

MEETING HIGHLIGHTS

MENTAL HEALTH CARE AND CHEMICAL DEPENDENCY SUBCOMMITTEE
Clackamas Community College
Wilsonville, Oregon
Room 218
January 21, 2009
8:30 – 11:30 a.m.

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

Members Absent: Donalda Dodson, RN, MPH; Ann Uhler.

Staff Present: Ariel Smits, MD, MPH; Darren Coffman.

Guests: David Fischer, AMHD; Tina Kitchin, MD, DHS-SPD; Kathryn Weit, HSC member; Bob Nickel, MD, OHSU; David Pass, MD, Health Resources Director; Bruce Abel, LaneCare.

TOPIC	ACTION	RESPONSIBILITY	DATE
<p>Review of Meeting Highlights November 19, 2008 highlights were reviewed.</p>	No modifications were suggested. .	Dorothy will post on web.	ASAP
<p>HSC/OHFB Update Darren Coffman reports that in December and January the HSC reviewed and approved new codes and guideline revisions that will take effect April 1, 2009 Prioritized List. The Dental Services Workgroup met in November, 2008 and is now an official subcommittee. That group will perform a comprehensive review of all dental lines over the next year. The Palliative Care Task Force has met once and will be meeting again soon to continue their discussions to suggest revisions to the Commission's Statement of Intent on Comfort Care.</p> <p>The Oregon Health Fund Board presented the final report to the Governor and key legislators in late November. It was happily noted that the Governor's Recommended Budget includes many of the OHFB's proposals including funding for Healthy Kids, expanding OHP Standard and establishing an all-payer all-claims database.</p> <p>He also notes that the ICD-10-CM implementation has been pushed back to October 1, 2013. This group should begin the review of the 50+ mental health and chemical dependency lines later this year/early next year.</p>	None		

TOPIC	ACTION	RESPONSIBILITY	DATE
<p>AMHD Update</p> <p>David Fischer reports that one area of focus for AMHD has been the issues arising from the roll-out of the new MMIS, mostly involving the managed care side of business. Other area's of work:</p> <ul style="list-style-type: none"> • reviewing OHP's rate structure with plans and ASU along with risk adjustment policy. • looking at Jarvis cost study on how costs relate to DMAP's reimbursement rates to determine if any changes need to be made. • The behavioral health integration project headed by Bob Nickel, which is a subset of the larger DHS transformation. It was suggested individuals contact Bob for more information, as this is just recently moving beyond being an internal process. <p>Kathy noted that there has been some backpeddling from the suggestion from the McKinsey report to combine physical health and mental health contracting. She also notes there is legislation to pull DMAP out of DHS and place it under a new Health Care Authority.</p> <p>Gary Cobb asked what is happening in terms of potential cuts to addiction services. Kathy pointed out that the Governor's Recommended Budget would actually bring OHP Standard enrollment up in trying to recover from the declines over the last six years. Also, there is a real push for the managed care plans to increase evidence-based A&D screening in the medical setting. Seth cautioned that the infrastructure is in a crisis mode and that the OHP side of business is clearly impacted just as all other sectors are by the current economical climate.</p>	None		
<p>Technical Adjustment Addition of Code H0023</p> <p>David Fischer, on behalf of AMH, requested that HCPCS code H0023 (Behavioral health outreach service, planned approach to reach a targeted population) be added to the list as a technical adjustment.</p> <p>Seth indicated that the plans can currently get capitated for these activities through the prevention, education, and outreach section of</p>	Come back with additional information in memo form on how this relates to CPMS and what documentation (e.g., diagnosis codes) is needed to satisfy federal requirements.	David Fischer	Feb. mtg

