Behavioral Health Toolkit
for Primary Care Providers

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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 conditions commonly seen in the Primary Care setting. Included in the toolkit are chapters addressing:

- Assessment and Diagnosis of Behavioral Health Conditions in the Primary Care Setting including:
  - Depression
  - Alcohol and Substance Use Disorders
- HEDIS Tips including:
  - Antidepressant Medication Management
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Risk Adjustment education for:
  - Major Depression
  - Alcohol and Substance Use Disorders
  - Bipolar Disorder
  - Schizophrenia

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

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Vice President, Behavioral Health

Contact Molina Healthcare

Provider Portal	https://provider.molinahealthcare.com/
California	888-665-4621/press 1
Florida	866-472-4585/press 1
Illinois	855-866-5462
Michigan	855-322-4077
New Mexico	800-377-9594/press 3
Ohio	855-322-4079
Puerto Rico	888-558-5501
South Carolina	855-237-6178
Texas	866-449-6849/press 1
Utah	888-483-0760/press 1
Washington	800-869-7165/press 1
Wisconsin	888-999-2404/press 1

Assessment and Diagnosis of Behavioral 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 Specialist.

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

Depression Screening

Molina Healthcare recommends the use of the ***PHQ-9 Depression Assessment Tool*** to assess depression.

- A component of the longer *Patient Health Questionnaire,* 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.
- Refer to Molina's ***Depression Clinical Guidelines Quick Reference Guide (QRG)*** included in this guide for recommended treatment interventions based on the results of the *PHQ-9*.
- For claims billing confirmation:
  - Use HCPCS G8431 if positive screen for clinical depression and follow-up plan is documented
  - Use HCPCS G8510 if negative screen for clinical depression.
  - Use the codes indicated above only if appropriate for the service/s rendered.

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	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself and/or your family down	0	1	2	3
7. Trouble concentrating on things such as reading the newspaper or watching television	0	1	2	3
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	0	1	2	3
9. Thoughts that you would be better off dead or thoughts of hurting yourself in some way	0	1	2	3
Scoring:	0	+ _____	+ _____	+ _____
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?

☐ **Not difficult at all** ☐ **Somewhat difficult** ☐ **Very difficult** ☐ **Extremely difficult**

Consider total score as possible indicator of level of depression. Circle the appropriate score/severity indicator	
	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression
Q.10 – 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

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

- Kroenke K, Spitzer RL, and Williams JBW. *The PHQ-9: validity of a brief depression severity measure.* J Gen Intern Med. 2001 Sep; 16(9): 606–613.

DSM-5 Diagnostic Criteria – Diagnosing Depression

Complete diagnostic criteria for *Depressive Disorders* can be found in the DSM-5 (*Diagnostic and Statistical Manual of Mental Disorders, 5th Edition*)

Overview of Criteria for Major Depressive Disorder (adapted from DSM-5)

Single Episode: 296.2x/F32.x; Recurrent Episode: 296.3x/F33.x

A. Five (or more) of the following symptoms have been present during the same 2- week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

- Depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others.
- Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.
- Significant weight loss when not dieting or weight gain or decrease or increase in appetite nearly every day.
- Insomnia or hypersomnia nearly every day.
- Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
- Fatigue or loss of energy nearly every day.
- Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day.
- Diminished ability to think or concentrate, or indecisiveness, nearly every day.
- Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

C. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

Additional Provider Resource

- **The MacArthur Foundation Initiative on Depression and Primary Care's** *Depression Management Tool Kit* can be found at http://otgateway.com/articles/13macarthurtoolkit.pdf

Depression Clinical Guidelines QRG

To ensure that Molina Member care providers are using a standardized and, effective model for managing the of quality of care for members with Depression. For the purposes of this process, the member's score on the Patient Health Questionaire (PHQ-9) will be a determinant on frequency and scope of interventions provided.

The PHQ-9, scoring instructions, and description of the 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*

NOTE: If member answers YES to question #9 no matter what the overall scoring is, crisis protocols should be followed. At all levels, crisis policies for the practice should be followed.

LOW/MAINTENANCE (MEMBER WILL HAVE ONE OR MORE OF THE FOLLOWING)

- PHQ-9 Score 0-9
- A member may also have a diagnosis of depression, but symptoms are managed by medication, therapy, or a combination of both and is maintaining self advocacy through community supports – the member is in what is considered the maintenance phase of treatment.

Interventions that can be provided at this Level:

- Provide health education/coaching on Wellness Self-Management
  - Identification of and recognition of triggers
  - Review with member self-identified healthy coping management techniques
  - Provide medication education (if member is currently on anti-depressant medications) to ensure adherence.
- Provide service coordination including transportation coordination and appointment scheduling
- Provide additional community based referrals based on member identified needs for psychosocial support needs such as: AA/Alanon, Consumer Credit Counseling, Food Assistance, Victim Assistance

MODERATE RISK (MEMBER WILL HAVE ONE OR MORE OF THE FOLLOWING)

- PHQ-9 Score between 10-19
- A member may also have identified one or more moderate risk depression items on the PHQ-9 but none in the severe range but still has a score of 9 or below
- Member has had recent hospitalization for depression (within last 6 months)

Interventions that can be provided at this Level:

- All interventions listed for LOW RISK
- Conduct medication review and education on efficacy, side effects, and proper administration to ensure adherence to treatment plans
- If member is not currently on anti-depressant medication, member should be evaluated for medication needs
- Have member identify internal and external supports – including social supports, providers, social service agency involvement, cultural supports, family as well as self identified strengths.
- Rule-out potential medical disorders that may be mimicking, masking, or affecting symptoms
- Consider referral to Molina Case Management Team for additional support

Depression Clinical Guidelines QRG

MODERATE INTERVENTIONS (CONTINUED)

- Review for ROI for coordination of care with behavioral health provider (if there is established behavioral health provider)
  - If ROI is present, contact providers and inform of current treatment plan
  - If ROI is not present, request member sign and send ROI paperwork to member with provider information completed
  - If member does not have current behavioral health provider, offer to assist member with locating provider and obtaining appointment. Coordinate ROI paperwork with provider and member once appointment is secured
- Refer for therapy if warranted and/or psychiatric assessment with psychiatrist and assist with appointment scheduling
  - If member has current behavioral health provider (medication management and/or talk therapy):
    - Contact provider to confirm next appointment and coordinate services including transportation for appointments and medication refills (can engage Health Plan CM to assist)
    - If member has BH talk therapy provider, if there is no improvement within 4-6 weeks, discuss possible assessment for medication
    - If member has Medication therapy only provider, discuss with member augmenting through talk therapy (especially if increased psychosocial stressors are present)
    - If member has a provider but no upcoming appointments, coordinate appointment scheduling
  - If member does not have behavioral health provider: (Evaluate for next steps)
    - Is member's BH medication needs being met through PCP?
      - If so, then consider referral to psychiatric prescriber (psychiatrist or nurse practitioner).
    - If not, then does member have a preference for treatment?
      - Talk therapy – counselor/therapist
      - Medication only - psychiatrist
      - Considerations for both types of providers
        - ✓ Provider gender preference
        - ✓ Cultural preferences and language needs
        - ✓ Transportation needs (i.e. on a bus line?)
        - ✓ Specific scheduling needs - Office hour needs (days, times, evening appointments needed)

