCare.Com

Molina Healthcare Education Tool for Bipolar Disorder

Heightening and extreme shifts between moods is characteristic of Bipolar Disorder. Patients may exhibit symptoms that are a noticeable change from their usual behavior. Practitioners may initially suspect Major Depression if the patient is experiencing depression after a manic episode. The symptoms may include: Inflated self-esteem or grandiosity; Decreased need for sleep; More talkative than usual or pressure to keep talking; Flight of ideas or subjective experience that thoughts are racing; Distractibility; Increase in goal-directed activity or psychomotor agitation; and Excessive involvement in activities that have high potential for painful consequences.

***ICD codes capture current symptoms severity AND onset**

Bipolar Disorder, current episode depressed, mild	Bipolar disorder, current episode manic without psychotic features, unspecified
ICD 10: F31.31	ICD 10: F31.10

29-year old married, mother of a young child age 2, presents with a history of recurrent and disabling depression and headaches. For the past week, she "rushes around, laughs a lot and has more anxiety." A past trial with Wellbutrin was poorly tolerate because of sweating episodes, insomnia and agitation. Several weeks ago, she became severely depressed and had difficulty moving, had diminished appetite, had crying spells much of the day and felt suicidal. She is on Prozac 20 mg a day, and describes herself as getting "manicky" on the Prozac. Her depression is worsening despite the Prozac treatment. Family history of Bipolar disorder - father and paternal grandmother.

Assessment/Diagnosis: Diagnosis of major depressive disorder is suspect, given patient's poor response to both antidepressants. Prozac was discontinued because it appeared to be worsening the underlying mood swings. Diagnosis of Bipolar Disorder, single episode, manic can be made given patient's symptoms and family history. (**ICD-10 Code:** F30.11*, Bipolar disorder, manic episode without psychotic symptoms, mild)

Plan: Discontinue Prozac. Patient placed on Seroquel 100mg at bedtime. Also referred to supportive psychotherapy.

Assess: Use a standard tool to assess the severity your patient's mood swings.

Diagnose: The patient's diagnosis reflects the clinical documentation.

Coding & Documentation: Appropriate coding assist the patient in determining treatment options.

Refer: If applicable, refer your patient to a Mental Health Professional.

You are able to refer your patient to Molina Healthcare's Case Management services for additional assistance.

The Mood Disorder Questionnaire **(MDQ)** is an effective screening instrument for bipolar disorder. The tool is not diagnostic, but is indicative of the existence of bipolar disorder. A positive screen must be followed by a clinical assessment to determine diagnosis.

**For specific Risk Adjustable codes related to Bipolar Disorder, contact RAMP.Operations@MolinaHealthCare.Com

Molina Healthcare Education Tool for Substance Use Disorders

A pattern of substance use (alcohol or other drugs) may lead to clinical impairment affecting your patient's overall health and well-being. During your evaluation of your patient, you may discover a further need to assess the frequency of use, drug of choice (prescribed or non-prescribed) due to presenting factors, including: a developed tolerance leading to more use over time; persistent inability to cut down or stop use; a strong desire or urge to use substances resulting in failure to fulfill major role obligations at work, school or home.

***ICD codes capture current symptoms severity AND onset**

Opioid Dependence with Withdrawal	Opioid Dependence with opioid-induced mood disorder
F11.23	**F11.24**

48 yo male presents with tolerance - use has increased from 12 12-oz beers daily to 18-20 12-oz beers daily. Has tried but states he's unable to stop use despite work and marriage problems due to alcohol dependence. Missing work 3-4 days/month. Late to work several times/week. Increase in intensity of arguments with wife., whom is threatening to divorce.

Assessment/Diagnosis: Patient is aware of risks of continuing use especially given A-fib and Coumadin medication therapy.
(F10.20*, Alcohol dependence, uncomplicated)

Plan: Referred patient to AA meetings or other 12-step support program. Patient will consider.

Assess: Use a standard tool to assess the severity your patient's substance use

Diagnose: The patient's diagnosis reflects the clinical documentation.

Coding & Documentation: Appropriate coding assist the patient in determining treatment options.

Refer: If applicable, refer your patient to a substance use treatment facility of provider with training in addiction

You are able to refer your patient to Molina Healthcare's Case Management services for additional assistance.

The CAGE-AID is a 4 question screening designed to quickly capture Substance Use (Alcohol and Other Drugs). Positive answers to any of these questions may indicate the need for further assessment by a clinician .

* AID refers to *"Adapted to Include Drug Use"*

**For specific Risk Adjustable codes related to Substance Use Disorders, contact RAMP.Operations@MolinaHealthCare.Com

Molina Healthcare Education Tool for Schizophrenia

Schizophrenia is a chronic, disabling brain disorder that affects more than one percent of the population. Your patient's level of functioning may dramatically decrease due to the presence of delusions, hallucinations (auditory/visual/tactile) , disorganized speech, and ability to complete activities of daily living. Symptoms usually persist for at least 6 months. Some patients previously diagnosed with Schizophrenia may be under the care of a psychiatrist. The patient may also have family members or friends helping them to maintain stability in the community.

***ICD codes capture current symptoms severity AND onset**

Paranoid Schizophrenia	Schizoaffective Disorder, Depressive Type
ICD 10: F20.0	ICD 10: F25.1

23yo male presents for office visit with a his girlfriend. During the visit, he appears to be listening to something unseen and whispers to self. His girlfriend indicates that she and patient's family are worried because lately, he has refused to answer or make calls on his cell phone, claiming that if he does it will activate a deadly chip that was implanted in his brain by evil aliens. He accuses parents of conspiring with the aliens to have him killed so they can remove his brain and put it inside one of their own. Patient drinks beer occasionally but has never been known to abuse alcohol or use drugs. Over the past few weeks his family and friends have noticed increasingly bizarre behaviors. Maternal aunt has been in and out of psychiatric hospitals over the years due to erratic and bizarre behavior.

Assessment/Diagnosis: Patient experiencing first psychotic episode. Diagnosis of Schizophrenia, first episode, currently in acute episode can be made given patient's symptoms and family history.
(F20.9*, Schizophrenia, unspecified)

Plan: Start patient on Zyprexa 10 mg daily. Refer for psychiatric assessment and individual therapy. Consider partial hospitalization program.

Assess: Current symptoms and family history.

Diagnose: The patient's diagnosis reflects the clinical documentation.

Coding & Documentation: Appropriate coding assist the patient in determining treatment options.

Refer: Refer your patient to a Psychiatrist. Work closely with your patient's psychiatrist/therapist to coordinate care.

Encourage compliance with medication regimen. Also, you are able to refer your patient to Molina Healthcare's Case Management services for additional assistance.

CLINICAL TIP:

Patients with Schizophrenia and Other Psychotic Disorders typically have multiple people involved in their care. If your patient is not able to have a focused conversation, identify if there is a legal guardian/caregiver that you can speak with on the patient's behalf. If not, try to obtain the patient's permission to speak with a family member or friend.

**For specific Risk Adjustable codes related to Substance Use Disorders, contact RAMP.Operations@MolinaHealthCare.Com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