TOPIC	ACTION	RESPONSIBILITY	DATE
<p>Technical Adjustment Addition of Code H0023 (Cont'd) their submitted financial reports. any of these activities can currently be billed under other codes and there would be no budget affect. This may involve checking in with someone who had a problem a year ago, in which case about 2 in 10 will be found to be in need of services.</p> <p>Bruce Abel wondered if H0024-H0025 would be more appropriate as there are directed to individuals instead of a population. Darren suggested that the V79 series, Special screening for mental disorders and developmental handicaps, could act as a possible diagnosis code.</p>			
<p>Appropriate Placement of Services on Chronic Organic Mental Disorders & Autism Spectrum Disorders Lines Darren described the handouts on this topic:</p> <ul style="list-style-type: none"> • Codes and their descriptions currently on both lines. • Which of the top fifty procedure codes billed for individuals with ASD fall on the Prioritized List. <p>During the general discussion on the topic, the following issues/points were raised:</p> <ul style="list-style-type: none"> • 60% of children in intensive treatment programs in LaneCare have a diagnosis of ASD. They also are in residential and community-based treatment programs. Some clarity needs to be provided on who is responsible for these services (MHOs vs. Dept. of Education vs. SPD). • There is some evidence that Respiridol is effective at treating some features of autism. • How are Applied Behavioral Analysis (ABA) services coded, who can provide the services, and how much will it cost? • Pennsylvania is providing ABA services under a carve out of their medical assistance program through a waiver. Individuals can qualify if they are under 300% FPL and have hit the lifetime benefit limit of their private plan. • Two versions of an insurance mandate are being sponsored by Rep. Buckley along with another bill that would aim to coordinate services between systems. 	<p>See about getting breakouts by age (pediatrics vs. adult) and provider for top 50 procedure codes billed.</p> <p>Bring conduct disorder guideline to next meeting.</p> <p>Attempt to link MHCD Subcommittee with Governor's Commission on Autism</p>	<p>Darren will make inquiry to DMAP</p> <p>Darren</p> <p>Katherine Weit</p>	<p>ASAP</p> <p>Feb. mtg</p> <p>ASAP</p>

TOPIC	ACTION	RESPONSIBILITY	DATE
<p>Appropriate Placement of Services on Chronic Organic Mental Disorders & ASD Lines (Cont'd)</p> <p>The Subcommittee began going through the list of codes currently associated with ASD, looking first at those codes in the list of top 50 billings, and recommends including following codes (and any like them) on this line:</p> <ul style="list-style-type: none"> • ICD-9: 299.xx • CPT: 90801,90804-90806,90846-90847,90862 (w/a guideline),90882,90887,99201-99205,99211-99215 • HCPCS: G0176-G0177,H0031,H0034,H2010, H2014,H2032,T1016 <p>The subcommittee recommends removing the following codes from the ASD line that were on the list of top 50 billings (and any like them), many due to the fact that a comorbidity must be present:</p> <ul style="list-style-type: none"> • CPT: 90848,90850-90852 (invalid codes) • HCPCS: H0004,H0017-H0019,H0036-H0037,H0039,H2012,T1005 <p>The subcommittee did not reach a conclusion on the following codes:</p> <ul style="list-style-type: none"> • 90853 – Group psychotherapy • H0032 – Mental health service plan development • H2021 & H2022 – Community-based wraparound services <p>Future work:</p> <ul style="list-style-type: none"> • Develop a guideline that includes a list of common comorbid conditions that should be screened for (e.g., anxiety), similar to that done for the severe conduct disorder line. • Review PT/OT/speech guideline in relation to this population. 			
<p>Public Comment</p> <p>There was no public comment at this time.</p>	None		
<p>Other Business</p> <p>The next meeting was set for Wednesday, February 18th, from 8:30 – 11:00 am.</p>	Acquire a meeting room and send a notice to members.	Dorothy	ASAP

MEETING HIGHLIGHTS

MENTAL HEALTH CARE AND CHEMICAL DEPENDENCY SUBCOMMITTEE
Clackamas Community College Wilsonville Training Center
Wilsonville, Oregon
Room 218
February 18, 2009
8:30 – 11:00 a.m.

Members Present: Kathy Savicki, LCSW; Seth Bernstein, PhD; Michael Reaves, MD; David Pollack, MD; Donald Dodson, RN, MPH; Ann Uhler.

Members Absent: Gary Cobb; Carole Romm, RN.

Staff Present: Ariel Smits, MD, MPH; Darren Coffman.

Guests: David Fischer, AMHD; Tina Kitchin, MD, DHS-SPD; Kathryn Weit, HSC member; David Pass, MD, Health Resources Director.

