

MEETING HIGHLIGHTS

MENTAL HEALTH CARE AND CHEMICAL DEPENDENCY SUBCOMMITTEE Clackamas Community College Wilsonville Training Center, Room 111

Wilsonville, Oregon

December 15, 2010

8:30 a.m. – 12:00 p.m.

Members Present: Donalda Dodson, RN, MPH, Chair; Kathy Savicki, LCSW, Michael Reaves, MD; David Pollack, MD; Ann Uhler; Seth Bernstein, PhD; Carole Romm, RN; Larry Betcher, MSW, LCSW.

Members Absent: Gary Cobb.

Staff Present: Darren Coffman; Cat Livingston, MD, MPH; Jason Gingerich, Dorothy Allen (by phone).

Guests: Caroline Price, DMAP.

Please see Attachment A for a summary of the recommendations being forwarded to the Health Services Commission on January 13, 2011.

Topic: Review of Meeting Highlights

Discussion

November 17, 2010 draft highlights reviewed and accepted.

Action:

Dorothy Allen will post final highlights on the website.

Topic: HSC/OHA Update

Discussion:

Darren Coffman reported the Health Outcomes Subcommittee met on December 15, 2010. Along with the new CPT codes review, they added the MHCD-recommended alcohol and drug (A&D) treatment plan code to be carried to the HSC for final approval.

The Oregon Health Policy Board met yesterday and heard feedback from focus groups which had been conducted state-wide with employers, consumers, providers and insurers on value-based benefit design. Reaction was mixed. Some believe it will result in high administrative costs and higher cost sharing for many and others believe it is too hard to explain and administrate. The Board holds firm the design is logical and other cost cutting measures are more arbitrary. They are ready to suggest implementation, after a look at simplification.

Proposed cuts to the Oregon Health Plan were mentioned, which includes a proposal to move the funding line on the Prioritized List of Health Services. The current funding level is through line 502 (Cysts of Bartholin's Gland and Vulva). One proposal would be to raise the funding level just below line 492 (Chronic Otitis Media). Classically, CMS has

not approved cuts which de-fund coverage of chronic otitis media. Another proposal would have 50 lines removed from coverage.

Regarding national health reform, Dr. David Pollock mentioned a very informative video, produced by the Keizer Family foundation which is worth viewing. "Health Reform Explained" video can be viewed at: <http://healthreform.kff.org/the-basics.aspx>

Topic: AMHD Update - Maternal Depression

David Fischer could not attend and there is no update on this topic.

Topic: ICD-10-CM Conversion

Note: All line numbers indicated in this section are tentative lines for the Biennial List which will go into effect on January 1, 2012.

ICD-10-CM Codes Mapping to MHCD and Dysfunction Lines

Line 305 Anorexia Nervosa

ICD-10-CM codes:

F50.00 Anorexia nervosa, unspecified

F50.01 Anorexia nervosa, restricting type

F50.02 Anorexia nervosa, binge eating/purging type

Decision: The codes belong on line 305.

Line 316 Acute Stress Disorder

Decision: ICD-10-CM code F43.0, Acute stress reaction, is correctly placed as the only code on line 316.

Line 318 Neurological Dysfunction in Posture and Movement Caused By Chronic Conditions

ICD-10-CM codes:

F84.3 Other childhood disintegrative disorder

F84.8 Other pervasive developmental disorders

F01.50 Vascular dementia without behavioral disturbance

F01.51 Vascular dementia with behavioral disturbance

F03 Unspecified dementia

F06.1 Catatonic disorder due to known physiological condition

F06.8 Other specified mental disorders due to known physiological condition

F84.0 Autistic disorder

Discussion: Darren mentioned there is a separate review of this line being conducted by Dr. Tina Kitchin of DHS SPD. Kathy stated the codes listed are in the mental health codeset but all the interventions are medical therapy.

Decision: All codes listed in the meeting materials belong on line 318.

Rationale: David commented it is useful to acknowledge these mental health conditions merit medical interventions. Michael commented philosophically this fits well with the new proposed Organic Mental Health Disorder guideline he and Seth have been drafting.

Line 334 Autism Spectrum Disorders

ICD-10-CM codes:

F84.3 Other childhood disintegrative disorder

F84.5 Asperger's syndrome

F84.8 Other pervasive developmental disorders

F84.9 Pervasive developmental disorder, unspecified
F84.0 Autistic disorder

Discussion: Kathy suggested renaming the line to make it more inclusive of the ICD-10-CM code placements. Seth argued perhaps the non-autism codes should be moved to a different line. Kathy felt it is fine to keep the codes together as the interventions are similar. David agreed and stated ASD is a component of PDD.

Decision: Rename Line 334 and the guideline to Pervasive Developmental Disorders, including Autism Spectrum Disorders.

Rationale: To clarify the line's coding composition.

Line 375 Neurological Dysfunction in Communication Caused by Chronic Conditions

ICD-10-CM codes:

F84.3 Other childhood disintegrative disorder

F84.8 Other pervasive developmental disorders

F01.50 Vascular dementia without behavioral disturbance

F01.51 Vascular dementia with behavioral disturbance

F03 Unspecified dementia

F06.1 Catatonic disorder due to known physiological condition

F06.8 Other specified mental disorders due to known physiological condition

F84.0 Autistic disorder

Decision: Make no changes.

Line 390 Conversion Disorder, Child

Line 390 ICD-10-CM codes:

F44.9 Dissociative and conversion disorder, unspecified

F44.4 Conversion disorder with motor symptom or deficit

F44.5 Conversion disorder with seizures or convulsions

F44.6 Conversion disorder with sensory symptom or deficit

F44.7 Conversion disorder with mixed symptom presentation

Discussion: Darren stated the codes map to lines 390 and 518, which makes a distinction between coverage for children (line 390) and adults (below the funding line at line 518). Kathy stated interventions for children are more effective and affects the "impact on healthy life years" category so the line scoring places one above and one below the line. David asked where somatoform disorder falls (line 398) and suggested the treatments and outcomes for adult conversion disorder might be well matched with the interventions for somatoform disorder.

Decision: Kathy and David suggested to combine lines 390 (Conversion Disorder, Child), 398 (Somatization Disorder; Somatoform Pain Disorder) and 518 (Conversion Disorder, Adult) to create a new line titled "Somatization Disorder; Somatoform Pain Disorder, Conversion Disorder," and add "Medical/Psychotherapy" as the treatment description, to the agreement of the subcommittee members.

ICD-10-CM Codes to combine on new line:

From Line 398 Somatization Disorder; Somatoform Pain Disorder

F45.0 Somatization disorder

F45.1 Undifferentiated somatoform disorder

F45.20 Hypochondriacal disorder, unspecified

F45.21 Hypochondriasis

F45.22 Body dysmorphic disorder

F45.29 Other hypochondriacal disorders

F45.41 Pain disorder exclusively related to psychological factors

F45.42 Pain disorder with related psychological factors
F45.8 Other somatoform disorders
F45.9 Somatoform disorder, unspecified
F52.5 Vaginismus not due to a substance or known physiological condition

From Line 518 Conversion Disorder, Adult
F44.9 Dissociative and conversion disorder, unspecified
F44.4 Conversion disorder with motor symptom or deficit
F44.5 Conversion disorder with seizures or convulsions
F44.6 Conversion disorder with sensory symptom or deficit
F44.7 Conversion disorder with mixed symptom presentation

The new line will be rescored at the February, 2011 meeting.

Rationale: The conditions are similar and are generally manageable and similar in outcomes. Referral of these conditions will generally come from the medical side. There is minimal financial impact from this change.

Line 407 Dysfunction Resulting in Loss of Ability to Maximize Level of Independence in Self-directed Care Caused by Chronic Conditions that Cause Neurological Dysfunction

F84.3 Other childhood disintegrative disorder
F84.8 Other pervasive developmental disorders
F01.50 Vascular dementia without behavioral disturbance
F01.51 Vascular dementia with behavioral disturbance
F03 Unspecified dementia
F06.1 Catatonic disorder due to known physiological condition
F06.8 Other specified mental disorders due to known physiological condition
F84.0 Autistic disorder

Discussion: This line is similar to line 318, above.

Decision: All codes listed belong on line 407.

Rationale: These mental health conditions merit medical interventions.

Line 412 Bulimia Nervosa

Discussion: The members discussed the differences between bulimia and anorexia in terms of severity, impact and treatment outcomes.

Decision: ICD-10-CM code F50.2, Bulimia nervosa, is appropriately placed on line 412.

Rationale: This condition has much less of a physical impact than anorexia.

417 Separation Anxiety Disorder

Discussion: Does ICD-10-CM code F93.0, Separation anxiety disorder of childhood, belong on its own line? Kathy questioned if there is a need to have this condition separate from other similar conditions.

Decision: Members agreed it does.

Rationale: This is a distinct disorder from other anxiety disorders.

419 Panic Disorder; Agoraphobia

ICD-10-CM codes:

F40.00 Agoraphobia, unspecified
F40.01 Agoraphobia with panic disorder
F40.02 Agoraphobia without panic disorder

F41.0 Panic disorder [episodic paroxysmal anxiety] without agoraphobia
Decision: The codes above are properly placed on line 419.

Line 425 Eating Disorder NOS

F50.8 Other eating disorders

F50.9 Eating disorder, unspecified

F98.29 Other feeding disorders of infancy and early childhood

Discussion: David stated this line could be combined with the bulimia line. The group discussed other eating related conditions such as pica and failure to thrive as having similar features, interventions and outcomes.

Decision: Create new line titled "Feeding and Eating Disorders of Infancy or Childhood" to be combined with the pica, eating disorder and rumination of infancy lines. Eliminate line 425. Leave the bulimia line as it is.

- Move F50.8 to Signs and Symptoms file.
- Move F50.9 to bulimia line.
- Move F98.29 to new pica, rumination, feeding and eating line.

The new line will be rescored at the February, 2011 meeting.

Rationale: Converting the lines to match what is in the DSM-IV.

Line 431 Dissociative Disorders

ICD-10-CM codes:

F44.2 Dissociative stupor

F44.89 Other dissociative and conversion disorders

F44.0 Dissociative amnesia

F44.1 Dissociative fugue

F44.81 Dissociative identity disorder

F48.1 Depersonalization-derealization syndrome

Decision: The codes above are appropriate on line 431.

Line 437 Schizotypal Personality Disorders

Decision: ICD-10-CM code F21 is appropriate on line 437.

