

Issues to Consider Using Claims Data to Measure Primary Care Screening for Depression and Substance Abuse and Follow-up for Adolescents in Oregon

Background: The Oregon Pediatric Improvement Partnership is providing consultation to the Oregon Pediatric Society (OPS) on a project to develop and implement a START module focused on screening adolescents for depression and substance abuse and creating follow-up plans within primary care practices. As part of these efforts, they are interested in measuring and assessing provider behavior related to screening and follow-up. One potential data source for measurement being considered is the claims data submitted by practices and/or maintained by the practice.

Purpose of this Brief: Before developing strategies for using claims data to measure provider behavior, OPIP wanted to gather information about potential claims-data based measures and potential issues with the reliability and validity of the measures. Specifically, OPIP was interested in the potential for two of the Oregon Coordinated Care Organization (CCO) Incentive Measure measures: **1) Depression Screening** and **2) Screening for alcohol and drug misuse, Brief Intervention, and Referral to treatment (SBIRT)**. OPIP contacted a number of public and private partner stakeholders to gather general issues related to this topic area, what is documented in the medical chart and claims data, and specific issues related to each of the measures. Included in this group were six primary care sites for which we are providing practice facilitation support that have implemented depression and substance abuse screening. Lastly, OPIP polled a number of colleagues across the country to understand claims that are used in other states to bill for and track adolescent screening and follow-up services (including the *Listserv for the National Improvement Partnership, state colleagues within the CHIPRA Demonstration Grants*).

Summary of Learnings: The feedback and input received from our various partners and colleagues highlighted a number of general and specific issues that impact whether practices submit claims related to this topic area. Secondly, there are a number of issues with the current CCO measures as they relate to adolescents and to the providers that care for adolescents. These issues are important to thoughtfully consider before practices use claims data and before a measurement strategy is anchored to use of claims data, as there are number of barriers to their use or potential unintended negative consequences. Lastly, there appear to be a number of policy-level implications from the preliminary learnings that will be highlighted for policymakers.

For this brief, we have gathered and distilled the learnings related to the following areas:

- A. *General, overarching issues (Page 2)*
- B. *Issues specific to coding related to depression screening and follow-up for adolescents (Page 3)*
- C. *Issues specific to coding related to substance abuse screening and follow-up for adolescents (Page 4)*
- D. *Practices who are billing, strategies used (Page 5)*
- E. *Strategies used in other states (Page 6)*
- F. *Potential Policy-Level Improvements Identified Through this Evaluation Measurement Exploration (Page 7)*

A. General, Overarching Issues Related to Primary Care Provider Billing of Individual Screening and Treatment Services:

1. **Adolescent Confidentiality**

- Many providers noted not wanting to submit specific claims reflecting what happened in the course of the visit in order to maintain the adolescent's confidentiality. If the claims are submitted then bills for specific screens and interventions often reveal the provision of what should be confidential services. For example, the code included in the SBIRT measure will list "brief intervention for substance abuse" on the bill received by parents, thereby violating adolescent confidentiality. This may be why NONE of the practices polled who are billing for screening are billing for intervention services. This line of reasoning is also true for what is documented in the chart, given the increased access of parents to their teens health care through portals available in the EMR.

2. **Bundled Payments and/or Capitated Payment: Lack Of Provider Billing For Individual Services**

- All of the providers we interviewed conduct screening in the context of well or preventive care visits, which is one component on the long list of things they do. For some, that means they consider the screening as a component of well visits, and are not generating separate claims for the components of that well-visit. Providers who receive bundled and/or capitated payments have a further disincentive to bill for individual processes that are included in the bundled payment.

3. **Lack Of Reimbursement From Private Plan Providers; Practice Patient Mix Matters**

- A number of practices reported the codes in the incentive metrics are non-reimbursable by private health plans. Practices cannot have differential billing patterns, so for those where a majority of their patients are NOT publicly insured, this is a real issue and barrier to using the claims. Practices are hesitant to use codes that may result in higher out-of-pocket expenses to the patient, particularly for tools that are completed by the patient like the PHQ-9 and CRAFFT which are often passed on to the patient as part of the procedural deductible.

4. **Lack Of Incentive Metric For Adolescents; Not Prioritized For Pediatric Only Providers**

- Depression Screening Incentive Metric: Currently, the incentive metric for CCOs is for individuals 18 and older. The measure is being tracked for those 12 and older.
- SBIRT Incentive Metric: The current metric for CCOs is for patients 18 and older.

5. **ICD-10 Conversion Will Impact The Current Specifications**

- The current metric includes V codes that are specific to ICD-9, and will be replaced before the end of this calendar year. Therefore, practices are hesitant to build a work-around within a coding system that will soon retire.

