American Academy of Pediatrics

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AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

IMPROVING MENTAL HEALTH SERVICES IN PRIMARY CARE: REDUCING ADMINISTRATIVE AND FINANCIAL BARRIERS TO ACCESS AND COLLABORATION

BACKGROUND

The Statistics

Approximately 70% of children and adolescents who are in need of treatment do not receive mental health services. Of those who seek treatment, only 1 in 5 children use mental health specialty services. Thus, approximately 75% to 85% fail to receive specialty services, and most of these children fail to receive any services at all.[1] For the families that seek services, 40% to 50% terminate treatment prematurely because of lack of access, lack of transportation, financial constraints, child mental health professional shortages, and stigma related to mental health disorders.[1,2] Only a small proportion of these children receive treatment from mental health professionals. The vast majority of these children receive services from primary care clinicians. In 2005, 25.3% of children 4 to 17 years of age who received nonpsychopharmacologic treatment for emotional or behavioral difficulties in the past 12 months were seen by their pediatric or general medical practice.[3]

Although many mental health disorders in children are not being diagnosed, primary care clinicians have been identifying emotional and behavioral disorders in children at an increasing rate. From 1979 to 1996, pediatrician-identified psychosocial problems rose from 6.8% to 18.7% among children 4 to 15 years of age.[3] As a result, primary care clinicians are seeing a growing population of patients with mental health needs and have taken on a greater role in prescribing psychotropic medications. Between 1987 and 1996, psychotropic drug use among children and adolescents nearly tripled, growing from 1.4% to 3.9%, or more than 2 million children.[4]

The need for primary care clinicians to treat children with emotional and behavioral disorders will only continue to increase in the future. In 2005, 16% of US children 4 to 17 years of age had parents who had talked to a health care professional or school personnel about their child's emotional or behavioral difficulties in the past 12 months.[3] The federal Bureau of Health Professions estimates that simply to maintain the current utilization rates of psychiatric care, the nation will need 12 624 child and adolescent psychiatrists in 2020; unfortunately, only 8312 are anticipated to be in practice at that time.[5] In addition, the child and adolescent psychiatric workforce is not anticipated to increase significantly in future years, as the number of positions in child and adolescent psychiatry residency programs has continued to decrease—from 130 in 1980 to 114 in 2002.[5]

The American Academy of Pediatrics (AAP) Pediatric Research in Office Settings Network and the American Academy of Family Physicians' Ambulatory Sentinel Practice Network study (2000) found that pediatricians are quite variable in their sense of responsibility for providing

mental health care. Although most pediatricians surveyed reported it was their responsibility to identify children with a wide range of mental health or substance abuse disorders (eg, attention-deficit/hyperactivity disorder [ADHD], depression, anxiety, learning disorders), fewer than half reported they felt it was their responsibility to manage any disorder beyond ADHD.[6,7] This comfort level with managing ADHD is likely a result of a thoughtful and planned educational effort.

KEY ISSUES FOR PEDIATRICIANS AND PSYCHIATRISTS

Inadequate Range of Diagnostic ICD-9-CM Codes

Many time-consuming pediatric developmental and behavioral problems do not meet the criteria for a "disorder" diagnosis as specified in the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV)* and the *Internal Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM)*. These include conditions described in *The Classification of Child and Adolescent Mental Diagnoses in Primary Care: Diagnostic and Statistical Manual for Primary Care (DSM-PC)*, which emphasizes situational problems, behavioral aberrations, or concerns, which, if addressed early, might not evolve into pathology (disorders). The current array of diagnostic codes does not fully capture the wide range of developmental and behavioral problems presenting in children. Consequently, absent the codes acceptable to payers, primary care clinicians are typically not paid for their time spent identifying, treating, and managing these problems.