HIGH RISK (MEMBER WILL HAVE ONE OR MORE OF THE FOLLOWING)

- PHQ-9 Score 20 or higher
- A member may also have identified one or more severe risk depression items on the PHQ-9 but has a score below 20
- Member has had recent hospitalization for depression (within last 1-3 months)

Interventions that can be provided at this Level:

- All interventions listed for **MODERATE RISK**
- Monitoring of post-discharge aftercare and encourage patient to be seen within the first week following discharge from inpatient psychiatric care if applicable by a behavioral health practitioner
  - Phone contact with the member to encourage them to make this scheduled aftercare appointment
  - Consider a nutritional assessment and meal plan completed by a registered dietitian
- Referral to Molina Case Management Team for additional support

- The member should receive regular re-evaluation until the member's PHQ-9 drops below 20 or the member's high-risk items have been resolved (supplemental mental health screening tools may be considered when score increases or stays constant $\geq$ 3 months)

- At the choice of the member, provide "coaching" in the form of phone contact to review member's tolerance of initial side effects of antidepressants during the 6 to 12 weeks following its prescription, given the risk this period presents to medication adherence

Screening for Clinical Depression & Follow-Up Plan for Members Enrolled in a Medicare-Medicaid Plan (MMP)

Purpose

- The *Centers for Medicare & Medicaid Services* requires all members enrolled in a Medicare-Medicaid Plan (also known as 'dual eligible') to be screened for depression on an annual basis using a standardized depression-screening tool. If positive, a follow-up plan is documented on the date of the positive screen. Depression screening and follow-up plan must be completed by a Molina Member Care Provider.
- All members who complete a physical or behavioral health outpatient visit must complete depression screening even in the absence of symptoms.
- This guidance is intended to ensure that Molina Member Care Providers are using a standardized screening tool, documenting a follow-up plan and correctly coding the service.

PHQ-9 (Standardized Depression Screening Tool)

- Molina endorses the use of the PHQ-9 (nine-question Patient Health Questionnaire), 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
- Also refer to Molina's *Depression Clinical Guidelines Quick Reference Guide* for recommended patient interventions based on risk-level.

Codes for Documenting Clinical Depression Screen

- The following HCPCS codes are required to document either a positive or a negative depression screen:

Code	Description
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.

- To improve coding capture, save these G codes as 'favorites' in your electronic medical record (EMR).

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:
  - Additional evaluation
  - Suicide risk assessment
  - Referral to a practitioner who is qualified to diagnose and treat depression
  - Pharmacological interventions
  - 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*:
  - 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

- The following HCPCS codes are required to document exclusions:

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

Alcohol and Other Drug Abuse & Dependence Screening

Molina Healthcare recommends the use of the ***CAGE-AID Screening Tool*** to assess 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
- Item responses on the CAGE-AID are scored 0 or 1, with a higher score indicating alcohol or drug use problems
- *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-opener*
- 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 ever felt that you ought to cut down on your drinking or drug use?		
2. Have people annoyed you by criticizing your drinking or drug use?		
3. Have you ever felt bad or guilty about your drinking or drug use?		
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?		
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

- Brown RL, Rounds LA. *Conjoint screening questionnaires for alcohol and other drug abuse: criterion validity in a primary care practice*. Wis Med J. 1995; 94: 135-40.

DSM-5 Diagnostic Criteria – Diagnosing Alcohol and Other Drug Abuse & Dependence

Complete diagnostic criteria for *Substance-Related and Addictive Disorders* can be found in the DSM-5 (*Diagnostic and Statistical Manual of Mental Disorders, 5th Edition*)

Overview of Criteria for Substance Use Disorder (adapted from DSM-5)

A problematic pattern of [substance] use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. [Substance] is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control [substance] use.
3. A great deal of time is spent in activities necessary to obtain [substance], use [substance], or recover from its effects.
4. Craving, or a strong desire or urge to use [substance].
5. Recurrent [substance] use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued [substance] use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of [substance].
7. Important social, occupational, or recreational activities are given up or reduced because of [substance] use.
8. Recurrent [substance] use in situations in which it is physically hazardous.
9. [Substance] use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by [substance].
10. Tolerance, as defined by either of the following:
    a. A need for markedly increased amounts of [substance] to achieve intoxication or desired effect.
    b. A markedly diminished effect with continued use of the same amount of [substance].
11. Withdrawal, as manifested by either of the following:
    a. The characteristic withdrawal syndrome for [substance].
    b. [Substance] (or a closely related substance) is taken to avoid withdrawal symptoms.

Severity

- **Mild (Abuse)**: Presence of 2-3 symptoms
- **Moderate (Dependence)**: Presence of 4-5 symptoms
- **Severe (Dependence)**: Presence of 6 or more symptoms

HEDIS Tips

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 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-10 codes to be used on or after 10/1/15

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

Updated 9/9/2015

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 Dependence Treatment

MEASURE DESCRIPTION

The percentage of adult members with a new diagnosis of alcohol or other drug (AOD) dependence with the following:

- *Initiation of AOD Treatment.* Initiate treatment through inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis.
- *Engagement of AOD Treatment.* Initiated treatment and had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

USING CORRECT BILLING CODES

Codes to Identify AOD Dependence

ICD-9-CM Diagnosis
291.0-291.5, 291.81, 291.82, 291.89, 291.9, 303.00-303.02, 303.90-303.92, 304.00-304.02, 304.10-304.12, 304.20-304.22, 304.30-304.32, 304.40-304.42, 304.50-304.52, 304.60-304.62, 304.70-304.72, 304.80-304.82, 304.90-304.92, 305.00-305.02, 305.20-305.22, 305.30-305.32, 305.40-305.42, 305.50-305.52, 305.60-305.62, 305.70-305.72, 305.80-305.82, 305.90-305.92, 535.30, 535.31, 571.1
ICD-10-CM Diagnosis (to be used on or after 10/1/15)
F10.10 – F10.20, F10.22 – F10.29, F11.10 – F11.20, F11.22 – F11.29, F12.10 – F12.20, F12.22 – F12.29, F13.10 – F13.20, F13.22 – F13.29, F14.10 – F14.20, F14.22 – F14.29, F15.10 – F15.20, F15.22 – F15.29, F16.10 – F16.20, F16.22 – F16.29, F18.10 – F18.20, F18.22 – F18.29, F19.10 – F19.20, F19.22 – F19.29