Line 445 Oppositional Defiant Disorder

Decision: ICD-10-CM code F91.3, Oppositional defiant disorder, is properly placed.

Line 457 Chronic Depression (Dysthymia)

Decision: ICD-10-CM code F34.1, Dysthymic disorder, is properly placed.

Line 462 Stereotypy/Habit Disorder and Self-Abusive Behavior Due to Neurological Dysfunction

Decision: ICD-10-CM code F98.4, Stereotyped movement disorders, is properly placed.

Line 469 Adjustment Disorders

ICD-10-CM codes:

F43.20 Adjustment disorder, unspecified

F43.21 Adjustment disorder with depressed mood

F43.22 Adjustment disorder with anxiety

F43.23 Adjustment disorder with mixed anxiety and depressed mood

F43.24 Adjustment disorder with disturbance of conduct

F43.25 Adjustment disorder with mixed disturbance of emotions and conduct
F43.29 Adjustment disorder with other symptoms
F43.8 Other reactions to severe stress
F43.9 Reaction to severe stress, unspecified

Discussion: David suggested moving codes F43.8 and F43.9 to line 316, Acute Stress Disorder. Further discussion argued against moving an unspecified code higher on the list.

Decision: Move F43.8 and F43.9 to Excluded file

Rationale: Generally, ambiguous unspecified codes are not covered. Practitioners should code more specifically.

Line 471 Tourette's Disorder and Tic Disorders

ICD-10-CM codes:

F95.0 Transient tic disorder
F95.1 Chronic motor or vocal tic disorder
F95.2 Tourette's disorder
F95.8 Other tic disorders
F95.9 Tic disorder, unspecified

Decision: Codes are appropriate as listed.

Rationale: The unspecified code included here is appropriate as a tic disorder has a physical or vocal manifestation even if the cause isn't immediately apparent.

Line 474 Reactive Attachment Disorder of Infancy or Early Childhood

ICD-10-CM codes:

F94.1 Reactive attachment disorder of childhood
F94.2 Disinhibited attachment disorder of childhood
F98.8 Other specified behavioral and emotional disorder

Decision: Move F98.8 to Signs and Symptoms file.

Rationale: This would allow for assessment and referral to mental health if appropriate.

Line 481 Factitious Disorders

ICD-10-CM codes:

F68.10 Factitious disorder, unspecified
F68.11 Factitious disorder with predominantly psychological signs and symptoms
F68.12 Factitious disorder with predominantly physical signs and symptoms
F68.13 Factitious disorder with combined psychological and physical signs and symptoms

Decision: Codes are appropriate as listed.

Line 483 Simple and Social Phobias

ICD-10-CM codes:

F40.8 Other phobic anxiety disorders
F40.10 Social phobia, unspecified
F40.11 Social phobia, generalized
F40.210 Arachnophobia
F40.218 Other animal type phobia
F40.220 Fear of thunderstorms
F40.228 Other natural environment type phobia
F40.230 Fear of blood
F40.231 Fear of injections and transfusions

F40.232 Fear of other medical care
F40.233 Fear of injury
F40.240 Claustrophobia
F40.241 Acrophobia
F40.242 Fear of bridges
F40.243 Fear of flying
F40.248 Other situational type phobia
F40.290 Androphobia
F40.291 Gynephobia
F40.298 Other specified phobia

Decision: Codes are appropriate as listed.

Line 487 Obsessive-Compulsive Disorders

Discussion: The members think this line might be ranked too low. Cat mentioned treatment outcomes may have affected the ranking of this line.

Decision: ICD-10-CM code F42, Obsessive-compulsive disorder, is appropriate on this line. However, this line should be rescored as part of the biennial review.

Line 488 Overanxious Disorder; Generalized Anxiety Disorder; Anxiety Disorder, Unspecified

ICD-10-CM codes:

F41.1 Generalized anxiety disorder
F41.3 Other mixed anxiety disorders
F41.8 Other specified anxiety disorders
F41.9 Anxiety disorder, unspecified

Discussion: The members think this line might be ranked too low.

Decision: Codes are appropriate as listed and this line should be rescored.

Rationale: It is generally difficult to diagnose anxiety more specifically so inclusion of the unspecified and other non-specific codes is appropriate.

Line 496 Functional Encopresis

Discussion: Kathy wondered if this condition can now be a sign & symptom code. Donald stated this condition is a big issue with children.

Decision: ICD-10-CM code F98.1, Encopresis not due to a substance or known physiological condition, is appropriate on this line. Retitle to "Encopresis Not Due to a Physiological Condition."

Line 500 Selective Mutism

Decision: ICD-10-CM code F94.0, Selective mutism, is appropriate on this line

Line 508 Conduct Disorder, Age 18 or Under

ICD-10-CM codes:

F91.9 Conduct disorder, unspecified
F91.0 Auto Conduct disorder confined to family context
F91.1 Auto Conduct disorder, childhood-onset type
F91.2 Auto Conduct disorder, adolescent-onset type
F91.8 Auto Other conduct disorders

Decision: Codes are appropriate as listed.

Line 521 Gender Identification Disorder, Paraphilias and Other Psychosexual Disorders

ICD-10-CM codes:

F64.1 Gender identity disorder in adolescence and adulthood
F64.2 Gender identity disorder of childhood
F64.8 Other gender identity disorders

F64.9 Gender identity disorder, unspecified
F65.1 Transvestic fetishism
F65.2 Exhibitionism
F65.4 Pedophilia
F65.89 Other paraphilias
F65.9 Paraphilia, unspecified

Decision: Codes are appropriate as listed.

Line 544 Delusional Disorder

ICD-10-CM code
F22 Delusional disorders

Discussion: David stated DSM-IV includes eroto-manic delusions which can lead to stalking behaviors and is highly treatable.

Decision: Eliminate line 544 and add F22 to line 295, Other Psychotic Disorder.

Rationale: Inappropriately below the funding line.

Line 546 Sexual Dysfunction

ICD-10-CM codes:

*F10.181 Alcohol abuse with alcohol-induced sexual dysfunction
*F10.281 Alcohol dependence with alcohol-induced sexual dysfunction
*F10.981 Alcohol use, unspecified with alcohol-induced sexual dysfunction
*F11.181 Opioid abuse with opioid-induced sexual dysfunction
*F11.281 Opioid dependence with opioid-induced sexual dysfunction
*F11.981 Opioid use, unspecified with opioid-induced sexual dysfunction
*F13.181 Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced sexual dysfunction
*F13.281 Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sexual dysfunction
*F13.981 Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced sexual dysfunction
*F14.181 Cocaine abuse with cocaine-induced sexual dysfunction
*F14.281 Cocaine dependence with cocaine-induced sexual dysfunction
*F14.981 Cocaine use, unspecified with cocaine-induced sexual dysfunction
*F15.181 Other stimulant abuse with stimulant-induced sexual dysfunction
*F15.281 Other stimulant dependence with stimulant-induced sexual dysfunction
*F15.981 Other stimulant use, unspecified with stimulant-induced sexual dysfunction
*F19.181 Other psychoactive substance abuse with psychoactive substance-induced sexual dysfunction
*F19.281 Other psychoactive substance dependence with psychoactive substance-induced sexual dysfunction
*F19.981 Other psychoactive substance use, unspecified with psychoactive substance-induced sexual dysfunction
F52.0 Hypoactive sexual desire disorder
F52.1 Sexual aversion disorder
F52.21 Male erectile disorder
F52.22 Female sexual arousal disorder
F52.31 Female orgasmic disorder
F52.32 Male orgasmic disorder
F52.4 Premature ejaculation

F52.6 Dyspareunia not due to a substance or known physiological condition
F52.8 Other sexual dysfunction not due to a substance or known physiological condition
F52.9 Unspecified sexual dysfunction not due to a substance or known physiological condition
N52.01 Erectile dysfunction due to arterial insufficiency
N52.02 Corporo-venous occlusive erectile dysfunction
N52.03 Combined arterial insufficiency and corporo-venous occlusive erectile dysfunction
N52.1 Erectile dysfunction due to diseases classified elsewhere
N52.2 Drug-induced erectile dysfunction
N52.31 Erectile dysfunction following radical prostatectomy
N52.32 Erectile dysfunction following radical cystectomy
N52.33 Erectile dysfunction following urethral surgery
N52.34 Erectile dysfunction following simple prostatectomy
N52.39 Other post-surgical erectile dysfunction
N52.8 Other male erectile dysfunction
N52.9 Male erectile dysfunction, unspecified
R37 Sexual dysfunction, unspecified

Discussion: David wondered if the drug use codes should be on a separate line as they seem inappropriate here.

Decision: Move the codes marked with an asterisk (*) to placeholder line 1103.

Rationale: To consistently group substance use and abuse codes.

Line 569 Impulse Disorders Excluding Pathological Gambling

ICD-10-CM codes:

F63.1 Pyromania

F63.2 Kleptomania

F63.3 Trichotillomania

F63.81 Intermittent explosive disorder

F63.89 Other impulse disorders

Decision: Since line 222 was renamed as: "Non-Substance- Related Addictive Behavioral Disorders," re-title this line to read: "Impulse Disorders."

Rationale: To be consistent and to reinforce gambling is not an impulse disorder.

Line 576 Shyness Disorder of Childhood or Adolescence

ICD-10-CM code:

F94.8 Other childhood disorders of social functioning

Decision: Delete line 576 and add code F94.8 to the Excluded list.

Rationale: This condition does not exist in DSM-IV.

Line 609 Anti-Social Personality Disorder

ICD-10-CM code:

F60.2 Auto Antisocial personality disorder

And

Line 610 Personality Disorders Excluding Borderline, Schizotypal and Anti-Social

ICD-10-CM codes:

F68.8 Other specified disorders of adult personality and behavior

F60.0 Paranoid personality disorder

F60.1 Schizoid personality disorder

F60.4 Histrionic personality disorder
F60.5 Obsessive-compulsive personality disorder
F60.6 Avoidant personality disorder
F60.7 Dependent personality disorder
F60.81 Narcissistic personality disorder
F60.89 Other specific personality disorders
F60.9 Personality disorder, unspecified
F69 Unspecified disorder of adult personality and behavior

Decision: Combine lines 609 and 610 and change title to “Personality Disorders Excluding Borderline and Schizotypal.”

Rationale: Scoring placed these conditions close on the list and no reason to leave separate.

Line 682 Mental Disorders with No or Minimally Effective Treatments or No Treatment Necessary

Decision: ICD-10-CM code F48.8, Other specified nonpsychotic mental disorders, is appropriate on this line.