Mental Health Carve-outs

Given the current shortage of child psychiatrists, developmental/behavioral pediatric specialists, and child psychologists, much of the burden of treating child and adolescent behavioral disorders falls on the shoulders of primary care pediatricians. These physicians are frequently not appropriately paid for their time spent in treating and managing the care of children's mental health disorders, in large part, because of mental health "carve-outs." In many private and public insurance plans, behavioral health services, identified by the ICD-9-CM diagnostic codes 290-319 used to identify the treated condition, have been "carved out" from other health care expenditures. In such an arrangement, a managed behavioral health care organization pays only the contracted behavioral health specialists on its behavioral health "panel" for these services. Pediatricians typically are not credentialed to provide care in the mental health panel and, thus, are considered ineligible to bill for the mental health care services they provide in their office. This is a significant barrier to access to mental health care for many children and this suggests a subtle form of discrimination against children with identified mental health conditions. Only through consistent and universal parity of mental health codes with physical health codes among all third-party payers will this aspect of limited access be addressed.

In addition to "diagnostic parity," "procedural parity" has been a part of the *Current Procedural Terminology (CPT)* 908xx mental health procedure codes since their initial valuation by the Centers for Medicare and Medicaid Services (CMS) for payment under the Medicare Resource-Based Relative Value Scale (RBRVS). For fairly equivalent services, in terms of time spent and complexity of the service, evaluation and management (E/M) codes have had higher RBRVS relative value units (RVUs) assigned when compared with 908xx codes. For example (see Table 1), an initial new patient consultation visit in the office setting for concerns reflecting underlying

depression is worth 3.77 work RVUs for a professional using E/M consultation code 99245 ("consultation, new or established patient"). This is more highly valued when compared with 2.80 work RVUs earned for 90801 ("psychiatric diagnostic interview examination") customarily mandated as the appropriate code for use by mental health professionals. Not only are the 908xx codes undervalued relative to the E/M service codes, but the expected postservice work time is significantly longer for the 90801 service (55 minutes) when compared with expected postservice work for the E/M service 99245 (20 minutes). There is more work "captured" in a code, which is also undervalued in RVUs. This certainly could be a factor in many mental health providers' decision to only accept cash payment from families and not to accept these contract terms from managed care payers.

Table 1. Valuation Comparisons of Evaluation and Management Codes and Psychiatric Services

Code	Work RVUs	Nonfacility Total RVUs	RBRVS Intraservice Time (minutes)	CPT Time (minutes)	RBRVS Payment 2009: Nonfacility*
99245 Consultation: new or established patient	3.77	6.28	60	80	$226.50
90801 Psychiatric diagnostic interview exam	2.80	4.24	60	Not specified	$152.92
99215 Level five office visit: established patient	2.00	3.46	35	40	$124.79
90807 Office visit (psychotherapy w/ E/M service) (45-50 min)	2.02	2.77	50	45 to 50	$99.90
99214 Level four office visit: established patient	1.42	2.56	25	25	$92.33
90805 Individual psychotherapy with medical E/M services	1.37	1.97	30	20 to 30	$71.05

Work RVUs indicates physician work RVUs; nonfacility, practice-based setting; nonfacility total RVUs, sum of the work, nonfacility practice expense, and professional liability insurance RVUs; intraservice time, typical face-to-face time between the physician and the patient/family.

* Calculated using $36.0666, the 2009 Medicare conversion factor. For more information on the Medicare conversion factor, access the AAP RBRVS brochure at http://www.aap.org/visit/rbrvsbrochure.pdf.

Inadequate Benefit Packages

With the future implementation of the federal mental health parity law in 2010, many more Americans will have access to plans with equivalent mental and physical health benefits. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 applies to all group health plans with 50 or more employees, whether they are self-funded (regulated under ERISA) or fully insured (regulated under state law), that provide mental health or substance use benefits. However, the new law does not apply to individual health plans and health plans offered by businesses with 50 or fewer employees.

Robust implementation of the new parity law is necessary, because under current state laws, many insurance plans have policies that limit access to mental health services. These may include separate deductibles, high copays, and annual spending limits lower than those established for medical services. These policies impede access to mental health services for many children and add to pediatricians' burden in providing or finding needed care. Also adding to the issues, purchasers (eg, employers) often determine the scope of benefits coverage, thereby creating more barriers to pediatricians' ability to provide or refer to appropriate services.