Codes to Identify Outpatient, Intensive Outpatient and Partial Hospitalization 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, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99408, 99409, 99411, 99412, 99510	G0155, G0176, G0177, G0396, G0397, G0409-G0411, G0443, G0463, H0001, H0002, H0004, H0005, H0007, H0015, H0016, H0020, H0022, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, H2035, H2036, M0064,S0201, S9480, S9484, S9485, T1006, T1012, T1015	0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0902-0907, 0911-0917, 0919, 0944, 0945, 0982, 0983

CPT		POS
90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876	WITH	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 33, 49, 50, 52, 53, 57, 71, 72
99221-99223, 99231-99233, 99238, 99239, 99251-99255	WITH	52, 53

HOW TO IMPROVE HEDIS® SCORES

- ❒ Consider using screening tools or questions to identify substance abuse issues in patients.
- ❒ If a substance abuse issue is identified, document it in the patient chart and submit a claim with the appropriate codes, as described above.
- ❒ Using diagnosis codes that are the result of alcohol or drug dependency (ex. Cirrhosis) also qualify patients for the measures, so avoid inappropriate use of these codes.
- ❒ When giving a diagnosis of alcohol or other drug dependence, 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.
- ❒ 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.
- ❒ If a Molina Care Manager contacts you about a recent encounter by a patient for substance dependency, it will be important to work collaboratively with the Care Manager to motivate the patient to initiate treatment.
- ❒ The timeframe for initiating treatment is brief (14 days) but ongoing discussions with patients about treatment help increase their willingness to commit to the process.

Updated 10/20/2015

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

- 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

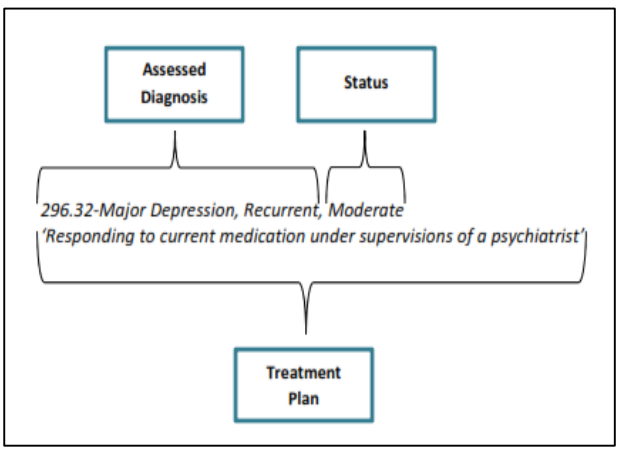
Acceptable Risk Adjustment diagnostic codes for the behavioral health conditions listed below can be found in this document:

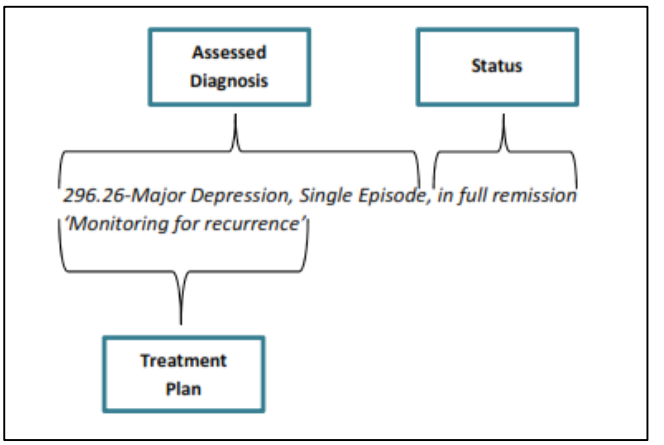
- Major Depressive Disorder
- Alcohol and Other Drug Dependencies
- Bipolar Disorder
- Schizophrenia

❖ 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 order
        - Monitoring, planning to follow-up
- Examples of complete documentation:





Molina Healthcare Education Tool
for Major Depression

Clinicians often struggle with accurately diagnosing Major Depression. The distinction between a single episode and a recurrent episode is necessary to identify and document the manifestations of your patient's disease burden. The other key factor to remember is that the term chronic can apply to a recurrent or single episode. To further clarify, a single or first time event is coded as **296.20* (ICD-9)/F32.0-F32.5* (specifier required) (ICD-10)** and any patient who has experienced subsequent episodes should be coded as **296.30* (ICD-9)/F33.9* (ICD-10).**

ICD-9: 296.20*, Major Depressive Disorder, *single episode, unspecified*

ICD-10: F32.0-F32.5*, Major Depressive Disorder, *single episode, specifier required* *(e.g., mild, F32.0*; moderate, F32.1*; severe without psychotic symptoms, F32.2*; severe with psychotic symptoms, F32.3*; in partial remission, F32.4*; in full remission, F32.5*)*

OR

ICD-9: 296.30*, Major Depression, *recurrent, unspecified*

ICD-10: F33.9*, Major Depressive Disorder, *recurrent, unspecified*

Documentation Examples:

- 65 year old Latina presenting with new onset depressive symptoms for past 2 months including daily depressed mood, loss of energy and inability to concentrate. PHQ-9 score of 12 (moderate depression).

  Assessment: Patent is newly diagnosed with major depression, single episode, moderate; needing medical and cognitive therapy

  Plan: Start Citalopram 20 mg and refer for psychotherapy

  ICD-9: 296.22*, Major Depressive Disorder, single episode, moderate

  ICD-10: F32.1*, Major Depressive Disorder, single episode, moderate

  OR

- 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: Patient diagnosed with Major Depression, recurrent, unspecified; currently symptoms not controlled

  Plan: Increase SSRI dosage and close follow-up recommended.