Rationale: The conditions listed in the code book are specific as opposed to general and non-specific codes, which usually are added to the Excluded file.

Abuse Line and PTSD Discussion:

At the October meeting it was decided to remove all the abuse and neglect codes from the PTSD line. In the process of removing the codes, it came to light the codes are not on a line which would pair them with mental health treatment codes.

Ann asked if we want to keep the mental and physical lines separate from medical lines. There seems to be a move toward integration of behavioral and physical health.

Darren commented the separation goes back to the original list, which included a mandate to create separate mental health lines as those lines were to be funded differently. There may still be potential actuarial issues but recently dental lines have been added to medical lines, so there may be no issue.

David said the diagnoses involved are *phenomena* which are happening to the individual. It is appropriate then to refer the patient to a mental health provider with an additional diagnosis of acute stress disorder, depression or other appropriate diagnosis. After a month, an acute stress disorder diagnosis could be coded as PTSD.

Kathy Savicki and other members voiced their agreement.

Decision:

Keep the codes on line 132; changing the line name to “Abuse and Neglect.”
Make no change to the coding changes previously approved.

Substance Use, Intoxication, and Delirium:

Line 1102 Abuse of Nonaddictive Substances

ICD-10-CM codes:

F55.0 Abuse of antacids
F55.1 Abuse of herbal or folk remedies
F55.2 Abuse of laxatives
F55.3 Abuse of steroids or hormones
F55.4 Abuse of vitamins
F55.8 Abuse of other non-psychoactive substances

Line 1103 Other Disorders Due to Substances

ICD-10-CM codes:

- F10.188 Alcohol abuse with other alcohol-induced disorder
- F10.19 Alcohol abuse with unspecified alcohol-induced disorder
- F10.288 Alcohol dependence with other alcohol-induced disorder
- F10.29 Alcohol dependence with unspecified alcohol-induced disorder
- F10.99 Alcohol use, unspecified with unspecified alcohol-induced disorder
- F11.188 Opioid abuse with other opioid-induced disorder
- F11.19 Opioid abuse with unspecified opioid-induced disorder
- F11.288 Opioid dependence with other opioid-induced disorder
- F11.29 Opioid dependence with unspecified opioid-induced disorder
- F11.90 Opioid use, unspecified, uncomplicated
- F11.988 Opioid use, unspecified with other opioid-induced disorder
- F11.99 Opioid use, unspecified with unspecified opioid-induced disorder
- F12.188 Cannabis abuse with other cannabis-induced disorder
- F12.19 Cannabis abuse with unspecified cannabis-induced disorder
- F12.288 Cannabis dependence with other cannabis-induced disorder
- F12.29 Cannabis dependence with unspecified cannabis-induced disorder
- F12.988 Cannabis use, unspecified with other cannabis-induced disorder
- F12.99 Cannabis use, unspecified with unspecified cannabis-induced disorder
- F13.188 Sedative, hypnotic or anxiolytic abuse with other sedative, hypnotic or anxiolytic-induced disorder
- F13.19 Sedative, hypnotic or anxiolytic abuse with unspecified sedative, hypnotic or anxiolytic-induced 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
- F13.90 Sedative, hypnotic, or anxiolytic use, unspecified, uncomplicated
- F13.988 Sedative, hypnotic or anxiolytic use, unspecified with other sedative, hypnotic or anxiolytic-induced disorder
- F13.99 Sedative, hypnotic or anxiolytic use, unspecified with unspecified sedative, hypnotic or anxiolytic-induced disorder
- F14.188 Cocaine abuse with other cocaine-induced disorder
- F14.19 Cocaine abuse with unspecified cocaine-induced disorder
- F14.288 Cocaine dependence with other cocaine-induced disorder
- F14.29 Cocaine dependence with unspecified cocaine-induced disorder
- F14.90 Cocaine use, unspecified, uncomplicated
- F14.988 Cocaine use, unspecified with other cocaine-induced disorder
- F14.99 Cocaine use, unspecified with unspecified cocaine-induced disorder
- F15.188 Other stimulant abuse with other stimulant-induced disorder
- F15.19 Other stimulant abuse with unspecified stimulant-induced disorder
- F15.288 Other stimulant dependence with other stimulant-induced disorder
- F15.29 Other stimulant dependence with unspecified stimulant-induced disorder
- F15.90 Other stimulant use, unspecified, uncomplicated
- F15.988 Other stimulant use, unspecified with other stimulant-induced disorder
- F15.99 Other stimulant use, unspecified with unspecified stimulant-induced disorder

F16.188 Hallucinogen abuse with other hallucinogen-induced disorder
 F16.19 Hallucinogen abuse with unspecified hallucinogen-induced disorder
 F16.288 Hallucinogen dependence with other hallucinogen-induced disorder
 F16.29 Hallucinogen dependence with unspecified hallucinogen-induced disorder
 F16.90 Hallucinogen use, unspecified, uncomplicated
 F16.988 Hallucinogen use, unspecified with other hallucinogen-induced disorder
 F16.99 Hallucinogen use, unspecified with unspecified hallucinogen-induced disorder
 F17.229 Nicotine dependence, chewing tobacco, with unspecified nicotine-induced disorders
 F18.180 Inhalant abuse with inhalant-induced anxiety disorder
 F18.188 Inhalant abuse with other inhalant-induced disorder
 F18.19 Inhalant abuse with unspecified inhalant-induced disorder
 F18.288 Inhalant dependence with other inhalant-induced disorder
 F18.29 Inhalant dependence with unspecified inhalant-induced disorder
 F18.988 Inhalant use, unspecified with other inhalant-induced disorder
 F18.99 Inhalant use, unspecified with unspecified inhalant-induced disorder
 F19.188 Other psychoactive substance abuse with other psychoactive substance-induced disorder
 F19.19 Other psychoactive substance abuse with unspecified psychoactive substance-induced 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
 F19.90 Other psychoactive substance use, unspecified, uncomplicated
 F19.988 Other psychoactive substance use, unspecified with other psychoactive substance-induced disorder
 F19.99 Other psychoactive substance use, unspecified with unspecified psychoactive substance-induced disorder
 F12.90 Cannabis use, unspecified, uncomplicated
 F18.90 Inhalant use, unspecified, uncomplicated

Discussion: Cat explained currently, intoxication and unspecified complications of substance use are on the same line. The treatments for these may be very different (e.g. hospitalization for delirium tremens versus the “munchies” for cannabis use). It may make sense to separate these into two lines; however, prioritizing the unspecified line may be quite challenging given the range of potential serious and non-serious conditions it may encompass. Also a number of “use” codes were mapped to Line 5, which is inappropriate. The definition states these explicitly exclude abuse and dependence.

Kathy asked if these types of codes are candidates for being “never covered.” Darren explained the criteria for suggesting a diagnosis code be designated as “never covered,” stating generally those include unspecified codes and secondary diagnosis codes where the primary code must be listed first. Codes designated at “other” generally find a place on the list.

Discussion: Ann expressed concern over the inclusion of code F55.3, Abuse of steroids or hormones, on this line. More professionals are agreeing this condition meets the criteria for addiction, such as cravings and withdrawal. Proper line placement was discussed.

Decision:

- Create lower substance line 1103 (placeholder line number), Other Disorders Due To Substances.
- Remove “use” codes F11.90, F13.90, F14.90, F15.90, F16.90, and F19.90 from Line 5 (these exclude abuse/dependence). Place on lower substance use line 1103).
- Rename Line 68: “Substance-Induced Mood, Anxiety, and Delusional Disorders; Intoxication”
- Place codes for “intoxication” on Line 70, Substance-Induced Delirium.
- Remove substance-induced psychotic disorders from delirium line (many on both 68 and 70). Place on substance induced delusional and mood disorders line 68.
- Add F16.283, Hallucinogen dependence with hallucinogen persisting perception disorder (flashbacks), to line 68.
- Add F10.26 Alcohol dependence with alcohol-induced persisting amnestic disorder and F10.97 Alcohol use, unspecified with alcohol-induced persisting dementia to line 209 only.
- Add F18.180 Inhalant abuse with inhalant-induced anxiety disorder to line 68
- Duplicate code F55.3, Abuse of steroids or hormones, on line 5, adding a coding guideline to restrict inclusion on this line to anabolic-androgenic steroids, as per the National Institute on Drug Abuse (NIDA) recommendations.
- Review all remaining codes for Excluded file consideration.

Rationale: To consistently group substance use and abuse codes.

Topic: Prevention Tables Revision

Discussion: Cat explained the HSC is thinking about creating two prevention lines, with one containing only very highly effective services and a lower line to capture the other services, removing the prevention tables entirely.

Kathy shared when the prevention tables were first introduced, there were no official recommendations on preventive MHCD services and this subcommittee offered suggestions based on clinical practice at the time. The members agreed to accept the evidence-based USPSTF A & B recommendations. Further discussion confirmed a consensus placing drug and alcohol screening on Line 3.

Topic: Other Business**Discussion:**

Kathy asked about decisions reached at the last meeting when she was unable to attend.

- ICD-10-CM code F06.31 (Mood disorder due to known physiological condition with depressive features) was added to line 209 (Organic Mental Disorders Including Dementias). She is concerned about mood disorders associated with other conditions, such as heart attack. David clarified this particular code is for conditions for which psychotherapy would not be appropriate, such as a thyroid condition causing the depression. A review of the procedure codes on line 209 show appropriate pairings and Kathy was satisfied with the placement.
- ICD-10-CM code F07.81 (Postconcussional syndrome) was added to line 587 (Postconcussion syndrome). The HOSC recently heard testimony about developments in treating postconcussion syndrome, including mental health intervention for treatment of many conditions including adjustment disorder, anxiety, depression, insomnia, adjustment disorder, etc. Kathy wondered if the code should be included on line 209. David suggests the diagnosis stay on its own line.

Rationale: Do not add mental health treatment codes to the postconcussion line because a patient with postconcussional syndrome should be referred to appropriate mental health treatment and appropriately coded for diagnosis and treatment.

Discussion:

Kathy asked if conversion to ICD-10-CM would mean a change in coding practices for mental health professionals who see OHP patients. Currently, coding is submitted using DSM-IV language and a program translates the information to ICD-9-CM for billing. Ann mentioned there is recent statute requiring mental health professionals to have recent DSM-IV training.

Decision: Cat will email DMAP for clarification.