Such limitations in mental health benefits frequently have been motivated by cost concerns. Experience has shown that improving children's access to outpatient mental health services may actually reduce the cost of mental health care. In 1992, North Carolina introduced full coverage parity of mental health and nonmental health conditions into its state health plan (SHP) for state employees: a single insurance deductible, full freedom of choice of mental health providers, and only moderate management of generous benefits through a contract with Value Behavioral Health.[8] By 1998, North Carolina saw mental health payments as a percentage of total health payments decrease from 6.4% to 3.1%.[9] Mental health hospital days during this period decreased by 70%.[9] This outcome was documented also by Sturm, who studied insurance plans offering parity in behavioral health spending limits.[6] These findings support the thesis that increasing access to outpatient mental health services through parity of mental health benefits is both economically and medically beneficial.[10]

Incentives to Support Colocation of Care

Physicians have a long-established pattern of extending access to their medical services through the employment of nurse practitioners and physician assistants in their offices to treat patients under their supervision. Medicare pays for these services as being billed as services provided directly by the physician so long as they are provided according to Medicare "incident to" regulations. Insurance companies follow the same billing conventions for medical services but do not provide similar economic incentives for psychiatric services provided by psychiatric advanced practice nurses, psychologists, and social workers employed in medical and psychiatric group practice settings, even though they meet the same "incident to" standards. Without this incentive, there is no recognition that a psychologist employed by a child and adolescent psychiatrist and working in the same office suite delivers team-based care that improves access to care and the complexity of service. Such incentives are important to the development of models of colocated primary and mental health care.

Lack of Payment for Non–Face-to-Face Aspects of Care

Many plans do not pay for team medical conferences among professionals involved with the

child's care, ongoing monitoring as aspects of mental health care, communication with other medical and nonmedical professionals, including consultants, teachers, and therapists; medical conferences; or many other nonclinical aspects of caring for these children (care plan oversight, health risk assessment, etc). There is growing evidence that non–face-to-face services are not only are more cost-effective but also are preferred by families because of time constraints and convenience.[11] They are also critical to care plan oversight (CPT codes 99339-99340), allowing the primary care clinician to oversee all aspects of care being provided to the patient.

CPT codes for care plan oversight (99339-99340) have RVUs published on the Medicare RBRVS and may be reported in addition to face-to-face E/M services. Payers have been uneven about payment for these services, however. Because mental health care implicitly involves coordinated care among services in school, outpatient therapies, and the care coordinator, payment denial for this care plan oversight by behavioral managed care again suggests discrimination against the child with mental health care needs.

A very significant amount of care coordination involves telephone communication beyond the typical "postservice" work included in the E/M CPT codes. Frequently, telephone care involves communication with family members. In 2006, the AAP published the "Payment for Telephone Care" policy statement citing evidence that telephone care does not increase overall health care costs. Recommendations were made for pediatricians to develop office policies and procedures to ensure consistent processes for reporting telephone care, to notify the families of their patients before initiating a fee for telephone care, and to code for appropriately-documented telephone calls (using CPT codes 99441-99443). The AAP and American Academy of Child and Adolescent Psychiatry (AACAP) have worked nationally to obtain valuation of these 3 codes. Inclusion of values for these services on the Medicare RBRVS will allow non-Medicare payers to utilize these values in establishing their own fee schedules.