  ICD-9: 296.30*, Major Depression, recurrent

  ICD-10: F33.9*, Major Depressive Disorder, recurrent, unspecified

**The codes used in this document are for illustrative purposes only*

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

Have Questions?
Contact: Ramp@MolinaHealthcare.com

Major Depression Diagnoses - Risk Adjustable Codes	
ICD-9	
ICD-9 codes to be used if the date of service is before 10/1/15	
29621	Major depressive disorder, single episode-mild
29622	Major depressive disorder, single episode-moderate
29623	Major depressive disorder, single episode-severe, without mention of psychotic behavior
29624	Major depressive disorder, single episode-severe, specified as with psychotic behavior
29625	Major depressive disorder, single episode-in partial or unspecified remission
29626	Major depressive disorder, single episode-in full remission
29630	Major depressive disorder, recurrent episode-unspecified
29631	Major depressive disorder, recurrent episode-mild
29632	Major depressive disorder, recurrent episode-moderate
29633	Major depressive disorder, recurrent episode-severe, without mention of psychotic behavior
29634	Major depressive disorder, recurrent episode-severe, specified as with psychotic behavior
29635	Major depressive disorder, recurrent episode-in partial or unspecified remission
29636	Major depressive disorder, recurrent episode-in full remission

Major Depression Diagnoses - Risk Adjustable Codes	
ICD-10	
ICD-10 codes to be used on or after 10/1/15	
F32.0	Major depressive disorder, single episode-mild
F32.1	Major depressive disorder, single episode-moderate
F32.2	Major depressive disorder, single episode, severe without psychotic features
F32.3	Major depressive disorder, single episode, severe with psychotic features
F32.4	Major depressive disorder, single episode-in partial remission
F32.5	Major depressive disorder, single episode-in full remission
F33.0	Major depressive disorder, recurrent episode-mild
F33.1	Major depressive disorder, recurrent episode-moderate
F33.2	Major depressive disorder, recurrent severe without psychotic features
F33.3	Major depressive disorder, recurrent, severe with psychotic symptoms
F33.40	Major depressive disorder, recurrent, in remission, unspecified
F33.41	Major depressive disorder, recurrent episode-in partial remission
F33.42	Major depressive disorder, recurrent episode-in full remission
F33.8	Other recurrent depressive disorders
F33.9	Major depressive disorder, recurrent, unspecified

Molina Healthcare Education Tool
for Alcohol Dependency

DSM-5 diagnostic criteria for:
Alcohol dependency (moderate to severe)

A problematic pattern of alcohol use leading to clinical impairment as manifested by 4 or more of the following symptoms within a 12-month period:

1. Alcohol taken in larger amounts or over longer period than was intended.
2. Persistent desire or unsuccessful efforts to cut down or control use.
3. Large amount of time spent in activities necessary to obtain or use alcohol, or recover from effects.
4. Craving, or a strong desire or urge to use alcohol.
5. Recurrent use resulting in failure to fulfill major role obligations at work, school or home.
6. Continued use despite knowledge of having persistent or recurrent social/interpersonal problems caused or exacerbated by effects of alcohol.
7. Important social, occupational or recreational activities given up or reduced because of use.
8. Recurrent use in situations in which it's physically hazardous.
9. Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely caused or exacerbated by alcohol.
10. Tolerance, as defined by either of the following:
    a. A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.
    b. A markedly diminished effect with continued use of the same amount of alcohol.
11. Withdrawal, as manifested by either of the following:
    a. The characteristic withdrawal symptoms of alcohol.
    b. Alcohol (or a closely related substance, e.g., a benzodiazepine) is taken to relieve or avoid withdrawal symptoms.

Documentation Examples:

1. ***Assessment:*** Patient 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. Wife threatening to divorce. Patient is aware of risks of continuing use especially given A-fib and Coumadin medication therapy.

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

   ICD-9 Code: 303.90*, Alcohol dependence, unspecified

   ICD-10 Code: F10.20*, Alcohol dependence, uncomplicated

2. ***Assessment:*** Patient is alcohol dependent, sober for 8 years.

   Plan: Patient encouraged to continue abstinence and continue AA attendance.

   ICD-9 Code: 303.93*, Alcohol dependence, in remission

   ICD-10 Code: F10.21*, Alcohol dependence, in remission

**The codes used in this document are for illustrative purposes only*

The ***CAGE Questionnaire*** is an effective tool in assessing alcohol abuse and dependence. The tool is not diagnostic but is indicative of the existence of an alcohol problem. A positive screen must be followed by a clinical assessment to determine diagnosis.

Have Questions?
Contact: Ramp@MolinaHealthcare.com

Alcohol and Other Drug Dependence Diagnoses - Risk Adjustable Codes	
ICD-9	
ICD-9 codes to be used if the date of service is before 10/1/15	
30301	Acute alcohol intoxication-continuous
30302	Acute alcohol intoxication-episodic
30303	Acute alcohol intoxication-in remission
30390	Other and unspecified alcohol dependence-unspecified
30391	Other and unspecified alcohol dependence-continuous
30392	Other and unspecified alcohol dependence-episodic
30393	Other and unspecified alcohol dependence-in remission
30400	Opioid type dependence-unspecified
30401	Opioid type dependence-continuous
30402	Opioid type dependence-episodic
30403	Opioid type dependence-in remission
30410	Sedative, hypnotic or anxiolytic dependence-unspecified
30411	Sedative, hypnotic or anxiolytic dependence-continuous
30412	Sedative, hypnotic or anxiolytic dependence-episodic
30413	Sedative, hypnotic or anxiolytic dependence-in remission
30420	Cocaine dependence-unspecified
30421	Cocaine dependence-continuous

Alcohol and Other Drug Dependence Diagnoses - Risk Adjustable Codes	
ICD-9	
ICD-9 codes to be used if the date of service is before 10/1/15	
30422	Cocaine dependence-episodic
30423	Cocaine dependence-in remission
30430	Cannabis dependence-unspecified
30431	Cannabis dependence-continuous
30432	Cannabis dependence-episodic
30433	Cannabis dependence-in remission
30440	Amphetamine and other psychostimulant dependence-unspecified
30441	Amphetamine and other psychostimulant dependence-continuous
30442	Amphetamine and other psychostimulant dependence-episodic
30443	Amphetamine and other psychostimulant dependence-in remission
30450	Hallucinogen dependence-unspecified
30451	Hallucinogen dependence-continuous
30452	Hallucinogen dependence-episodic
30453	Hallucinogen dependence-in remission
30460	Other specified drug dependence-unspecified
30461	Other specified drug dependence-continuous
30462	Other specified drug dependence-episodic

Alcohol and Other Drug Dependence Diagnoses - Risk Adjustable Codes	
ICD-9	
ICD-9 codes to be used if the date of service is before 10/1/15	
\30463	Other specified drug dependence-in remission
30470	Combinations of opioid type drug with any other drug dependence-unspecified
30471	Combinations of opioid type drug with any other drug dependence-continuous
30472	Combinations of opioid type drug with any other drug dependence-episodic
30473	Combinations of opioid type drug with any other drug dependence-in remission
30480	Combinations of drug dependence excluding opioid type drug-unspecified
30481	Combinations of drug dependence excluding opioid type drug-continuous
30482	Combinations of drug dependence excluding opioid type drug-episodic
30483	Combinations of drug dependence excluding opioid type drug-in remission
30490	Unspecified drug dependence-unspecified
30491	Unspecified drug dependence-continuous
30492	Unspecified drug dependence-episodic
30493	Unspecified drug dependence-in remission