Issues for next meeting:

- A&D case management as a value-based service
 - Organic Mental Disorder guideline
 - Line re-ranking
 - Excluded code review
 - Payment system issues
 - Diagnostic code: R45.84, Anhedonia
-

Next meeting:

Next meeting is scheduled for February 16, 2011 in room 213 of the Wilsonville Training Center.

MHCD Recommendations Summary

For Presentation to:
Health Services Commission on
January 13, 2011

For specific coding recommendations, please see the text of the 12/15/10 MHCD minutes.

Note: All line numbers indicated in this document are tentative lines for the Biennial List which will go into effect on January 1, 2012. Line numbers >1000 are placeholder lines until the prioritization methodology is used to develop a recommended placement for that line on the Prioritized List. The Prioritized List resulting from the conversion to ICD-10-CM is not scheduled to go into effect until October 1, 2013.

The subcommittee members reviewed line structure and placement recommendations for ICD-10-CM codes for mental health and addiction lines and in addition to the straight-forward code conversions suggested by the General Equivalence Mapping (GEM) supplied by CMS, also recommend:

CREATE NEW LINES

- Placeholder Line 1102, Abuse of Nonaddictive Substances - Add codes meeting nonaddictive criteria here with the exception of “abuse of steroids” which should also be added to line 5, Abuse or Dependence of Psychoactive Substance.
- Placeholder Line 1103, Other Disorders Due to Substances – Remove “use” codes from Line 5 (these exclude abuse/dependence) and place here.

DELETE LINE

- Delete Line 576, Shyness Disorder of Childhood or Adolescence, and recommend DMAP place the code for “Other childhood disorders of social functioning” on the Excluded File.

COMBINE MULTIPLE LINES

- Create a new line “Feeding and Eating Disorders of Infancy or Childhood” by combining Pica (line 661), Eating Disorders NOS (line 425) and Rumination of Infancy (line 589). Rescore for appropriate placement.
- Create a new line titled “Somatization Disorder; Somatoform Pain Disorder, Conversion Disorder” editing the treatment description to read “Medical/Psychotherapy” by combining lines 390 (Conversion Disorder, Child), 398 (Somatization Disorder; Somatoform Pain Disorder) and 518 (Conversion Disorder, Adult). Rescore for appropriate placement.
- Add diagnostic code for “delusional disorders” to line 295, Other Psychotic Disorder and delete line 544, Delusional Disorder.
- Create a new line by combining lines 609 (Anti-Social Personality Disorder) and 610 (Personality Disorders Excluding Borderline, Schizotypal and Anti-Social) and change title to “Personality Disorders Excluding Borderline and Schizotypal”

RENAME LINES

- Line 68: “Substance-Induced Mood, ~~Anxiety~~, and Delusional Disorders; ~~Intoxication~~”
- Line 334 and guideline: “Pervasive Developmental Disorders, including Autism Spectrum Disorders”
- Line 496: “~~Functional~~ Encopresis Not Due to a Physiological Condition”
- Line 132: “~~Physical and Sexual Abuse Including Rape and Neglect~~”
- Line 569: “Impulse Disorders ~~Excluding Pathological Gambling~~”

CODE MOVEMENT

- Move substance use and abuse codes from Line 546, Sexual Dysfunction, to placeholder line 1103.
- Place codes for “intoxication” on Line 70, Substance-Induced Delirium.
- Remove codes for substance-induced psychotic disorders from delirium line (many on both 68 and 70). Place on substance induced delusional and mood disorders line 68.
- Add code for hallucinogen dependence with hallucinogen persisting perception disorder (flashbacks) to line 68.
- Add codes for alcohol dependence with alcohol-induced persisting amnesic disorder and alcohol use, unspecified with alcohol-induced persisting dementia, to line 209 only.
- Add code for inhalant abuse with inhalant-induced anxiety disorder to line 68.
- Duplicate code for abuse of steroids or hormones, on line 5, adding a coding guideline to restrict inclusion on this line to anabolic-androgenic steroids, as per the National Institute on Drug Abuse (NIDA) recommendations.

RESCORE

In addition to the lines noted above, the members suggest rescore the following lines:

- 487, Obsessive-Compulsive Disorders
- 488, Overanxious Disorder; Generalized Anxiety Disorder; Anxiety Disorder

PREVENTION TABLE RECOMMENDATIONS

- The members added their support to the HSC's prevention table revision direction of creating two prevention lines, with one containing only very highly effective services and a lower line to capture the other services, removing the prevention tables entirely.

MEETING HIGHLIGHTS

MENTAL HEALTH CARE AND CHEMICAL DEPENDENCY SUBCOMMITTEE
Clackamas Community College Wilsonville Training Center, Room 111
Wilsonville, Oregon
November 17, 2010
8:30 – 11:00 a.m.

Members Present: Donalda Dodson, RN, MPH, Chair; David Pollack, MD; Ann Uhler; Seth Bernstein, PhD; Carole Romm, RN (until 10:30 am); Larry Betcher, MSW, LCSW.

Members Absent: Kathy Savicki, LCSW; Michael Reaves, MD; Gary Cobb.

Staff Present: Darren Coffman; Cat Livingston, MD, MPH; Jason Gingerich; Dorothy Allen (via teleconference).

Guests: David Fischer, Addictions and Mental Health Division, DHS; Caroline Price, DMAP; Jonathan Eames, OPERA.

TOPIC	ACTION	RESPONSIBILITY	DATE
<p>Review of Meeting Highlights Highlights reviewed.</p>	<p>Larry Betcher was in attendance at the September meeting. He was inadvertently omitted from the list of attendees. David Pollack recalls leaving the meeting at 9:30 am.</p>	<p>Dorothy will correct and post on web.</p>	<p>ASAP</p>
<p>HSC/OHA Update/Other Updates</p> <p>The Health Services Commission has not met since the last MHCD meeting, there is no update.</p> <p>Darren Coffman mentioned a legislative concept proposal which would merge the HSC and Health Resources Commission into one body for streamlining and consolidating the state's comparative effectiveness bodies. He also reported that our office has recently been given responsibility for administration of the Oregon Pain Management Commission.</p> <p>The January HSC meeting will be reviewing recommendations to make changes to the April 1, 2011 Prioritized List of Health Services.</p> <p>Darren reported that he and others shared a presentation to the Health Policy Board (HPB) on the Value-based Benefit Package pricing. Research shows the package will produce a 3-5% cost reduction, based on increased cost-sharing on Tier III & IV services, combined with behavior changes that should be encouraged by the no/lower-cost-sharing on value-based and Tier I services.</p>			

TOPIC	ACTION	RESPONSIBILITY	DATE
<p>David Pollack reported that the Healthcare Workforce Committee has given their recommendations to the HPB. The report included priorities focused on increasing the number of primary care providers, support for primary care homes and mental health integration. He also mentioned that Senator Merkley is having a Healthcare Workforce Summit at OHSU on December 10, 2010.</p> <p>Seth Bernstein reported that DMAP has identified proposed cuts to the Oregon Health Plan at certain reduction levels in anticipating revenue shortfalls during the 2011-13 biennium. Specifically, at the proposed 15% reduction level, among others items, 11 mental health lines including chronic depression and lines affecting children, such as reactive attachment disorder, would be defunded. Darren mentioned that CMS must review and approve any proposed cuts to the categorically eligible population; past proposals have not been approved.</p>			
<p>ICD-10-CM Conversion <i>Note that all Line numbers indicated in this section are for the Biennial List that will go into effect on January 1, 2012.</i></p> <p><u>Line 5 (Abuse or Dependence of Psychoactive Substance)</u> Discussion began with the alcohol and drug dependence codes. Darren suggested splitting out addictive substances vs. non-addictive, such as ICD-10-CM code F55.0 Abuse of Antacids. David Pollack commented that some non-addictive substances, such as overuse of vitamin A or anabolic steroids, for example, are very serious issues that require medical treatment. There was general agreement when Ann suggested that those instances might be rare occurrences. Darren reminded the members that the Prioritized List of Health Services is being considered as a model for private health insurance so it is important to place each code as accurately as possible, even if it may not be utilized often.</p> <p>Cat Livingston shared that she has encountered overuse of vitamins and other non-addictive substances by patients with OCD or delusional issues. It was suggested that the treatments would be focused on the comorbid condition.</p> <p>Proposed to add a new line called "Abuse of Non-Addictive Substances and Agents" to include codes F55.0-F55.8. This line would need to be scored for appropriate placement on the List. If the new line is placed in the unfunded region these services could be provided via the co-morbidity rule.</p> <p>Seth suggested that staff come back with a recommendation for placement for the members to review.</p> <p>The group agreed that hallucinogen abuse and dependence should remain on line 5.</p> <p><u>Line 6 (Tobacco Dependence)</u> The group agreed to accept recommendations listed in the meeting materials.</p>	<p>Develop recommendations.</p>	<p>Staff</p>	<p>Next meeting</p>

TOPIC	ACTION	RESPONSIBILITY	DATE
<p>that most conditions/codes were placed on all four of the dysfunction lines, even when only one or two of the neurological impairments were likely to result from a chronic condition.</p> <p>David pointed out there are abuse and neglect codes on lines 78, 318 (Neurological Dysfunction In Posture And Movement Caused By Chronic Conditions) and 375 (Neurological Dysfunction In Communication Caused By Chronic Conditions). He feels there should be the ability to code an injury or trauma that would have had to have happened to justify inclusion on the “dysfunction” lines, especially as the List may be used for commercial plans.</p> <p>All of the codes in question are also placed on line 132 (Physical and Sexual Abuse Including Rape). The members suggest removing the T-codes from the dysfunction lines.</p> <p><u>Line 209 (Chronic Organic Mental Disorders Including Dementias)</u> Delete ICD-10-CM code F06.9, Unspecified mental disorder due to known physiological condition, as a more specific code should be used.</p> <p><u>Line 212 (Depression and Other Mood Disorders, Mild or Moderate)</u> Keep all the codes on this line except: -Delete ICD-10-CM code F06.31 (Mood disorder due to known physiological condition with depressive features) from 212 and leave on line 209 in order to remove duplication. -Add ICD-10-CM code F34.0, Cyclothymic disorder (and remove from line 32), as its severity level better matches the conditions here.</p> <p><u>Line 222 (Pathological Gambling)</u> David wondered if there are ICD-10-CM codes for other behavioral addictions such as internet, gaming or pornography addiction. A review of the codes show there are not. The term “pathological” is an outdated term. It was agreed to rename line 222 “Non-Substance-Related Addictive Behavioral Disorders.”</p> <p><u>Line 269 (Psychological Factors Aggravating Physical Condition)</u> No change recommended.</p> <p><u>Line 295 (Other Psychotic Disorders)</u> -F53 Puerperal psychosis includes post-partum depression spectrum so should remain here. -Delete F84.3 (Other childhood disintegrative disorder) from this line and keep it on the dysfunction lines. -Delete from F84.8 (Other pervasive developmental disorders) and place it on line 334.</p> <p>Please see Attachment A for a complete list of ICD-10-CM code placement suggestions.</p> <p>Please see Attachment B for a complete list of CPT code placement recommendations.</p>	<p>Identify non-T codes for review at December meeting.</p> <p>Identify potential missing codes discussed in October to bring back to December meeting.</p>	<p>Staff</p> <p>Staff</p>	<p>Next meeting</p> <p>Next meeting</p>