Lack of Payment for Sessions With Parents Alone

Children's mental health treatment is most effective when providers develop a partnership with parents and/or other caregivers. Separate meetings with parents frequently are necessary for gathering history, providing education, and working with parents to develop strategies for helping their child and dealing with challenging behavior. Often during well-child examinations, more time is needed to speak with parents without the child present. Pediatricians are increasingly communicating face-to-face with parents and counseling them on child/adolescent developmental and behavioral issues. Child and adolescent psychiatrists and psychologists have a specific valued CPT code for this type of service (90846) but have been concerned about the lack of payment for this type of session. Payment must be supported for these sessions, which is best accomplished by paying for E/M codes for pediatricians and child and adolescent psychiatrists using time as the key factor.[12]

Access to Child and Adolescent Psychiatric Specialty Treatment

Pediatricians will encounter children whose problems do not improve with initial interventions and/or children with a severe level of impairment or complex coexisting conditions that require specialty consultation and, often, specialty treatment. The AACAP publication "When to Seek Referral or Consultation with a Child Adolescent Psychiatrist" details the parameters related to this referral process.[5]

Primary care practitioners generally need consultation in the following circumstances:

1. When a child or adolescent demonstrates an emotional or behavioral problem that constitutes a threat to the safety of the child/adolescent or the safety of those around him/her (eg, suicidal behavior, severe aggressive behavioral, an eating disorder that is out of control, other self-destructive behavior);
2. When a child or adolescent demonstrates a significant change in his or her emotional or behavioral functioning for which there is **no obvious or recognized precipitant** (eg, the sudden onset of school avoidance, a suicide attempt or gesture in a previously well-functioning individual);
3. When a child or adolescent demonstrates emotional or behavioral problems (regardless of severity) and the primary caregiver has serious emotional impairment or substance abuse problem (eg, a child with emotional withdrawal, whose parent is significantly depressed, a child with behavioral difficulties whose parents are going through a "hostile" divorce);
4. When a child or adolescent demonstrates an emotional or behavioral problem in which there is evidence of significant disruption in day-to-day functioning or reality contact (eg, a child/adolescent who has repeated severe tantrums with no apparent reason, a child reports hallucinatory experiences without an identifiable physical cause);
5. When a child or adolescent is hospitalized for the treatment of a psychiatric illness;
6. When a child or adolescent with behavioral or emotional problems has had a course of treatment intervention for 6 to 8 weeks without meaningful improvement;
7. When child or adolescent presents with complex diagnostic issues involving cognitive, psychological, and emotional components that may be related to an organic etiology or complex mental health/legal issues;
8. When a child or adolescent has a history of abuse, neglect and/or removal from home, with current significant symptoms as a result of these actions;
9. When a child or adolescent whose symptom picture and family psychiatric history suggests that treatment with psychotropic medication may result in an adverse response (eg, the prescription of stimulants for a hyperactive child with a family history of bipolar disorder or schizophrenia);
10. When a child or adolescent has had only a partial response to a course of psychotropic medication or when any child is being treated with more than 2 psychotropic medications;
11. When a child younger than 5 years experiences emotional or behavioral disturbances that are sufficiently severe or prolonged as to merit a recommendation for the ongoing use of a psychotropic medication; or
12. When a child or adolescent with a chronic medical condition demonstrates behavior that seriously interferes with the treatment of that condition.
13. When a child or adolescent is having difficulty with school performance and attempts to remediate the problem(s) by the PCP and school personnel have not resulted in significant improvement.

Joint effort involving pediatricians, child and adolescent psychiatrists, health plan administrators, and other mental health professionals should actively plan to deal with the availability of these consultation and referral services in routine, urgent, and emergency situations.

Coordination Between the Pediatrician and the Child and Adolescent Psychiatrist or Other Treating Providers

Even in the fortunate situations in which a child or adolescent psychiatrist or mental health professionals are available, unless the mental health specialist is physically colocated within the medical home, communication between these professionals and primary care physicians is often fragmented, as previously described. Thus, those providing the care are often deprived of the collegial "give and take," which enhances treatment skills and facilitates the placement of patients in the optimal therapeutic setting. For services to be effective and efficient and meet the families' needs, health care professionals must communicate and coordinate with each other as previously described.

This communication may properly involve a written report. Written summaries often requisite to fully describe all the events germane to the child's mental health condition are frequently much longer and more detailed than the usual report developed to document a physical condition or surgical procedure. Creating these documents almost always extends beyond the stated "postservice" work, and the current state of payment places the burden on the mental health provider and/or primary care clinician. There is an inherent demand for an unpaid service.

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