Alcohol and Other Drug Dependence Diagnoses - Risk Adjustable Codes	
ICD-10	
ICD-10 codes to be used on or after 10/1/15	
F10.20	Alcohol dependence, uncomplicated
F10.21	Alcohol dependence, in remission
F10.220	Alcohol dependence with intoxication, uncomplicated
F10.221	Alcohol dependence with intoxication delirium
F10.229	Alcohol dependence with intoxication, unspecified
F10.230	Alcohol dependence with withdrawal, uncomplicated
F10.231	Alcohol dependence with withdrawal delirium
F10.232	Alcohol dependence with withdrawal with perceptual disturbance
F10.239	Alcohol dependence with withdrawal, unspecified
F10.24	Alcohol dependence with alcohol-induced mood disorder
F10.250	Alcohol dependence with alcohol-induced psychotic disorder with delusions
F10.251	Alcohol dependence with alcohol-induced psychotic disorder with hallucinations
F10.259	Alcohol dependence with alcohol-induced psychotic disorder, unspecified
F10.26	Alcohol dependence with alcohol-induced persisting amnestic disorder
F10.27	Alcohol dependence with alcohol-induced persisting dementia
F10.280	Alcohol dependence with alcohol-induced anxiety disorder
F10.281	Alcohol dependence with alcohol-induced sexual dysfunction

Alcohol and Other Drug Dependence Diagnoses - Risk Adjustable Codes	
ICD-10	
ICD-10 codes to be used on or after 10/1/15	
F10.282	Alcohol dependence with alcohol-induced sleep disorder
F10.288	Alcohol dependence with other alcohol-induced disorder
F10.29	Alcohol dependence with unspecified alcohol-induced disorder
F11.20	Opioid dependence, uncomplicated
F11.21	Opioid dependence, in remission
F11.220	Opioid dependence with intoxication, uncomplicated
F11.221	Opioid dependence with intoxication delirium
F11.222	Opioid dependence with intoxication with perceptual disturbance
F11.229	Opioid dependence with intoxication, unspecified
F11.23	Opioid dependence with withdrawal
F11.24	Opioid dependence with opioid-induced mood disorder
F11.250	Opioid dependence with opioid-induced psychotic disorder with delusions
F11.251	Opioid dependence with opioid-induced psychotic disorder with hallucinations
F11.259	Opioid dependence with opioid-induced psychotic disorder, unspecified
F11.281	Opioid dependence with opioid-induced sexual dysfunction
F11.282	Opioid dependence with opioid-induced sleep disorder
F11.288	Opioid dependence with other opioid-induced disorder

Alcohol and Other Drug Dependence Diagnoses - Risk Adjustable Codes	
ICD-10	
ICD-10 codes to be used on or after 10/1/15	
F11.29	Opioid dependence with unspecified opioid-induced disorder
F12.20	Cannabis dependence, uncomplicated
F12.21	Cannabis dependence, in remission
F12.220	Cannabis dependence with intoxication, uncomplicated
F12.221	Cannabis dependence with intoxication delirium
F12.222	Cannabis dependence with intoxication with perceptual disturbance
F12.229	Cannabis dependence with intoxication, unspecified
F12.250	Cannabis dependence with psychotic disorder with delusions
F12.251	Cannabis dependence with psychotic disorder with hallucinations
F12.259	Cannabis dependence with psychotic disorder, unspecified
F12.280	Cannabis dependence with cannabis-induced anxiety disorder
F12.288	Cannabis dependence with other cannabis-induced disorder
F12.29	Cannabis dependence with unspecified cannabis-induced disorder
F13.20	Sedative, hypnotic or anxiolytic dependence, uncomplicated
F13.21	Sedative, hypnotic or anxiolytic dependence, in remission
F13.220	Sedative, hypnotic or anxiolytic dependence with intoxication, uncomplicated
F13.221	Sedative, hypnotic or anxiolytic dependence with intoxication delirium

Alcohol and Other Drug Dependence Diagnoses - Risk Adjustable Codes	
ICD-10	
ICD-10 codes to be used on or after 10/1/15	
F13.229	Sedative, hypnotic or anxiolytic dependence with intoxication, unspecified
F13.230	Sedative, hypnotic or anxiolytic dependence with withdrawal, uncomplicated
F13.231	Sedative, hypnotic or anxiolytic dependence with withdrawal delirium
F13.232	Sedative, hypnotic or anxiolytic dependence with withdrawal with perceptual disturbance
F13.239	Sedative, hypnotic or anxiolytic dependence with withdrawal, unspecified
F13.24	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced mood disorder
F13.250	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions
F13.251	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations
F13.259	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified
F13.26	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting amnestic disorder
F13.27	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting dementia
F13.280	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced anxiety disorder
F13.281	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sexual dysfunction
F13.282	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sleep disorder
F13.288	Sedative, hypnotic or anxiolytic dependence with other sedative, hypnotic or anxiolytic-induced disorder
F13.29	Sedative, hypnotic or anxiolytic dependence with unspecified sedative, hypnotic or anxiolytic-induced disorder
F14.20	Cocaine dependence, uncomplicated

Alcohol and Other Drug Dependence Diagnoses - Risk Adjustable Codes	
ICD-10	
ICD-10 codes to be used on or after 10/1/15	
F14.21	Cocaine dependence, in remission
F14.220	Cocaine dependence with intoxication, uncomplicated
F14.221	Cocaine dependence with intoxication delirium
F14.222	Cocaine dependence with intoxication with perceptual disturbance
F14.229	Cocaine dependence with intoxication, unspecified
F14.23	Cocaine dependence with withdrawal
F14.24	Cocaine dependence with cocaine-induced mood disorder
F14.250	Cocaine dependence with cocaine-induced psychotic disorder with delusions
F14.251	Cocaine dependence with cocaine-induced psychotic disorder with hallucinations
F14.259	Cocaine dependence with cocaine-induced psychotic disorder, unspecified
F14.280	Cocaine dependence with cocaine-induced anxiety disorder
F14.281	Cocaine dependence with cocaine-induced sexual dysfunction
F14.282	Cocaine dependence with cocaine-induced sleep disorder
F14.288	Cocaine dependence with other cocaine-induced disorder
F14.29	Cocaine dependence with unspecified cocaine-induced disorder
F15.20	Other stimulant dependence, uncomplicated
F15.21	Other stimulant dependence, in remission