TOPIC	ACTION	RESPONSIBILITY	DATE
<p>The December meeting will begin discussion of the ICD-10-CM conversion starting at Line 305.</p>			
<p>Other Business</p> <p><i>A. Case Management Codes as a Value-Based Service</i> Ann sent an article (see meeting materials) to further discuss A&D case management.</p> <p><i>B. Prevention Tables Revision – Update</i> Darren mentioned that the Health Outcomes Subcommittee is looking at reworking the Prevention Tables section of the Prioritized List. These tables are based on the prevention recommendations of the US Preventive Taskforce from 1996, which were updated on September, 2010. The HSC will focus on the A and B recommendations, found in section one at: http://www.ahrq.gov/clinic/pocketgd1011/.</p> <p><i>C. Proposed guideline for Chronic Organic Mental Disorders (COMD) Line</i> Seth would like to work with someone on the subcommittee to develop a guideline for the treatment of the conditions that fall on this line. It was suggested that he work with Michael Reeves.</p>	<p>Tabled until the December meeting.</p> <p>Tabled until the December meeting.</p> <p>Connect with Michael to draft a guideline.</p>	<p>Seth</p>	<p>Due next meeting.</p>
<p>Public Comment</p> <p>No public comment was offered.</p>			
<p>Adjournment</p> <p>Next meeting is scheduled for December 15, in room 111 at the Wilsonville Training Center and will be extended to run from 8:30 am - Noon.</p> <p>The meeting was adjourned at 10:55.</p>	<p>Send a reminder notice to members.</p>	<p>Dorothy</p>	

Appendix A

Placement recommendations after 11/17/2010 MHCD committee meeting.

All line numbers are tentative line numbers for the 1/1/2012 Biennial Review list, except that line 1102 are placeholders recommended new lines to be placed near the Pica line.

Not included on this lists are cases where staff was requested to research codes for movement. See the minutes for a description of these requests.

ICD10	Code Description	New Placement
F06.31	Mood disorder due to known physiological condition with depressive features	209 CHRONIC ORGANIC MENTAL DISORDERS INCLUDING DEMENTIAS
F06.9	Unspecified mental disorder due to known physiological condition	Excluded/Never.
F07.81	Postconcussional syndrome	587 POSTCONCUSSION SYNDROME
F07.89	Other personality and behavioral disorders due to known physiological condition	Excluded/Never.
F34.0	Cyclothymic disorder	212 DEPRESSION AND OTHER MOOD DISORDERS, MILD OR MODERATE
F55.0	Abuse of antacids	1102 ABUSE OF NONADDICTIVE SUBSTANCES
F55.1	Abuse of herbal or folk remedies	1102 ABUSE OF NONADDICTIVE SUBSTANCES
F55.2	Abuse of laxatives	1102 ABUSE OF NONADDICTIVE SUBSTANCES
F55.3	Abuse of steroids or hormones	1102 ABUSE OF NONADDICTIVE SUBSTANCES
F55.4	Abuse of vitamins	1102 ABUSE OF NONADDICTIVE SUBSTANCES
F55.8	Abuse of other non-psychoactive substances	1102 ABUSE OF NONADDICTIVE SUBSTANCES
F84.3	Other childhood disintegrative disorder	78,318,334,375,407.
F84.5	Asperger's syndrome	334 AUTISM SPECTRUM DISORDERS
F84.8	Other pervasive developmental	78,318,334,375,407.

ICD10	Code Description	New Placement
	disorders	
T74.01xA	Adult neglect or abandonment, confirmed, initial encounter	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T74.01xD	Adult neglect or abandonment, confirmed, subsequent encounter	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T74.01xS	Adult neglect or abandonment, confirmed, sequela	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T74.02xA	Child neglect or abandonment, confirmed, initial encounter	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T74.02xD	Child neglect or abandonment, confirmed, subsequent encounter	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T74.02xS	Child neglect or abandonment, confirmed, sequela	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T74.11xA	Adult physical abuse, confirmed, initial encounter	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T74.11xD	Adult physical abuse, confirmed, subsequent encounter	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T74.11xS	Adult physical abuse, confirmed, sequela	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T74.12xA	Child physical abuse, confirmed, initial encounter	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T74.12xD	Child physical abuse, confirmed, subsequent encounter	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T74.12xS	Child physical abuse, confirmed, sequela	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T74.21xA	Adult sexual abuse, confirmed, initial encounter	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T74.21xD	Adult sexual abuse, confirmed, subsequent encounter	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T74.21xS	Adult sexual abuse, confirmed, sequela	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T74.22xA	Child sexual abuse, confirmed, initial encounter	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T74.22xD	Child sexual abuse, confirmed, subsequent encounter	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T74.22xS	Child sexual abuse, confirmed, sequela	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T74.31xA	Adult psychological abuse,	132 PHYSICAL AND SEXUAL

ICD10	Code Description	New Placement
	confirmed, initial encounter	ABUSE INCLUDING RAPE
T74.31xD	Adult psychological abuse, confirmed, subsequent encounter	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T74.31xS	Adult psychological abuse, confirmed, sequela	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T74.32xA	Child psychological abuse, confirmed, initial encounter	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T74.32xD	Child psychological abuse, confirmed, subsequent encounter	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T74.32xS	Child psychological abuse, confirmed, sequela	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T74.91xA	Unspecified adult maltreatment, confirmed, initial encounter	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T74.91xD	Unspecified adult maltreatment, confirmed, subsequent encounter	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T74.91xS	Unspecified adult maltreatment, confirmed, sequela	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T74.92xA	Unspecified child maltreatment, confirmed, initial encounter	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T74.92xD	Unspecified child maltreatment, confirmed, subsequent encounter	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T74.92xS	Unspecified child maltreatment, confirmed, sequela	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T76.01xA	Adult neglect or abandonment, suspected, initial encounter	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T76.01xD	Adult neglect or abandonment, suspected, subsequent encounter	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T76.01xS	Adult neglect or abandonment, suspected, sequela	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T76.02xA	Child neglect or abandonment, suspected, initial encounter	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T76.02xD	Child neglect or abandonment, suspected, subsequent encounter	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T76.02xS	Child neglect or abandonment, suspected, sequela	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T76.11xA	Adult physical abuse, suspected, initial encounter	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T76.11xD	Adult physical abuse, suspected,	132 PHYSICAL AND SEXUAL

ICD10	Code Description	New Placement
	subsequent encounter	ABUSE INCLUDING RAPE
T76.11xS	Adult physical abuse, suspected, sequela	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T76.12xA	Child physical abuse, suspected, initial encounter	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T76.12xD	Child physical abuse, suspected, subsequent encounter	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T76.12xS	Child physical abuse, suspected, sequela	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T76.21xA	Adult sexual abuse, suspected, initial encounter	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T76.21xD	Adult sexual abuse, suspected, subsequent encounter	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T76.21xS	Adult sexual abuse, suspected, sequela	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T76.22xA	Child sexual abuse, suspected, initial encounter	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T76.22xD	Child sexual abuse, suspected, subsequent encounter	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T76.22xS	Child sexual abuse, suspected, sequela	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T76.31xA	Adult psychological abuse, suspected, initial encounter	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T76.31xD	Adult psychological abuse, suspected, subsequent encounter	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T76.31xS	Adult psychological abuse, suspected, sequela	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T76.32xA	Child psychological abuse, suspected, initial encounter	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T76.32xD	Child psychological abuse, suspected, subsequent encounter	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T76.32xS	Child psychological abuse, suspected, sequela	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T76.91xA	Unspecified adult maltreatment, suspected, initial encounter	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T76.91xD	Unspecified adult maltreatment, suspected, subsequent encounter	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T76.91xS	Unspecified adult maltreatment,	132 PHYSICAL AND SEXUAL

ICD10	Code Description	New Placement
	suspected, sequela	ABUSE INCLUDING RAPE
T76.92xA	Unspecified child maltreatment, suspected, initial encounter	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T76.92xD	Unspecified child maltreatment, suspected, subsequent encounter	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
T76.92xS	Unspecified child maltreatment, suspected, sequela	132 PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE

Appendix B

Placement recommendations after 11/17/2010 MHCD committee meeting.

Line 69 is Substance-Induced Delirium; Line 577 is Rumination Disorders of Infancy.