TOPIC	ACTION	RESPONSIBILITY	DATE
<p>Review of Meeting Highlights January 21, 2009 highlights were reviewed.</p>	No modifications were suggested.	Dorothy will post on web.	ASAP
<p>HSC/OHFB Update Darren Coffman reported that the Health Services Commission (HSC) had not met since the last Subcommittee meeting. The Palliative Care Task Force finished up there recommendations on a set of three statements of intent to replace the current Statement of Intent on Comfort/Palliative Care. The Dental Services Subcommittee held their first meeting to review the eight dental lines and their associated guidelines earlier in the month.</p> <p>A series of six bills have been submitted by OHPPR to represent the recommendations of the Oregon Health Fund Board (OHFB). They are currently being reviewed by the House Health Care Committee along with HB 2009, Rep. Greenlick's bill on health care reform.</p> <p>Darren mentioned that he received a request to add 90875-90876 to certain mental health and chemical dependency lines for individual psychotherapy that incorporates the use of biofeedback. A citation was provided on the effectiveness of biofeedback for certain conditions, but not the actual article.</p>	The request to add 90875-90876 will be added to the April agenda, with materials on the topic obtained and distributed in advance.	Darren	April 1

TOPIC	ACTION	RESPONSIBILITY	DATE
<p>AMHD Update David Fischer indicated that AMH is finalizing a memo on the request to add HCPCS code H0023 (Behavioral health outreach service, planned approach to reach a targeted population) to the list as a technical adjustment.</p>	<p>Come back with memo on how H0023 relates to CPMS and what documentation (e.g., diagnosis codes) is needed to satisfy federal requirements.</p>	<p>David Fischer</p>	<p>April mtg</p>
<p>Appropriate Placement of Services on Chronic Organic Mental Disorders & Autism Spectrum Disorders Lines The Subcommittee continued to work on completing the handout on the code placement on these two lines for the 2010-11 list.</p> <p>The Subcommittee recommends including the following codes on the new ASD line:</p> <ul style="list-style-type: none"> • CPT: 90849, 96101, 96118, 98966-98969, 99051, 99060, 99366, 99441-99444 • HCPCS: H0002, H0038, H2011, H2027, S9484, T1013, T1023 <p>The Subcommittee confirmed that the following codes that are similar to those recommended for inclusion on the ASD line at the January meeting should also be included:</p> <ul style="list-style-type: none"> • CPT: 90807, 99201-99205, 99211-99212, 99215, 99241-99245 <p>The subcommittee recommends removing the following codes from the ASD line that are on the combined for 2008-09:</p> <ul style="list-style-type: none"> • CPT: 90853, 96150-96154 (also should not appear on COMD line), 99217-99220, 99605-99607 • HCPCS: H0032, H0033, H0035, H0045, H2013, H2021, H2022, H2023 <p>The Subcommittee confirmed that the following codes that are similar to those recommended for exclusion from the ASD line at the January meeting should also not be included:</p> <ul style="list-style-type: none"> • CPT: 90816-90819, 90823-90824, 90826-90827, 99221-99223, 99231-99236, 99238-99239, 99251-99255, 99304-99310, 99315, 99316, 99318, 99477, • HCPCS: S5151 <p>During the general discussion on the topic, the following issues/points were raised:</p> <ul style="list-style-type: none"> • Darren reported that DMAP was not able to provide the breakdown of ASD claims by age or by provider in time for this meeting. 	<p>Continue working on code placement on Chronic Organic Mental Disorders line.</p>	<p>Subcommittee</p>	<p>April mtg</p>

TOPIC	ACTION	RESPONSIBILITY	DATE
<p>Appropriate Placement of Services on Chronic Organic Mental Disorders & Autism Spectrum Disorders Lines (cont'd)</p> <ul style="list-style-type: none"> • ABA studies say a minimum of 15-20 hours per week needed to be effective. This is not considered a medical benefit. • Kathryn Weit indicated that a Governor executive order is in the works to set up a commission on autism with specific tasks. A bill is not necessary to do this. Legislation being proposed to set up a fund for insurance. A private insurance mandate bill on ASD services is expected. It will likely include some limits that are based on model legislation developed by Autism Speaks (send out to committee). • The wraparound initiative is struggling to understand the relationship between autism and comorbid conditions. Governor's Commission should sponsor a recommendation/be a facilitating group in these discussions. <p>A guideline was drafted to be attached to the ASD and read:</p> <p>Autism is a pervasive developmental disability that is characterized by <i><list core signs and symptoms></i>. Patients with this condition occasionally present with conditions and behaviors that may meet criteria for other co-morbid psychiatric disorders, including various mood disorders, anxiety disorders, or attention deficit disorder.</p> <p>While there is currently limited evidence of the effectiveness of treatment for autism itself, the focus of effective treatment is generally for associated behaviors, such as agitation, or for co-morbid mental health conditions. The treatment of co-morbid mental health conditions should be consistent with the treatment methods, frequency, and duration applied to those diagnoses. The treatment of associated behaviors that do not meet the criteria for co-morbid mental health diagnoses should be limited in frequency to a maximum of 8 hours of behavioral health service per month, subject to utilization management review by the MHO or other relevant payer. subject to utilization management review.</p>	<p>Revise draft guideline to include need for a functional behavioral assessment conducted by a clinician who has relevant expertise.</p>	<p>Darren to revise and distribute.</p>	<p>ASAP</p>