Alcohol and Other Drug Dependence Diagnoses - Risk Adjustable Codes	
ICD-10	
ICD-10 codes to be used on or after 10/1/15	
F15.220	Other stimulant dependence with intoxication, uncomplicated
F15.221	Other stimulant dependence with intoxication delirium
F15.222	Other stimulant dependence with intoxication with perceptual disturbance
F15.229	Other stimulant dependence with intoxication, unspecified
F15.23	Other stimulant dependence with withdrawal
F15.24	Other stimulant dependence with stimulant-induced mood disorder
F15.250	Other stimulant dependence with stimulant-induced psychotic disorder with delusions
F15.251	Other stimulant dependence with stimulant-induced psychotic disorder with hallucinations
F15.259	Other stimulant dependence with stimulant-induced psychotic disorder, unspecified
F15.280	Other stimulant dependence with stimulant-induced anxiety disorder
F15.281	Other stimulant dependence with stimulant-induced sexual dysfunction
F15.282	Other stimulant dependence with stimulant-induced sleep disorder
F15.288	Other stimulant dependence with other stimulant-induced disorder
F15.29	Other stimulant dependence with unspecified stimulant-induced disorder
F16.20	Hallucinogen dependence, uncomplicated
F16.21	Hallucinogen dependence, in remission
F16.220	Hallucinogen dependence with intoxication, uncomplicated

Alcohol and Other Drug Dependence Diagnoses - Risk Adjustable Codes	
ICD-10	
ICD-10 codes to be used on or after 10/1/15	
F16.221	Hallucinogen dependence with intoxication with delirium
F16.229	Hallucinogen dependence with intoxication, unspecified
F16.24	Hallucinogen dependence with hallucinogen-induced mood disorder
F16.250	Hallucinogen dependence with hallucinogen-induced psychotic disorder with delusions
F16.251	Hallucinogen dependence with hallucinogen-induced psychotic disorder with hallucinations
F16.259	Hallucinogen dependence with hallucinogen-induced psychotic disorder, unspecified
F16.280	Hallucinogen dependence with hallucinogen-induced anxiety disorder
F16.283	Hallucinogen dependence with hallucinogen persisting perception disorder (flashbacks)
F16.288	Hallucinogen dependence with other hallucinogen-induced disorder
F16.29	Hallucinogen dependence with unspecified hallucinogen-induced disorder
F18.20	Inhalant dependence, uncomplicated
F18.21	Inhalant dependence, in remission
F18.220	Inhalant dependence with intoxication, uncomplicated
F18.221	Inhalant dependence with intoxication delirium
F18.229	Inhalant dependence with intoxication, unspecified
F18.24	Inhalant dependence with inhalant-induced mood disorder
F18.250	Inhalant dependence with inhalant-induced psychotic disorder with delusions

Alcohol and Other Drug Dependence Diagnoses - Risk Adjustable Codes	
ICD-10	
ICD-10 codes to be used on or after 10/1/15	
F18.251	Inhalant dependence with inhalant-induced psychotic disorder with hallucinations
F18.259	Inhalant dependence with inhalant-induced psychotic disorder, unspecified
F18.27	Inhalant dependence with inhalant-induced dementia
F18.280	Inhalant dependence with inhalant-induced anxiety disorder
F18.288	Inhalant dependence with other inhalant-induced disorder
F18.29	Inhalant dependence with unspecified inhalant-induced disorder
F19.20	Other psychoactive substance dependence, uncomplicated
F19.21	Other psychoactive substance dependence, in remission
F19.220	Other psychoactive substance dependence with intoxication, uncomplicated
F19.221	Other psychoactive substance dependence with intoxication delirium
F19.222	Other psychoactive substance dependence with intoxication with perceptual disturbance
F19.229	Other psychoactive substance dependence with intoxication, unspecified
F19.230	Other psychoactive substance dependence with withdrawal, uncomplicated
F19.231	Other psychoactive substance dependence with withdrawal delirium
F19.232	Other psychoactive substance dependence with withdrawal with perceptual disturbance
F19.239	Other psychoactive substance dependence with withdrawal, unspecified
F19.24	Other psychoactive substance dependence with psychoactive substance-induced mood disorder

Alcohol and Other Drug Dependence Diagnoses - Risk Adjustable Codes	
ICD-10	
ICD-10 codes to be used on or after 10/1/15	
F19.250	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with delusions
F19.251	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with hallucinations
F19.259	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder, unspecified
F19.26	Other psychoactive substance dependence with psychoactive substance-induced persisting amnestic disorder
F19.27	Other psychoactive substance dependence with psychoactive substance-induced persisting dementia
F19.280	Other psychoactive substance dependence with psychoactive substance-induced anxiety disorder
F19.281	Other psychoactive substance dependence with psychoactive substance-induced sexual dysfunction
F19.282	Other psychoactive substance dependence with psychoactive substance-induced sleep disorder
F19.288	Other psychoactive substance dependence with other psychoactive substance-induced disorder
F19.29	Other psychoactive substance dependence with unspecified psychoactive substance-induced disorder

Molina Healthcare Education Tool
for Bipolar Disorder

DSM-5 diagnostic criteria for:
Bipolar I disorder, manic episode

A. A distinct period of abnormally and persistently elevated, expansive or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting at least 1 week and present most of the day, nearly every day.

B. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior:
   1. Inflated self-esteem or grandiosity.
   2. Decreased need for sleep.
   3. More talkative than usual or pressure to keep talking.
   4. Flight of ideas or subjective experience that thoughts are racing.
   5. Distractibility, as reported or observed.
   6. Increase in goal-directed activity (socially, at work or school, or sexually) or psychomotor agitation.
   7. Excessive involvement in activities that have high potential for painful consequences.

C. The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

D. The episode is not attributable to the physiological effects of a substance or to another medical condition.

NOTE: A manic episode that emerges during antidepressant treatment but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a manic episode and, therefore, a bipolar I diagnosis.

Documentation Example:

A 29-year old married, mother of a young child age 2, presents with a history of recurrent and disabling depression and headaches. Several weeks prior to presentation, 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. She "rushes around, laughs a lot and has more anxiety." A past trial with Wellbutrin was poorly tolerated because of sweating episodes, insomnia and agitation. Her depression is worsening despite the Prozac treatment.

She also describes a history of mood swings for many years. Family history revealed severe mood swings in both her father and paternal grandmother. Grandmother at times would take to bed for long spells, and she had been hospitalized for "unknown reasons".

Assessment: 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.