Code	Code Description	Placement Changes
90816	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient;	Remove from 69 and 577
90817	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services	Remove from 69 and 577
90818	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;	Remove from 69 and 577
90819	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services	Remove from 69 and 577
90823	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient;	Remove from 69 and 577
90824	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face	Remove from 69 and 577

Code	Code Description	Placement Changes
	with the patient; with medical evaluation and management services	
90826	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;	Remove from 69 and 577
90827	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services	Remove from 69 and 577

TOPIC	ACTION	RESPONSIBILITY	DATE
<p>HSC/OHA Update (Cont'd) Kathy Savicki reported that the Pediatric Primary Health Home Committee has displayed a strong recognition of the need for screening for family issues and addiction issues.</p> <p>Seth Bernstein said the Health Improvement and Outcomes Committee –is identifying metrics to determine if reform is achieving its desired outcomes, particularly around primary care homes.</p> <p>Questions were raised about payment reform for mental health integration into primary care regarding a mix of base payment and payment for outcomes. Concerns for how this impacts Medicaid.</p> <p>Gary Cobb noted the Prescription Drug Monitoring Program Commission needs to address pain management programs, which differs from addiction programs. If patients pay for prescriptions with cash, they do not need to report them to insurance. Plan to come up with better policies to protect patients and also to reduce misuse of narcotics.</p> <p>Mr. Coffman reported that the code for interpretive services has historically only appeared on the MHCD lines, but have been exempt (always covered) in DMAPs claims processing system. He had planned to bring the issue to this meeting for the MHCD subcommittee to discuss, but the HSC went ahead and removed it so that will be covered in all instances, whether associated with a covered or non-covered diagnosis. Unfortunately, he believes the subcommittees request to add the code for A&D case management (H1017) may not have made it onto the HSC agenda so that will need to be taken care of at the next meeting if it didn't.</p>	<p>Jill Archer has document on payment reform (per David Pollack). See also David Labby's discussion.</p> <p>None</p> <p>Send info to MHOs about changes relating to the MHCD lines.</p> <p>Determine what HSC approved last meeting.</p>	<p>Commission members</p> <p>AMH Staff</p> <p>HSC Staff</p>	<p>Before next meeting</p> <p>Before next meeting</p>
<p>AMHD Update The adult mental health initiative went into effective 9/1/10. It enables facilitation of moving adult mental health clients through the continuum of residential care to community settings.</p> <p>A state plan amendment to the Home and Community-Based Services Waiver is up to CMS for review. It aligns payment for community and residential based care for personal care services.</p> <p>The division is also working on the Central Oregon Initiative demonstration project involving changes in the management of chemical dependency and mental health in 3 counties that will result in a regional health authority.</p>	<p>None</p> <p>Provide update on Initiative</p>	<p>AMH Staff</p>	<p>In 6 months</p>

TOPIC	ACTION	RESPONSIBILITY	DATE
<p>AMHD Update (Cont'd) Maternal Depression – as long as a mother loses OHP, OHP is unable to provide specific services to her. General dissatisfaction was expressed by the subcommittee; however, no clear solution was identified. It was suggested a guideline note could be added to include the treatment of the mental health of the family, but this has much larger implications. Concern was expressed over legality and reimbursement. Perhaps family therapy is an option, but wouldn't address the need for medication management. Another option could be a short mental health benefit in CAWEM or a community county partnership to provide a Medicaid match.</p>	<p>Discuss with Medicaid fraud unit. Further conversations about options.</p> <p>Motion passed stating the subcommittee supports the availability of family therapy for postpartum depression beyond the eligibility of the mom.</p>	<p>Seth Bernstein (with Nurit Fischler in Ken Rosenberg's office and Tom Fronk)</p>	<p>No due date</p>
<p>A&D Case Management Codes as a Value-Based Service (VBS) Ann Uhler was not available so would like to revisit at next meeting. Need a definition of case management. Still covered on Line 5 even if not a VBS.</p>	<p>Revisit at next meeting</p>	<p>Ann Uhler</p>	<p>Next meeting</p>
<p>ICD-10-CM Conversion At the June meeting a process was introduced whereby codes with ambiguous mappings would be initial focus of review. Staff suggestion and members agreed to try looking at lines in their entirety, including both ambiguous and straightforward code mappings.</p> <p>Line 9 (Major Depression) – No changes</p> <p>Line 27 (Schizophrenic Disorders) – No changes</p> <p>Line 32 (Bipolar Disorders) – F06.33, F06.34 – move to Line 209</p> <p>Line 68 – Deferred until Ann Uhler present</p> <p>Line 107 (Personality Disorders) – No codes mapped to line. F60.3 needs to be on this line</p> <p>Line 133 (ADD) – no change</p> <p>Line 180 (PTSD) –3 F codes (F43.10-F43.12) and 4 Z codes (Z69.010, Z69.020, Z69.11, Z69.81) stay on PTSD line. All T codes should only appear on medical lines.</p>	<p>Identify missing codes for Line 209 to address next meeting.</p> <p>Determine which codes were not mapped in ICD 10 conversion</p>	<p>Staff</p>	

TOPIC	ACTION	RESPONSIBILITY	DATE
<p>ICD-10-CM Conversion (Cont'd) Line 209 (Chronic Organic Mental Disorders Including Dementias) Remove "Chronic" from description F34.8 and F34.9 - remove from List (too vague, other/better codes) Missing codes for Alzheimer's and senile & frontotemporal dementia.</p> <p>Line 334 (Autism Spectrum Disorders) – Not reviewed</p> <p>There was general agreement that this process of ICD-10-CM mapping is working.</p>			
<p>Other Business Next meeting is scheduled for November 17, 2010 at the Wilsonville Training Center. Entire meeting should be devoted to completing the ICD-10 conversion of the MHCD lines.</p>	<p>Send a reminder notice to members.</p>	<p>Dorothy</p>	

MEETING HIGHLIGHTS

MENTAL HEALTH CARE AND CHEMICAL DEPENDENCY SUBCOMMITTEE Clackamas Community College Wilsonville Training Center, Room 218 Wilsonville, Oregon June 16, 2010

8:30 – 11:00 a.m.

Members Present: Kathy Savicki, LCSW, Chair Pro Tempore; Larry Betcher, MSW, LCSW; Michael Reaves, MD; David Pollack, MD; Ann Uhler; Seth Bernstein, PhD; Gary Cobb (teleconference).

Members Absent: Donalda Dodson, RN, MPH, Chair; Carole Romm, RN.

Staff Present: Darren Coffman; Jason Gingerich, Dorothy Allen (teleconference).

Guests: David Fischer, Addictions and Mental Health Division, DHS; Ellen Lowe.

TOPIC	ACTION	RESPONSIBILITY	DATE
<p>Review of Meeting Highlights</p> <p>April 21, 2010 Highlights reviewed.</p>	No suggested changes were made.	Dorothy will post on web.	ASAP
<p>HSC/OHA Update</p> <p>Darren Coffman shared that the 2012-13 Biennial List was finalized on May 13, 2010 at the Health Services Commission meeting.</p> <p>The MHCD Subcommittee's recommendations were acted upon as follows:</p> <ul style="list-style-type: none"> • Accepted recommendation to add the two major depression codes (296.23, Major depressive disorder, single episode, severe and 296.24, Major depressive disorder, single episode, severe, with psychotic behavior) to line 9, which was retitled, "Major Depression, Recurrent; Major Depression, Single Episode, Severe" and remove the codes from line 213, Depression And Other Mood Disorders, Mild Or Moderate. • Accepted recommendation to re-prioritize the Autism Spectrum Disorder line; moved from 210 to 334. • Did not add TCAs as a value-based service for depression. • Did not accept recommendation to add case management codes to the A&D lines. They want more information. <p>Case management was originally incorporated into the list based on information from Steve Gallon of Northwest Frontier Addiction Treatment Technology Center.</p>	<p>Needed: MHCD representative to attend the August HSC.</p> <p>Steve Gallon should be contacted.</p>	<p>David Pollack</p> <p>Staff; Ann will help if needed.</p>	<p>8/12/10</p> <p>ASAP</p>

TOPIC	ACTION	RESPONSIBILITY	DATE
<p>HSC/OHA Update (Cont'd)</p> <p>At the HSC meeting there was a lengthy discussion about adding antidepressants to the VBS list for children with depression. The commissioner's voted against with a very small margin.</p> <p>Seth Bernstein suggested this group write a statement to go back to the HSC: <i>"Providing antidepressants for children who are depressed is an appropriate option for physicians to consider, but it is not the first choice of treatment of depression for children and should not be added to the VBS list."</i></p> <p>Also discussed was Eastern Cooperative Oncology Group (ECOG) scoring for cancer treatment and bariatric surgery expansion; those items were carried over to the next meeting.</p> <p>Health Policy Board update: With the recent federal reform passage, not a lot of direction is established as yet. The Cost Sharing Workgroup is still recommending Value-Based benefit design, even though it may be less flexible under the federal reform plan.</p>	<p>Kathy Savicki requested research on regarding this subject before taking any action.</p>	<p>Staff will provide.</p>	<p>9/15/10 MHCD meeting</p>
<p>AMHD Update</p> <p>David Fischer shared the status of projects:</p> <ul style="list-style-type: none"> • The Statewide Adult Mental Health Initiative (care of adult patients in the community) will kick off in September. • July 1 marks the kick-off for the Statewide Children's Wraparound Initiative. This involves three demonstration sites aimed at improving outcomes for children and families in Oregon. • The Fully Capitated Health Plans (FCHPs) have completed a self-assessment which was reviewed by AMHD. They will be offering technical support and collaborative efforts to improve A&D treatment for patients. • An amendment to the Home and Community-Based Services Waiver is being submitted to CMS; allowing individuals eligible for Medicaid who need the kind of long-term care and assistance provided by hospitals, nursing homes or intermediate care facilities for the mentally retarded (ICF/MR) to choose to receive care and assistance at home or in other community settings instead. 	<p>None</p>	<p>None</p>	<p>None</p>
<p>Maternal Depression</p> <p>Seth Bernstein asked how a mother of an infant covered by OHP, but is not on OHP herself, can be treated for postpartum depression. Clearly it is in the best interest of the child for that mother to be treated.</p> <p>Staff could find no other state that covers treatment of postpartum depression for a non-Medicaid mother using Medicaid funds. Doing so would also appear to violate Medicaid regulations.</p>	<p>Take the issue to AMHD and report back to the MHCD.</p>	<p>David Fischer</p>	<p>9/15/10 MHCD meeting</p>

TOPIC	ACTION	RESPONSIBILITY	DATE
<p>Maternal Depression (Cont'd)</p> <p>This issue does not fall in the HSC's authority. The subcommittee suggests that AMHD explore the possibility of reimbursing for either screening and/or treatment of non-OHP mothers using Prevention, Education and Outreach (PEO) codes.</p>			
<p>Coding Issues</p> <p><i>New ICD-9-CM codes:</i> The following new ICD-9-CM codes will go into effect October 1, 2010. Do any need to be placed on the Prioritized List?</p> <p>V62.85 - Suicidal and homicidal ideation 799.50 - Unspecified signs and symptoms involving cognition 799.51 - Attention or concentration deficit 799.52 - Cognitive communication deficit 799.53 - Visuospatial deficit 799.54 - Psychomotor deficit 799.55 - Frontal lobe and executive function deficit 799.59 - Other signs and symptoms involving cognition V62.85 - Homicidal ideation</p> <p><i>Should HCPCS code H0032 (Mental health service plan development by non-physician) be added to A&D lines?</i></p> <p>A brief discussion led to the conclusion that another code, T1007 (Alcohol and/or substance abuse services, treatment plan development and/or modification), had a better description for this purpose and should be added instead.</p>	<p>Recommend that DMAP classify 799.5x and V62.85 as diagnostic (signs & symptoms) codes.</p> <p>Recommend adding HCPCS code T1007 to Lines 5 (Abuse Or Dependence Of Psychoactive Substance) & 67 (Substance-Induced Delusional And Mood Disorders; Intoxication)</p>	<p>Staff will add this to the next HSC agenda.</p> <p>Staff will add this to the next HSC agenda.</p>	<p>8/12/10</p> <p>8/12/10</p>
<p>ICD-10-CM Conversion</p> <p>The members discussed the upcoming mandatory conversion from ICD-9-CM diagnostic coding to ICD-10-CM and made recommendations regarding diagnostic code placement of conditions that appear complicated.</p>	<p>Please see <i>Attachment A</i> for a summary of the recommendations</p>	<p>Work will continue at the next meeting</p>	
<p>Public Comment</p> <p>There was no public comment at this time.</p>			
<p>Other Business</p> <p>The next meeting is scheduled for September 15, 2010 at the Wilsonville Training Center, Room 110.</p>	<p>Send a reminder notice to members.</p>	<p>Dorothy</p>	
<p>Adjournment</p> <p>The meeting was adjourned at 11:05 am.</p>			