TOPIC	ACTION	RESPONSIBILITY	DATE
<p>Other Business</p> <p>Future work:</p> <ul style="list-style-type: none"> • Distribute draft ASD guideline for comment. • Review PT/OT/speech guideline in relation to this population. Do these limits include assessment, sensory integration, and/or environmental intervention? (David will talk to Rita) • Review early childhood mental disorder guidelines as many questions have arisen. • Take another look at Medicare guideline for 96150-96154, specifically the time restrictions and restrictions on provider types. Send out complete guideline to committee and see if there are other areas that need to be reviewed. 	<p>Darren will work to get this items on a future agenda if not for the next meeting.</p>		
<p>Public Comment</p> <p>There was no public comment at this time.</p>	<p>None</p>		
<p>Other Business</p> <p>The next meeting was set for Wednesday, April 15th, from 8:30 – 11:15 am.</p>	<p>Acquire a meeting room and send a notice to members.</p>	<p>Dorothy</p>	<p>ASAP</p>

MEETING HIGHLIGHTS

MENTAL HEALTH CARE AND CHEMICAL DEPENDENCY SUBCOMMITTEE
Clackamas Community College Wilsonville Training Center
Wilsonville, Oregon
Room 212
April 15, 2009
8:30 – 11:15 a.m.

Members Present: Donalda Dodson, RN, MPH, Chair; Kathy Savicki, LCSW; Seth Bernstein, PhD; David Pollack, MD; Ann Uhler.

Members Absent: Michael Reaves, MD; Gary Cobb; Carole Romm, RN.

Staff Present: Darren Coffman; Brandon Repp.

Guests: David Fischer, AMHD; Via teleconference: Dan Aspiri, Lana Loranger and Carrie Hall, Lincoln County; Kelli Parks-Freisen, Deschutes County; Bob Molesworth, Lutheran Community Services, Northwest; Teresa Wade, PH Tech; Sharon Orr, BestCare Treatment Services.

TOPIC	ACTION	RESPONSIBILITY	DATE
<p>Review of Meeting Highlights February 18, 2009 highlights were reviewed.</p>	No modifications were suggested.	Dorothy will post on web.	ASAP
<p>HSC/OHFB Update</p> <p>Darren Coffman reported that there have not been any HSC meetings since the MHCD met last.</p> <p>The April 1, 2009 Prioritized List has been loaded into the MMIS System with thanks to Brandon Repp, who also created a process for producing a valid and correct CPT code-placement file, which replaces the hand-edited files that have been used previously.</p> <p>Darren stated that codes 90828 and 90829 (inpatient 75-80 minute therapy session for children) were mistakenly not added to the current list and now must wait until October to be implemented.</p> <p>He reminded the subcommittee about a request discussed at February's meeting where a provider had asked to add codes 90875-90876 to certain mental health and chemical dependency lines for individual psychotherapy that incorporates the use of biofeedback. The provider has since consulted with a national Medicaid expert who advised him that the regular psychotherapy codes are appropriate for use in that situation.</p>	Ensure codes 90828 and 90829 are reviewed by the HSC and added to the October 1 list if approved.	HSC Staff	Next HSC meeting