6. **Some Systems Are Bumping Out Codes With A "Zero Value" Assigned**

- Given the issues above, one solution could be for practices to assign "zero values" to allow for counting screening without passing on bills to patients or parents, but still submit the claims.
- However, there are some systems that are throwing out claims with zero values, making them useless for measurement. For example, OCHIN and health plans is currently removing all zero-bill claims. Practices report that some health plans are doing the same.

7. **Some Practice's Mental Health Providers Cannot Bill For Services**

- An example of this issue is currently being experienced by Treasure Valley Pediatrics in Ontario. Internally hired mental health providers are not allowed to bill as the CCO requires these services to be provided by the contracted regional mental health provider. For this reason, Treasure Valley does not submit claims for brief intervention/follow-up services for Oregon Medicaid clients.

8. **Practice Capacity To Build In Work Flows And Claims Billing**

- The screening and follow-up that should happen are discrete parts of larger well-visits. In order to submit claims, practices need to develop templates in their EMRs or charts that would then trigger those claims. Practices that are part of larger health systems are beholden to their organization prioritizing this area for customizable EMR templates and related back-end billing. Consequently, a practice's ability to do this is quite varied and may be a limiting factor in some sites.

9. **Barriers Specific to Care Provided in School Based Health Centers**

- The capacities for SBHCs collect their own claims data varies across the state (and the nation). Most FQHCs have robust systems, but a few do not. The kind of data collected and/or billed for depends a great deal on having the capacity. SBHC's also require a "parent" organization. Some SBHC's may not be the primary care provider they need to get approval from the PCP before providing follow-up services OR they need to refer, so you may not see the follow-up steps billed or in the chart.

B. Specific Issues to the CCO Incentive Measure of Depression Screening and Follow-Up For Accessing Provider Behavior for Screening Adolescents and Providing Appropriate Follow-Up

1. **Lack of Recommended Periodicity for Standardized Screening of Adolescent Upon Which to Map the Measure:** Currently there is not a specific recommendation that calls for standardized, universal depression screening, using a standardized tool to happen at a specific periodicity. Without specific guidance as to the frequency or context of depression screening, providers must individually decide the best workflow for implementing screening programs. This impacts the denominator for this measure (Any visit? Well visits only? Annually?).
2. **Measure is a Hybrid Measure– Requires Medical Chart Review Data for Validity**
 - To be valid, this measure does require a chart review and is not just anchored to claims data alone. The state is requiring “proof of concept” from the CCOs and then plans to conduct chart reviews. For practices, this will need to be considered for practice-level use.
3. **Brief screens are not included in the measure** and yet this may be the appropriate standard of care for teens and a primary outcome measure desired for the OPS adolescent project focused on enhancing primary screening. Given that screening is often conducted in the course of a well visit, content other than depression screening must be addressed (school performance, safety, nutrition, sexual health, etc.). Conducting screening with a full screen rather than starting with a brief pre-screener (such as the PHQ-2) is not feasible.
 - Currently, the CCO Depression Measure is of those who: 1) had a visit and 2) were assessed (NOT using a primary screen) and 3) have a follow-up plan. The current guidelines suggest that a pre-screener is not billable, and therefore not countable in the metric.
4. **Claims Specified in the Numerator** and Applicability for Adolescents and Providers Who Care for Adolescents
 - **G-Codes:** One set of claims specified for the numerator are G Codes.
 - Codes are intended for Medicare; therefore pediatric use is a short term solution for the CCO measure that applies to publicly insured patients.
 - ✓ Some systems will deny submission from pediatric providers or for patients who are not Medicare eligible.
 - ✓ G codes are limited to very specific providers who can bill them, which may not be the providers in this practice that are conducting the screening.
 - Variation in practice-level contracts on reimbursement
 - ✓ Example: At the beginning, one of the practices was directed by CCOs to use G0444. Within their CCO, the G code has an RVU of 0.51 and they report being reimbursed.
 - ✓ Another office (NOT within this CCO) reported that with their contracts, the G codes are not reimbursable.
5. Specifying the **Denominator** for Adolescents
 - **Visit Criteria may be too broad**
 - ✓ Again, the current measure is anchored to patients with at least one eligible encounter during measurement period
 - ✓ That said, as noted above, there is not a recommended periodicity for use of standardized screening tools and explicit statement related to follow-up steps.
 - ✓ The practices that are currently doing this are doing this in the **context of well or preventive care visits.**
 - ✓ Therefore, it may be valuable to consider the “eligible” visit criterion specific to adolescent screening.
 - ✓ Further, to ensure adolescent confidentiality, parents would need to be excused from acute care visits to accurately conduct screening, which presents difficulties in the workflow and efficiency of these visits; providers fear that parents would be

suspicious of such a request given the current culture of practice typically doesn't exclude parents from visits for illness or injury.