ATTACHMENT A

ICD10	Code Description	Preliminary Line placement
F10.120	Alcohol abuse with intoxication, uncomplicated	68 SUBSTANCE-INDUCED DELUSIONAL AND MOOD DISORDERS; INTOXICATION
F10.27	Alcohol dependence with alcohol-induced persisting dementia	209 CHRONIC ORGANIC MENTAL DISORDERS INCLUDING DEMENTIAS
F11.251	Opioid dependence with opioid-induced psychotic disorder with hallucinations	68 SUBSTANCE-INDUCED DELUSIONAL AND MOOD DISORDERS; INTOXICATION 70 SUBSTANCE-INDUCED DELIRIUM
F12.251	Cannabis dependence with psychotic disorder with hallucinations	68 SUBSTANCE-INDUCED DELUSIONAL AND MOOD DISORDERS; INTOXICATION 70 SUBSTANCE-INDUCED DELIRIUM
F13.251	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations	68 SUBSTANCE-INDUCED DELUSIONAL AND MOOD DISORDERS; INTOXICATION 70 SUBSTANCE-INDUCED DELIRIUM
F14.251	Cocaine dependence with cocaine-induced psychotic disorder with hallucinations	68 SUBSTANCE-INDUCED DELUSIONAL AND MOOD DISORDERS; INTOXICATION 70 SUBSTANCE-INDUCED DELIRIUM
F15.251	Other stimulant dependence with stimulant-induced psychotic disorder with hallucinations	68 SUBSTANCE-INDUCED DELUSIONAL AND MOOD DISORDERS; INTOXICATION 70 SUBSTANCE-INDUCED DELIRIUM
F16.251	Hallucinogen dependence with hallucinogen-induced psychotic disorder with hallucinations	68 SUBSTANCE-INDUCED DELUSIONAL AND MOOD DISORDERS; INTOXICATION 70 SUBSTANCE-INDUCED DELIRIUM
F18.120	Inhalant abuse with intoxication, uncomplicated	68 SUBSTANCE-INDUCED DELUSIONAL AND MOOD DISORDERS; INTOXICATION
F18.251	Inhalant dependence with inhalant-induced psychotic disorder with hallucinations	68 SUBSTANCE-INDUCED DELUSIONAL AND MOOD DISORDERS; INTOXICATION 70 SUBSTANCE-INDUCED DELIRIUM
F19.21	Other psychoactive substance dependence, in remission	5 ABUSE OR DEPENDENCE OF PSYCHOACTIVE SUBSTANCE
F19.251	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with hallucinations	68 SUBSTANCE-INDUCED DELUSIONAL AND MOOD DISORDERS; INTOXICATION 70 SUBSTANCE-INDUCED DELIRIUM
F23	Brief psychotic disorder	295 OTHER PSYCHOTIC DISORDERS
F32.3	Major depressive disorder, single episode, severe with psychotic features	9 MAJOR DEPRESSION, RECURRENT; MAJOR DEPRESSION, SINGLE EPISODE, SEVERE
F33.3	Major depressive disorder, recurrent, severe with psychotic symptoms	9 MAJOR DEPRESSION, RECURRENT; MAJOR DEPRESSION, SINGLE EPISODE, SEVERE
F34.0	Cyclothymic disorder	32 BIPOLAR DISORDERS
F34.1	Dysthymic disorder	457 CHRONIC DEPRESSION (DYSTHYMIA)
F45.8	Other somatoform disorders	398 SOMATIZATION DISORDER; SOMATOFORM PAIN DISORDER
F10.96	Alcohol use, unspecified with alcohol-induced persisting amnesic disorder	209 CHRONIC ORGANIC MENTAL DISORDERS INCLUDING DEMENTIAS
F44.89	Other dissociative and conversion disorders	431 DISSOCIATIVE DISORDERS
F48.8	Other specified nonpsychotic mental disorders	681 MENTAL DISORDERS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY

TOPIC	ACTION	RESPONSIBILITY	DATE
<p>Reprioritization of line 5 Due to the relatively small proportion of addictions patients who are affected by moving methadone and buprenorphine from line 5 to the list of value-based services, the committee recommended not changing the prioritization of this line.</p>			
<p>HSC/OHSA Update Darren reviewed federal health reform. OHP is still trying to make sense of the new federal health law. Restrictions in the law may constrain Oregon's ability to use the previously-discussed benefit package with tiered copays for services with different rankings on the list. This doesn't stop the Health Services Commission work on the value-based services list. It won't affect the Oregon Health Plan as much as it will affect the exchange.</p>			
<p>AMHD Update David Fischer discussed the children's wraparound initiative. Three projects have been identified: Washington County, Mid-Valley, Rogue Valley (Jackson/Josephine Counties). They are working on an amendment to MHO 2010 contract.</p> <p>In addition, there is an adult MH initiative. Really trying to get MHOs engaged with mental health organizations in residential and community-based settings. Originally, there were a small group of early adopters. But eight of the nine eligible providers will participate; by next year it will be a requirement. It will be phased in, including short-term rental assistance for patients. MHOs will also be involved in facilitating utilization management as people move from state hospital to the community. These programs should start in about September, phased in over two to three years. Eventually managed care organizations will be captitated. Details are being finalized. Slower work is happening on demo sites in Northeast Oregon and Central Oregon. The state's 1915i waiver (for Home and Community-based services) remains in effect, which will require amending the state plan to get personal care services covered. It does mean opening the state plan up, which involves some risk of other things being changed. In addition, these changes will add peer-delivered services so that fee-for-service clients can access them.</p> <p>Regarding the state hospital, Richard Harris is spending more time onsite at the Hospital to help move things along.</p>			

MEETING HIGHLIGHTS

MENTAL HEALTH CARE AND CHEMICAL DEPENDENCY SUBCOMMITTEE
Clackamas Community College Wilsonville Training Center, Room 111
Wilsonville, Oregon
April 21, 2010
8:30 – 11:30 a.m.

Members Present: Donalda Dodson, RN, MPH, Chair. Kathy Savicki, LCSW; Michael Reaves, MD; David Pollack, MD; Seth Bernstein, PhD; Carole Romm, RN (left at 9:30 am), Gary Cobb.

Members Absent: Ann Uhler

Staff Present: Darren Coffman; Cat Livingston, MD, MPH, Jason Gingerich.

Guests: David Fischer, Addictions and Mental Health Division, DHS.

TOPIC	ACTION	RESPONSIBILITY	DATE
<p>Review of meeting highlights</p> <p>Carole Romm requested a correction on page 3 of the previous minutes—She was concerned that the full range of methadone treatments were not being included in the value-based services list. She didn't want to say there should be no medications on the value-based services list.</p> <p>Gary Cobb said on page 2, he wanted to clarify that he does want to see naturopathy as part of the conversation. The minutes may have been ambiguous.</p> <p>David Pollack said that on page 1 we should correct the name of the Patient Centered Primary Care Home Standards Advisory Committee and its acronym, PCPCH. He also pointed out that on page 2 the acronym "MCHD" should read "MHCD."</p>	<p>Correct minutes and post on website.</p>	<p>Dorothy will post on web.</p>	<p>ASAP</p>
<p>Review of removal of methadone to value based services list</p> <p>Carole Romm raised concerns about the inclusion of methadone on the value-based services list (along with the SBIRT evaluation tool). Some members are concerned it will drive patients to choose methadone over treatments which might be more appropriate, or might encourage long-term use of methadone. After much discussion, the committee took no action. The majority of the members felt that methadone and buprenorphine are the only services with the required level of evidence for effectiveness, and emphasized that other addictions services are already ranked very high on the list.</p>			

TOPIC	ACTION	RESPONSIBILITY	DATE
<p>Coding issues Discussed Autism Spectrum Disorder (ASD) codes. Code 299.8 appears on several lines, including the new ASD line. The group agreed that this is appropriate because code 299.8 includes autistic as well as psychotic disorders. Code 299.1 is on lines 27 and 210. Again, this code includes disorders appropriate for both lines. These decisions will need to be revisited when the ICD-10-CM codes are applied to the list.</p>			
<p>Depression lines Reviewed prioritization of these lines, based on how codes are actually used, and discussed whether they should be restructured. Darren asked about severity of Major depression. In the DSM-IV, Major depression includes mild, moderate and severe levels. Someone with recurrent Major depression could have mild, moderate or severe recurrent episodes. The group felt that it was important to have the distinction of recurrent versus nonrecurrent episodes, but to add Major Depression, Severe to the Line with recurrent episodes (as these tend to be people with more significant functional limitations due to the illness). The group discussed that the treatments are more important for patients with mild or moderate recurrent depression than for mild or moderate single episode depression and it makes sense to continue to have the lines as they currently are divided. In the end, the group chose not to split line 9, but changed the description to “Major depression, recurrent; major depression, single episode, severe” and add ICD-9 codes 296.23 and 296.24 to this line.</p> <p>The group also questioned HOSC’s decision to remove the tricyclic antidepressants from the value-based services list. The group recommended to refer this decision back to the HOSC based on recent research and expert contributions.</p> <p>The group also discussed reprioritizing line 9 now that the value-based services have been moved out of the line. This line now affects a much smaller population, for whom the value-based services are insufficient. Since the population is much smaller, the services remaining are still needed, effective and cost-efficient for the remaining population.</p> <p>Kathy said the HSC needs to clarify what population is being considered for prioritization after VBS services are taken out – the entire population with that condition or just</p>	<p>Changed the description for line 9 to “Major depression, recurrent; major depression, single episode, severe.”</p> <p>Requested that the HOSC revisit whether to add tricyclic antidepressants to the value-based services list.</p>	<p>Staff</p> <p>HOSC</p>	<p>All items to May 13 HOSC/ HSC mtg</p>