TOPIC	ACTION	RESPONSIBILITY	DATE
<p>AMHD Update</p> <p>David Fischer presented a memo from AMH asking that HCPCS code H0023 (Behavioral health outreach service, planned approach to reach a targeted population) be added to the list as a technical adjustment for managed care and encounter codes only. AMH does not expect a financial impact with this addition, only a more accurate code than is currently being used for more accurate data collection.</p> <p>Discussion: Should this or a comparable code be added to Alcohol and Drug lines? How does it relate or integrate to the physical side? Members are interested in exploring the possibility.</p> <p>David reports that he has participated in a series of meetings with the actuarial unit, which will help refine objectives and goals in the next budget cycle.</p> <p>DMAP and AMH continue to work on the MMIS implementation. There is some modest improvement.</p> <p>Discussion: Has the OHP reservation method been reviewed to consider individuals with A&D issues for whom a waiting list or lottery system does not work? A lottery system is bias against those who come for treatment in a crisis and favors those that can wait for care.</p> <p>For those in crisis, waiting is “clinically ineffective” and eventually creates a larger financial impact on the system. The burden of illness is worse for certain groups. Those that encounter a waiting list instead of crisis treatment may not bother to sign up.</p> <p>The Oregon Health Study may address at these questions.</p>	<p>MHCD recommends this code be added to all mental health lines on the October 1, 2009 List.</p> <p>Come back with information for adding this type of code to the A&D lines.</p> <p>None</p> <p>None</p> <p>Formulate questions to be included in the study.</p>	<p>HSC Staff</p> <p>David</p> <p>David will ensure that the questions are forwarded to the study.</p>	<p>Next HSC meeting</p> <p>Next meeting</p>
<p>Autism Spectrum Disorder Guideline</p> <p>Discussion: There needs to be a plan for providing services when the child and family are in crisis. If the guideline is entered into the MMIS system in a rigid fashion or with a strict interpretation (hardwired) it may be near impossible to enforce the line that reads “...subject to utilization management review by the mental health organization (MHO) or other relevant payer.” The appeals and exceptions processes take an extreme effort on the part of providers. Are there any appropriate crisis codes?</p>	<p>Approve and forward to the HOSC for adoption.</p>	<p>Darren/staff</p>	<p>Next HOSC meeting: June 11, 2009</p>

TOPIC	ACTION	RESPONSIBILITY	DATE
<p>Autism Spectrum Disorder Guideline (cont'd) In the event that there is a co-morbid mental health condition, the co-morbid condition should be billed as the primary diagnosis, say for example <i>adjustment disorder</i>.</p> <p><u>Revised guideline with incorporated suggestions:</u> Autism Spectrum Disorders (ASD) represent pervasive developmental disabilities that are characterized by impairments in social communication and interaction, along with patterns of restricted and repetitive behaviors. Patients with these diagnoses occasionally present with conditions that may meet criteria for other co-morbid psychiatric disorders, including various mood disorders, anxiety disorders, <u>adjustment disorder</u>, or attention deficit disorder. A functional behavioral assessment conducted by a clinician who has relevant expertise working with this population is imperative in identifying these potential co-morbid disorders. <u>for formulating a differential diagnosis.</u></p> <p>While there is currently limited evidence of the effectiveness of treatment for ASD itself, the focus of effective treatment is generally for associated behaviors, such as agitation, or for co-morbid mental health conditions. <u>If any co-morbid condition is the target of treatment, that condition, not an ASD diagnosis, should be the primary diagnosis for billing purposes.</u> The treatment of co-morbid mental health conditions should be consistent with the treatment methods, frequency, and duration applied to those diagnoses. The treatment of associated behaviors that do not meet the criteria for co-morbid mental health diagnoses should be limited in frequency to a maximum of 8 hours of behavioral health service per month, subject to utilization management review by the mental health organization (MHO) or other relevant payer.</p>			
<p>Appropriate Placement of Services on Chronic Organic Mental Disorders (COMD)</p> <p><u>Discussion:</u></p> <ul style="list-style-type: none"> • ICD-9-CM codes not on the ASD line should appear on COMD line • Should Traumatic Brain Injury (TBI) be present in this discussion? The co-morbid mental health condition should be the primary diagnosis. • Look at drafting a guideline associated with COMD. • Obtain billing data from DMAP for utilization of this line. • Talk to the Veteran's Administration (VA) about volume of treatment for this condition (Dr. Heims contact, and Tina for SDSD) 	<p>Put this topic back on the agenda for June meeting</p> <p>OHPR has access to the technology and will run a report.</p> <p>Contact Tina Kitchin from SPD and Dr. Heims.</p>	<p>Darren/Staff</p> <p>Darren/Brandon</p> <p>Darren/Staff</p>	<p>Next meeting</p> <p>Next meeting</p>
<p>Review of Early Childhood Mental Health Disorder Guidelines Mental health clinical and billing professionals from around the state joined in a conference call to discuss coverage of ICD-9-CM code 296.90, Unspecified</p>			