- **Exclusions and Exceptions:** Patients with active diagnosis for depression or bi-polar. This may be difficult for practices to identify and exclude using their claims data systems.
6. **The Metrics and Scoring Committee will need to Examine Issues with the Current Measure & Identifying Solutions (*Therefore the current specifications should not be considered gold standards or final upon which to base a measurement strategy*)**
- The committee will be considering expanding the incentive metric for depression screening and documented follow-up plan to include all patients over the age of 12 years. If this expansion occurs, consideration will need to be given to the differences between Medicaid and Medicare billing, policy level implications for ensuring confidentiality, and other unique aspects of pediatric care. These issues will need to be addressed by the Technical Advisory Group that analyzes measure specifications for the committee.
 - Options currently being explored to enhance the accuracy of the measures:
 - ✓ Adding the V code (**V79.1**) for screening for alcohol abuse to the well visit code as a secondary diagnosis. In theory, this would make things countable (not reimbursable) in terms of how many got a screening tool. Downside: the V code does not specify what tool was used (*was it a valid tool*) and obviously doesn't measure any aspect of the brief intervention / referral part. That would still require a chart review. Also technically only refers to alcohol screening, not substance abuse screening.
7. **None of the practices who responded to OPIP's questions who are screening adolescents using the PH-2 or PH-Q9 are using codes or documenting in a standardized way the follow-up.**

C. Specific Issues to the CCO Incentive Measure of Substance Abuse Screening and Follow-Up

1. **Lack of Recommended Periodicity for Universal Substance Abuse Screening Using a Standardized Tool Upon Which to Map the Measure:** There is not a specific recommendation that calls for substance abuse screening, using a standardized tool, to happen at a specific periodicity. Therefore, this impacts the appropriate denominator for this measure. Currently, Bright Futures recommends an assessment at well visits above the age of 11, with follow up steps taken if appropriate, and includes reference to the use of the CRAFFT. However, Bright Futures does not specify whether other visits should include screening, and does not necessarily require the use of validated tools.
2. **Brief screens are not included in the measure** and yet this may be the appropriate standard of care for teens and a primary measure desired for the project. Although it seems less common, a practice could appropriately use the first three items of the CRAFFT first and then only ask the remaining questions for teens who flag on the 1st screen. This first phase of screening is not included in this measure.
3. **Measures in Anchored to Those Who Were Screened, Identified at Risk, and Who Received an Intervention**
 - Therefore, the measure does not capture each of the individual process (screen, intervention, and referral) that may be of focus for the OPS adolescent project.
 - The current measure and projected improvements are based population-based estimates.
 - ✓ Targets used by CCOs are estimates of how many brief screens should be positive (based on the adult literature) that would likely trigger the full screen.
 - Then they are using estimation of how many of the positive full screens (using the adult literature) need brief intervention versus referral in order to identify the claims codes related to follow-up included in the measure.

- Estimates of prevalence and potential for improvements will need to be considered specifically for adolescents.
- 4. **Potential Issues with the 99420 Claim**
 - a. There is lack of clarity around the acceptability and terms of using the 99420 claim reported by some.
 - i. It is unclear whether a 99420 claim can be submitted with a well-child visit claim.
 - ii. It is unclear whether multiple 99420 claims can be submitted with one encounter.
- 5. **Potential Issues with How “Intervention” is Assessed Using the Claims Specified.**
 - a. Currently the incentive metric allows for some “grey” areas related to what counts for an “intervention”.
 - i. For example, they allowing 99420, with diagnoses code v79.1 or v82.9, for patients who received a full screen based on responses to the annual brief screening.
 - ii. There are no time limitations or requirements for this code.
 - iii. This claim can validly used by providers when a brief intervention lasting less than 15 minutes is performed. It can also be validly used by providers who screen and talk about the screen, but don’t do a brief intervention.
- 6. **None of the practices who responded to OPIP’s questions who are screening adolescents using the CRAFFT are using codes related to intervention.**

D. Practices in Oregon Who are Billing for Adolescents (We know of only Two) – What are they doing?

Pediatric Practices Billing for Adolescent Screening:

1) Pediatric Practice #1: 60% Medicaid, Primarily one CCO – who is engaged, Suburban

- i. **Using -33 modifier** on both CPT codes billing for CRAFFT and Depression Screening.
 - Use -33 modifier Preventive Service: Use when the primary purpose of the service is the delivery of an evidence-based service in accordance with a US Preventive Services Task Force A or B rating in effect; Preventive care and screenings for children as recommended by Bright Futures (American Academy of Pediatrics) and Newborn Testing (American College of Medical Genetics) as supported by the Health Resources and Services Administration; and 4. Preventive care and screenings provided for women (not included in the Task Force recommendations) in the comprehensive guidelines supported by the Health Resources and Services Administration.
- ii. Billing for Substance Abuse Assessment (CRAFFT: use the full tool)
 - **99420** (99420 - Administration of health risk assessment instrument (e.g., health hazard appraisal)) for all CRAFFT screens; **Coupled with V79.1** (Screening for alcoholism)
 - Not billing for intervention.
- iii. Depression Screening (Using the PHQ-9)
 - **Billing G0444** – annual depression screening, 15 minutes (Per request of CCO, only reimbursed by their CCO)
 - Not billing for intervention.