TOPIC	ACTION	RESPONSIBILITY	DATE
<p>Depression lines (Cont'd)</p> <p>those potentially accessing the non-VBS services remaining on the line. Darren agreed but said that it only seemed to make sense to include the population receiving the services on that line.</p> <p>The group rescored line 9, (changed suffering to 4, population to 2, effectiveness to 3, need for service to 1, and net cost to 3. This changed the score to 2925 from 3300, resulting in a placement near line 53. It is still tier 1. Agreed that this line doesn't need to be moved manually to a higher line like it was before, because moving many treatments to VBS makes the statement that was previously made by moving the line manually, and because services will still be covered in tier 1.</p> <p>Darren suggested adding a parenthetic (see VBS list) to lines from which services were removed.</p>	<p>Re-scored line 9 to 2925.</p> <p>Suggest adding parenthetic to all lines from which VBS were extracted.</p>	<p>Staff</p> <p>Staff</p>	<p>All items to May 13 HOSC/ HSC mtg</p>
<p>Schizophrenia</p> <p>Darren asked if there is an argument for hand-adjusting schizophrenia . Kathy said she tried to argue for this before the Commission, but the prevalence isn't high enough that she could convince the group to move it up. No action was taken.</p>			
<p>Bipolar disorder</p> <p>After discussion, the group decided not to change the ranking of bipolar disorder based on removal of certain services to the value-based list.</p>			
<p>Prioritization of specific lines</p> <p>The Autism Spectrum Disorders (ASD) was never subjected to the new prioritization methodology as it had not been determined what services would be included at the time of the last biennial review. The following ratings were given: Set category at 3; Impact on HLY at 5. (If there is no impact on lifespan the highest rating is a 5.) Suffering was set to a 4. Population effect is a 1. Vulnerable populations is 0. Effectiveness is 2. Need for services was set at 0.7. Net cost is 3. Score=1050. This would place it around line 333. Near cataract, cleft palate, gout, liver transplant for cirrhosis, cancer of esophagus, stroke. This would be tier 3. Cutoff for tier 2 is 311. The group decided to go with level 2 for effectiveness, noting that this is a conservative rating, but should be reviewed when more evidence comes in. All of these ratings reflect the fact that it will be the individuals with milder forms of the disorder who will access services on this line.</p>	<p>Provided criteria ratings for the ASD line which resulted in a score of 1050, placing it near line 333.</p> <p>Flagged this line for review when more evidence on effectiveness becomes available.</p>	<p>Staff</p>	<p>Take to 5/13 HSC mtg</p>

TOPIC	ACTION	RESPONSIBILITY	DATE
<p>Coding issues The group agreed to add H0032 to line 210 (Autistic Spectrum disorder). The group agreed that every mental health line should include H0032. Staff will review whether this should be paired with chemical dependency lines as well or see if there is an equivalent A&D code.</p> <p>Re: 96101. Group agreed to add 96101 to guideline note 28.</p>	<p>H0032 added to line 210 and every other mental health line.</p> <p>Added code 96101 to guideline note 28.</p>	<p>Staff will review whether H0032 should be added to chemical dependency lines as well.</p>	
<p>Other Business Scheduled an ICD-10 meeting so that staff has direction to work on this over the summer. It will be June 16. 8:30-11:00.</p>	<p>Schedule meeting</p>	<p>Dorothy Allen</p>	
<p>Public Comment No public comment</p>			

MEETING HIGHLIGHTS

MENTAL HEALTH CARE AND CHEMICAL DEPENDENCY SUBCOMMITTEE
Clackamas Community College Wilsonville Training Center, Room 218
Wilsonville, Oregon
February 17, 2010
8:30 – 11:00 a.m.

Members Present: Kathy Savicki, LCSW, Chair Pro Tempore; Michael Reaves, MD; David Pollack, MD; Ann Uhler; Seth Bernstein, PhD; Carole Romm, RN, Gary Cobb.

Members Absent: Donalda Dodson, RN, MPH, Chair.

Staff Present: Darren Coffman; Cat Livingston, MD, MPH.

Guests: David Fischer, Addictions and Mental Health Division, DHS; Jim Russell, Mid-Valley Behavioral Care Network, Salem; Venus Holder, Lilly USA

TOPIC	ACTION	RESPONSIBILITY	DATE
<p>Review of Meeting Highlights Highlights reviewed.</p>	<p>No suggested changes were made.</p>	<p>Dorothy will post on web.</p>	<p>ASAP</p>
<p>HSC/OHA Update Darren reported that the HSC had a meeting in January 2010, approved MHCD recommendations on amended guideline on behavioral assessment and intervention codes, and adding a clarification statement on provider types. They also added a new Statement of Intent, "Integrated Care SOI" allowing MHOs to use certain health and behavioral assessment and intervention codes. Added peer-delivered services codes to smoking cessation and alcohol and drug lines.</p> <p>April 1, 2010 list is complete, loaded into MMIS system, and is posted on the HSC website, including the extracted mental health lines.</p> <p>Darren is completing the letter to the legislature advising them of the changes in the Prioritized List.</p> <p>Three new members have joined the HSC, their terms officially start March 1, 2010 – Alberto Vasquez, Larry Betcher, and James Tyack.</p> <p>David Pollack reported that the Patient Centered Primary Care Home (PCPCH) Standards Advisory Committee has identified measures, attributes, and tiers for a PCPCH. They have completed their current work and it is available on the website. Carole Romm raised some concerns about payment, lack of prioritization of primary care, and differences in rural and urban areas that were discussed in the Committee. Continuing work on this issue will be done by the Incentives and Outcomes Committee and Quality Committees.</p>	<p>None.</p>		

TOPIC	ACTION	RESPONSIBILITY	DATE
<p>AMHD Update David Fischer reported on the Adult Mental Health Initiative, in exploratory talks with MHOs about adult residential care structures and processes. They are still looking for responses from the Mental Health Demonstration Project, to develop economies of scale into community mental health programs. Currently investigating getting reimbursement for peer-delivered services. There are a number of proposals submitted for the children's wraparound project so far.</p> <p>Concerns were raised that the most risky patients are carved out of coverage, due to the 16-bed federal rule.</p>	None.		
<p>Psychotropic Medication and the Availability of Non-Drug Services – Jim Russell Raised concerns about the coverage of psychotropic medications and the availability of non-drug services. Discussed that psychotropic medications can often diminish life quality and have a number of associated co-morbidities. Would like to find the home for examining this balance as a state policy issue.</p> <p>Ann Uhler discussed obtaining a list of reports on utilization of psychotropic medications, to compare to what is practiced compared to what is evidence-based and recommended.</p> <p>Gary Cobb raised the issue in support of having naturopaths and other alternative medicine providers to be a part of the conversation. Seth Bernstein discussed importance of evidence to show if these alternate therapies work if spending state dollars. Individual plans would be able to choose what to spend, but there may be issues with having some of these services being billable.</p> <p>Darren clarified that medications are not even on the List. Seth and Kathy discussed how the List is a blunt instrument to change this type of practice. David Pollack raised issue of how limitations would affect choices. Carole Romm recalled the political ramifications that previous discussions in the legislature had engendered.</p> <p>Carole Romm raised question of what are the alternatives to psychotropic medications. She also proposed potentially creating a guideline on the List and having the OHSU Evidence Based Practice Center examine this.</p> <p>Ann Uhler raised issue of how best can medication review occur. And also discussed how we need research to help guide oversight and recommendations.</p>	Jim Russell to continue discussions.		

TOPIC	ACTION	RESPONSIBILITY	DATE
<p>Lifting Restrictions on Extended Counseling Codes 90808 and 90809 – Seth Bernstein Seth presented recommendation to lift restrictions on use of these counseling codes, can be managed by plans, should not be micromanaged, Committee agreed.</p>	Lift restrictions.	Staff	
<p>The Prioritization of Lines form which Value-Based Services have been Extracted – Darren Coffman/Cat Livingston Reviewed the concept of the value-based services. Major concerns about the focus on medications. Multiple concerns were raised about medication without the context of counseling. There are real concerns about the political implications of having these types of services listed without counseling. There was also concern that the medication management and office visits would not be paid for.</p> <ul style="list-style-type: none"> a. Chemical Dependency – Carole Romm and others raised concerns that methadone is included as a value-based service and other services should also be included. Carole expressed concern that there are more likely to be studies about medication therapy because medications are tested for efficacy more readily by pharmaceutical companies who have the resources to fund studies. Other Committee members recognized this is an issue but felt methadone should still be listed as a value-based service (VBS). b. Depression – Committee was comfortable with both SSRIs and counseling. Seth raised the issue that CBT and IPT will then be covered for everything. c. Schizophrenia – discussed reasons for HSC removing schizophrenia from the VBS list due to controversial issues, lack of clear cut treatments, risk of overutilization of atypical antipsychotics, discussed reasons for this. d. Bipolar Disorder – there was some concern that bipolar is not a primary care condition, but then another issue relates to access. Conclusion felt that should remain on VBS list. <p>Line rankings – as VBS list goes into effect, those services will be extracted from existing lines. Next meeting the committee needs to readdress ranking and measure ratings of the lines. The MHCD committee did not have time to address this today and will discuss it next meeting.</p>	<p>Bring back to HSC that acamprosate should be covered, and that methadone should be switched to the VBS category of “Other” so as to include all methadone treatment.</p> <p>Raise issue that CBT and IPT will then be covered for everything, and will require some management (MHCD okay with this).</p> <p>Modifications to line ranking to be discussed at next meeting.</p> <p>Medication management codes</p>	Staff	May meeting
<p>Exclusion of insight oriented psychotherapy codes (90804 & 90806) from Guideline Note 28, Mood Disorders in Children Age 18 & Under Made a change to guideline for treatment for mood</p>	Include these codes.	Staff	

TOPIC	ACTION	RESPONSIBILITY	DATE
disorders from 5 and under up to 18. Now that expanded up to 18, needs to include insight oriented psychotherapy codes. Committee agrees to include these codes.			
Public Comment There was no public comment.	None		
Other Business Next meeting is scheduled for April 21, 2010 at the Wilsonville Training Center.	Send a reminder notice to members.	Dorothy	