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

ICD-9 Code: 296.01*, Bipolar I disorder, single manic episode, mild

ICD-10 Code: F30.11*, Bipolar disorder, manic episode without psychotic symptoms, mild

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.

**The codes used in this document are for illustrative purposes only*

Have Questions?
Contact: Ramp@MolinaHealthcare.com

Bipolar Disorder Diagnoses - Risk Adjustable Codes	
ICD-9	
ICD-9 codes to be used if the date of service is before 10/1/15	
29601	Bipolar I, disorder, single manic episode-mild
29602	Bipolar I, disorder, single manic episode-moderate
29603	Bipolar I, disorder, single manic episode-severe, without mention of psychotic behavior
29604	Bipolar I, disorder, single manic episode-severe, specified as with psychotic behavior
29605	Bipolar I, disorder, single manic episode-in partial or unspecified remission
29606	Bipolar I, disorder, single manic episode-in full remission
29610	Manic disorder, recurrent episode-unspecified
29611	Manic disorder, recurrent episode-mild
29612	Manic disorder, recurrent episode-moderate
29613	Manic disorder, recurrent episode-severe, without mention of psychotic behavior
29614	Manic disorder, recurrent episode-severe, specified as with psychotic behavior
29615	Manic disorder, recurrent episode-in partial or unspecified remission
29616	Manic disorder, recurrent episode-in full remission
29640	Bipolar I, disorder, most recent episode (or current) manic-unspecified
29641	Bipolar I, disorder, most recent episode (or current) manic-mild
29642	Bipolar I, disorder, most recent episode (or current) manic-moderate
29643	Bipolar I, disorder, most recent episode (or current) manic-severe, without mention of psychotic behavior
29644	Bipolar I, disorder, most recent episode (or current) manic-severe, specified as with psychotic behavior
29645	Bipolar I, disorder, most recent episode (or current) manic-in partial or unspecified remission
29646	Bipolar I, disorder, most recent episode (or current) manic-in full remission

Bipolar Disorder Diagnoses - Risk Adjustable Codes	
ICD-9	
ICD-9 codes to be used if the date of service is before 10/1/15	
29650	Bipolar I, disorder, most recent episode (or current) depressed-unspecified
29651	Bipolar I, disorder, most recent episode (or current) depressed-mild
29652	Bipolar I, disorder, most recent episode (or current) depressed-moderate
29653	Bipolar I, disorder, most recent episode (or current) depressed-severe, without mention of psychotic behavior
29654	Bipolar I, disorder, most recent episode (or current) depressed-severe, specified as with psychotic behavior
29655	Bipolar I, disorder, most recent episode (or current) depressed-in partial or unspecified remission
29656	Bipolar I, disorder, most recent episode (or current) depressed-in full remission
29660	Bipolar I, disorder, most recent episode (or current) mixed-unspecified
29661	Bipolar I, disorder, most recent episode (or current) mixed-mild
29662	Bipolar I, disorder, most recent episode (or current) mixed-moderate
29663	Bipolar I, disorder, most recent episode (or current) mixed-severe, without mention of psychotic behavior
29664	Bipolar I, disorder, most recent episode (or current) mixed-severe, specified as with psychotic behavior
29665	Bipolar I, disorder, most recent episode (or current) mixed-in partial or unspecified remission
29666	Bipolar I, disorder, most recent episode (or current) mixed-in full remission
2967	Bipolar I, disorder, most recent episode (or current) unspecified
29680	Bipolar disorder-unspecified
29681	Atypical manic disorder
29682	Atypical depressive disorder
29689	Bipolar disorder, not elsewhere classified
29690	Unspecified episodic mood disorder
29699	Other specified episodic mood disorder

Bipolar Disorder Diagnoses - Risk Adjustable Codes	
ICD-10	
ICD-10 codes to be used on or after 10/1/15	
F30.10	Manic episode without psychotic symptoms, unspecified
F30.11	Manic episode without psychotic symptoms, mild
F30.12	Manic episode without psychotic symptoms, moderate
F30.13	Manic episode, severe, without psychotic symptoms
F30.2	Manic episode, severe with psychotic symptoms
F30.3	Manic episode in partial remission
F30.4	Manic episode in full remission
F30.8	Other manic episodes
F30.9	Manic episode, unspecified
F31.0	Bipolar disorder, current episode hypomanic
F31.10	Bipolar disorder, current episode manic without psychotic features, unspecified
F31.11	Bipolar disorder, current episode manic without psychotic features, mild
F31.12	Bipolar disorder, current episode manic without psychotic features, moderate
F31.13	Bipolar disorder, current episode manic without psychotic features, severe
F31.2	Bipolar disorder, current episode manic severe with psychotic features
F31.30	Bipolar disorder, current episode depressed, mild or moderate severity, unspecified
F31.31	Bipolar disorder, current episode depressed, mild
F31.32	Bipolar disorder, current episode depressed, moderate

Bipolar Disorder Diagnoses - Risk Adjustable Codes	
ICD-10	
ICD-10 codes to be used on or after 10/1/15	
F31.4	Bipolar disorder, current episode depressed, severe, without psychotic features
F31.5	Bipolar disorder, current episode depressed, severe, with psychotic features
F31.60	Bipolar disorder, current episode mixed, unspecified
F31.61	Bipolar disorder, current episode mixed, mild
F31.62	Bipolar disorder, current episode mixed, moderate
F31.63	Bipolar disorder, current episode mixed, severe, without psychotic features
F31.64	Bipolar disorder, current episode mixed, severe, with psychotic features
F31.70	Bipolar disorder, currently in remission, most recent episode unspecified
F31.71	Bipolar disorder, in partial remission, most recent episode hypomanic
F31.72	Bipolar disorder, in full remission, most recent episode hypomanic
F31.73	Bipolar disorder, in partial remission, most recent episode manic
F31.74	Bipolar disorder, in full remission, most recent episode manic
F31.75	Bipolar disorder, in partial remission, most recent episode depressed
F31.76	Bipolar disorder, in full remission, most recent episode depressed
F31.77	Bipolar disorder, in partial remission, most recent episode mixed
F31.78	Bipolar disorder, in full remission, most recent episode mixed
F31.81	Bipolar II disorder
F31.89	Other bipolar disorder

Bipolar Disorder Diagnoses - Risk Adjustable Codes	
ICD-10	
ICD-10 codes to be used on or after 10/1/15	
F31.9	Bipolar disorder, unspecified
F33.8	Other recurrent depressive disorders
F34.8	Other persistent mood [affective] disorders
F34.9	Persistent mood [affective] disorder, unspecified
F39	Unspecified mood [affective] disorder

Molina Healthcare Education Tool
for Schizophrenia

DSM-5 diagnostic criteria for:
Schizophrenia

A. Two or more of the following, each present for a significant portion of time during a 1-month period. At least one of these must be (1), (2), or (3):
   1. Delusions.
   2. Hallucinations.
   3. Disorganized speech.
   4. Grossly disorganized or catatonic behavior.
   5. Negative symptoms.