2) Practice #2: 44% Publicly insured, Located in Suburban Area of Portland, Multiple CCOs

- I. Don’t use modifiers. Find the codes then get bundled and they don’t get reimbursed.
- II. Substance abuse screening (Using the full CRAFFT)
 - **Billing V65.42** Counseling on substance use and abuse and pair with 96110
 - ii. Depression Screening (Using the PHQ-2)
 - **v79.0 and pair with 99420** for depression screening
 - Not billing for intervention.

E. What is Happening In Other States: Codes Being Used to Assess Screening (None of the Persons Queried Reported Measures of Intervention)

Below is a high-level notation of claims colleagues in other states reported using for depression or substance abuse screening in adolescents. None of the colleagues who responded to OPIP's request for information reported billing for intervention services to date.

- **Connecticut:** Health Risk Assessment code **99420 as well as 96110** for mental health screening. Practices use modifier 59 and get payment from Medicaid and commercial insurers. (Lisa Honigfeld)
- **Indiana:** Health risk assessment (e.g., mental health, substance abuse screening) = **99420** for general depression screening. For Perinatal depression = **H1000** for prenatal risk screening; 99420 with HD modifier for postpartum depression screening (*can bill on Mom's claim or if screening conducted during a well child visit within first year of life can be billed using infant's recipient ID number*) (Julie B. Doetsch)
- **MassHealth :** Allows practices to claim for use of a standardized screening tool, chosen from a list of screening tools approved by MassHealth and included in its EPSDT regulations (includes PHQ9, PSC, and several others). Providers bill using **96110**, with a modifier that identifies the type of provider that administered the screening (MD, NP, etc, as these pay different rates) and whether the screen was positive or negative. MassHealth is not able to tell from the modifier which screening tool was used. (Louise Bannister)
- **North Carolina:** Working with practices on routine strengths and risks screening at well-visits for school-age patients and adolescents. The most common screens are PSC (school age) and Bright Futures Adolescent Supplemental. Specific secondary screens are used then as indicated: PHQ-9 Modified for Adolescents, SCARED, CRAFFT, Vanderbilt, etc. In NC, the code for all of these is **99420 and a practice can bill up to 2 per visit**. This work is happening inside their work on adolescent care, confidentiality, etc. Secondly, as part of the model EHR project happening in NC, they are looking into ways to document intervention - mental health integrated in practice, referral out, closer follow-up using common factors approaches and support. They are not tracking therapy claims codes. These could be very difficult to associate with a primary care provider visit unless integrated mental health professional in the practice. (Marian Earls)

See next page.

F. Potential Policy-Level Improvements Identified Through this Evaluation Measurement Exploration

- **Policies to Support and Protect Adolescent Confidentiality when Obtaining Services:** On a global level, there is confusion about what services, at what age, the teen has the right to access confidentially and clearer and explicit policies that practices could cite would be valuable. A number of the issues identified related to lack of documentation or use of claims data as providers didn't want documentation that could be shared with parents in way that may violate the teen's rights to confidential services. This is becoming an increasing issue with practices adopting patient portals and the related issues of what access the parent has to the teen's health care that is documented in the patient portal. Therefore, also addressing this issue in the health information technology and sharing discussions would be invaluable.
- **Policies Related to the Specific Codes:** A number of the policy issues were raised with the specific codes currently included in the incentive metrics:
 - Codes that pediatric providers or providers of specific kind can't bill.
 - Lack of clarity about whether specific screen codes can be submitted at the time of a well-visit code.
 - Lack of clarity about the number of codes that can be submitted for a specific visit.
- **Policies Related to State Standards and Expected Elements of Care:** There is some grey area in terms of expectations, and related payment supports, for adolescent well visits and the periodicity and level of substance abuse and depression screening recommended.
- **Policies Related Bundled and/or Capitated Payments with Expectations for Individual Claims Code Billing for Measurement Purposes :** Providers who receive bundled/capitated payments have a further disincentive to bill for individual processes that are included in the bundled payment. Furthermore, all of the providers we interviewed conduct screening in the context of well or preventive care visits, which is one component on the long list of things they do. For some, that means they consider the screening as a component of well visits, and are not generating separate claims for the components of that well-visit.

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