Behavioral Health Toolkit

For Primary Care and Behavioral Health Providers

MOLINA® HEALTHCARE
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WELCOME:

Thank you for being part of the Molina Dual Options 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)

- HEDIS Tips including:
    - Follow-up After Hospitalization for Mental Illness
    - Antidepressant Medication Management
    - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

- 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.

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Contact Molina Dual Options	
PROVIDER PORTAL	https://provider.molinahealthcare.com/
California	888-665-0898/option 5
Florida	866-472-4585/option 1
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 Dual Options-affiliated Behavioral Health or Substance Use Disorder Specialist.

Contact Molina Dual Options (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 Dual Options 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 Dual Options 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 Dual Options 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 following conditions are *documented in the patient's medical record.*

- o Patient has an active diagnosis of Depression or Bipolar Disorder.
- o Patient refuses to participate.
- o 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.
- o 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 Dual Options 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				
		Total Score		

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
o Extremely difficult

Consider <u>Total Score</u> 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 Dual Options 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

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.

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 Dual Options 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 Dual Options 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 Dual Options 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 Dual Options Care Coordinator 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

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

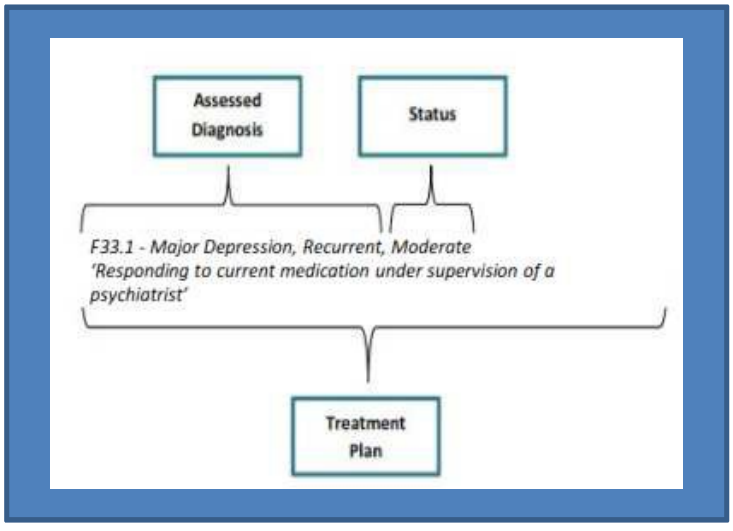
Required Medical Record Documentation

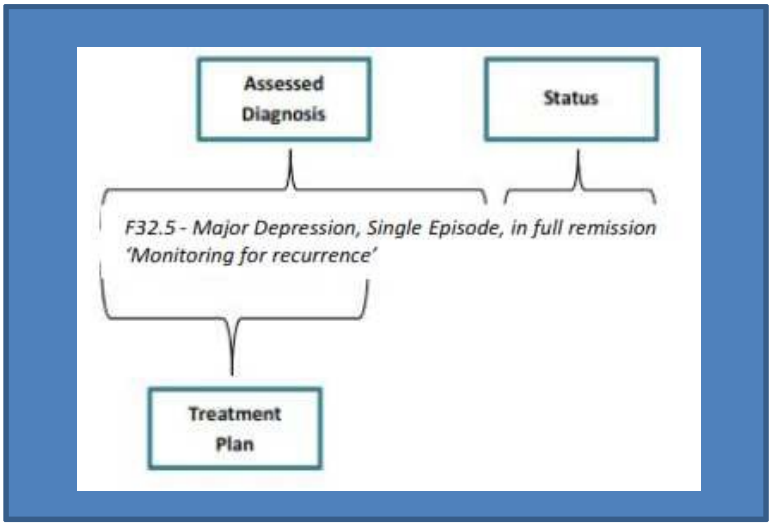
Documentation must include:

- 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 Dual Options 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

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 tearfulnessand 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 Dual Options 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 Dual Options 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 Dual Options 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

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 Dual Options 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 Dual Option'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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