B. For a significant portion of the time since the onset of the disturbance, level of functioning in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved prior to the onset.

C. Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms that meet Criterion A and may include periods of prodromal or residual symptoms.

D. Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out.

E. The disturbance is not attributable to the psychological effects of a substance or another medical condition.

Documentation Example:

Patient is a 21 year-old business major at a large university but has stopped attending classes altogether. Over the past few weeks his family and friends have noticed increasingly bizarre behaviors. On many occasions they've overheard him whispering in an agitated voice, even though there is no one nearby. 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.

Patient accuses parents on several occasions 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. Family history: Maternal aunt has been in and out of psychiatric hospitals over the years due to erratic and bizarre behavior.

Assessment: Patient experiencing first psychotic episode. Diagnosis of Schizophrenia, first episode, currently in acute episode can be made given patient's symptoms and family history.

Plan: Start patient on Zyprexa 10 mg daily. Refer for individual therapy and family therapy; consider partial hospitalization program.

ICD-9 Code: 295.90*, unspecified schizophrenia, unspecified condition

ICD-10 Code: F20.9*, Schizophrenia, unspecified

**The codes used in this document are for illustrative purposes only*

Have Questions?
Contact: Ramp@MolinaHealthcare.com

Schizophrenia Diagnoses - Risk Adjustable Codes	
ICD-9	
ICD-9 codes to be used if the date of service is before 10/1/15	
29501	Simple schizophrenia - subchronic condition
29502	Simple schizophrenia -chronic condition
29503	Simple schizophrenia - subchronic condition with acute exacerbation
29504	Simple schizophrenia - chronic condition with acute exacerbation
29505	Simple schizophrenia - in remission
29510	Disorganized schizophrenia-unspecified condition
29511	Disorganized schizophrenia-subchronic condition
29512	Disorganized schizophrenia-chronic condition
29513	Disorganized schizophrenia-subchronic condition with acute exacerbation
29514	Disorganized schizophrenia-chronic condition with acute exacerbation
29515	Disorganized schizophrenia-in remission
29520	Catatonic Schizophrenia- unspecified condition
29521	Catatonic Schizophrenia- subchronic condition
29522	Catatonic Schizophrenia- chronic condition
29523	Catatonic Schizophrenia- subchronic condition with acute exacerbation
29524	Catatonic Schizophrenia- chronic condition with acute exacerbation
29525	Catatonic Schizophrenia- in remission

Schizophrenia Diagnoses - Risk Adjustable Codes	
ICD-9	
ICD-9 codes to be used if the date of service is before 10/1/15	
29530	Paranoid schizophrenia- unspecified condition
29531	Paranoid schizophrenia - subchronic condition
29532	Paranoid schizophrenia - chronic condition
29533	Paranoid schizophrenia - subchronic condition with acute exacerbation
29534	Paranoid schizophrenia - chronic condition with acute exacerbation
29535	Paranoid schizophrenia - in remission
29540	Schizophreniform disorder- unspecified condition
29541	Schizophreniform disorder - subchronic condition
29542	Schizophreniform disorder - chronic condition
29543	Schizophreniform disorder - subchronic condition with acute exacerbation
29544	Schizophreniform disorder - chronic condition with acute exacerbation
29545	Schizophreniform disorder - in remission
29550	Latent schizophrenia- unspecified condition
29551	Latent schizophrenia- subchronic condition
29552	Latent schizophrenia - chronic condition
29553	Latent schizophrenia - subchronic condition with acute exacerbation
29554	Latent schizophrenia - chronic condition with acute exacerbation

Schizophrenia Diagnoses - Risk Adjustable Codes	
ICD-9	
ICD-9 codes to be used if the date of service is before 10/1/15	
29555	Latent schizophrenia - in remission
29560	Schizophrenic disorder residual type - unspecified condition
29561	Schizophrenic disorder residual type- subchronic condition
29562	Schizophrenic disorder residual type- chronic condition
29563	Schizophrenic disorder residual type- subchronic condition with acute exacerbation
29564	Schizophrenic disorder residual type- chronic condition with acute exacerbation
29565	Schizophrenic disorder residual type- in remission
29570	Schizoaffective disorder- unspecified condition
29571	Schizoaffective disorder - subchronic condition
29572	Schizoaffective disorder - chronic condition
29573	Schizoaffective disorder - subchronic condition with acute exacerbation
29574	Schizoaffective disorder - chronic condition with acute exacerbation
29575	Schizoaffective disorder - in remission
29580	Other specified types of schizophrenia- unspecified condition
29581	Other specified types of schizophrenia - subchronic condition
29582	Other specified types of schizophrenia - chronic condition
29583	Other specified types of schizophrenia - subchronic condition with acute exacerbation

Schizophrenia Diagnoses - Risk Adjustable Codes	
ICD-9	
ICD-9 codes to be used if the date of service is before 10/1/15	
29584	Other specified types of schizophrenia - chronic condition with acute exacerbation
29585	Other specified types of schizophrenia - in remission
29590	Unspecified schizophrenia - unspecified condition
29591	Unspecified schizophrenia - subchronic condition
29592	Unspecified schizophrenia - chronic condition
29593	Unspecified schizophrenia - subchronic condition with acute exacerbation
29594	Unspecified schizophrenia - chronic condition with acute exacerbation
29595	Unspecified schizophrenia - in remission
2970	Paranoid state, simple
2971	Delusional disorder
2972	Paraphrenia
2973	Shared psychotic disorder
2978	Other specified paranoid states
2979	Unspecified paranoid state

Schizophrenia Diagnoses - Risk Adjustable Codes	
ICD-10	
ICD-10 codes to be used on or after 10/1/15	
F20.0	Paranoid schizophrenia
F20.1	Disorganized schizophrenia
F20.2	Catatonic schizophrenia
F20.3	Undifferentiated schizophrenia
F20.5	Residual schizophrenia
F20.81	Schizophreniform disorder
F20.89	Other schizophrenia
F20.9	Schizophrenia, unspecified
F22	Delusional diosrders
F24	Shared psychotic disorder
F25.0	Schizoaffective disorder, bipolar type
F25.1	Schizoaffective disorder, depressive type
F25.8	Other schizoaffective disorders
F25.9	Schizoaffective disorder, unspecified

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