TOPIC	ACTION	RESPONSIBILITY	DATE
<p>Review of Early Childhood Mental Health Disorder Guidelines (cont'd) Episodic Mood Disorder, for individuals over the age of five and the associated <i>Guideline Note 28: Mood Disorders in Early Childhood.</i></p> <p>Guests expressed concern that there is an inconsistency of how claims are paid between open card and managed care clients. They are seeing claims under the Fee-For-Service model being paid even in adult diagnosis using code 296.90 and never under a managed care plan.</p> <p>There was also a question regarding the interpretation of the phrase "in early childhood." MHCD members clarified the phrase means, as the guideline text states, services for children age five and under.</p> <p>Darren stated that the guidelines may need retooling and offered a document thoroughly explaining all the early childhood disorder guidelines. He also cautioned that the HSC leans toward the use of more specific diagnostic codes and limits the use of NOS (not otherwise specified) or unspecified codes such as 296.90.</p> <p>It was clarified that code 296.90 was not available for any use until this guideline was adopted for the April 1, 2006 Prioritized List of Health Services and so has never been approved for use in individuals over the age of five.</p> <p><u>Guideline Revision suggestions:</u></p> <p>Guideline note changes with no fiscal impact can be reviewed by the HSC at any time during the year and changes made to the list in April and October.</p> <p>For clarity, change every guideline instance of "early childhood" to read "<u>children age five and under.</u>"</p> <p>Change second paragraph of Guideline Note 28, to read: Use of 296.90 for children five years old and under is limited to pairings with the following procedure codes:</p> <p>Guideline Note 25 should not be restricted by age. Move reference to age range from the first to the second paragraph. (See Attachment A)</p> <p>Guideline Note 45 needs rewording for clarity.</p>	<p>Check to see if Fee-For-Service system to ensure the age limit restriction is enforced. Darren will email codes that need to be researched to David.</p> <p>The expectation from the subcommittee is that mental health providers use the most specific diagnostic code possible, rather than NOS codes. Use of code 296.90 should be limited to use with children age 5 and younger only. Even for crisis intervention and assessment, a provisional diagnosis is appropriate.</p> <p>Work on wording and bring back to the next meeting for review and approval.</p>	<p>David</p> <p>Darren/Staff</p>	<p>ASAP</p> <p>Next meeting</p>

TOPIC	ACTION	RESPONSIBILITY	DATE
<p>Public Comment</p> <p>There was no public comment at this time.</p>	None		
<p>Other Business</p> <p>Concerns raised about the need for occupational therapy (OT) for kids with neurodevelopmental problems contributing to their mental health issues.</p> <p>The next meeting was set for Wednesday, June 17th, from 8:30 – 11:15 am, in room 218 of the Wilsonville Training Center.</p> <p>Future meetings will be set on a quarterly basis, starting in September.</p>	<p>Members will bring guests to comment on the guideline in this respect.</p> <p>Put this topic on the agenda for June meeting</p> <p>Send a reminder notice to members.</p>	<p>All</p> <p>Darren/Staff</p> <p>Dorothy</p>	<p>Next meeting</p> <p>Late May</p>

MEETING HIGHLIGHTS

MENTAL HEALTH CARE AND CHEMICAL DEPENDENCY SUBCOMMITTEE
Clackamas Community College Wilsonville Training Center
Wilsonville, Oregon
Room 218
June 17, 2009
8:30 – 11:15 a.m.

Members Present: Donalda Dodson, RN, MPH, Chair; Gary Cobb; Michael Reaves MD; Kathy Savicki, LCSW; David Pollack, MD; Ann Uhler.

Members Absent: Seth Bernstein, PhD; Carole Romm, RN.

Staff Present: Darren Coffman; Brandon Repp, Dorothy Allen.

Guests: David Fischer, AMHD

TOPIC	ACTION	RESPONSIBILITY	DATE
<p>Review of Meeting Highlights</p> <p>April 15, 2009 highlights were reviewed.</p> <p>Ann wanted to clarify this subcommittee's intent that the ASD guideline <u>not</u> be hard-wired into MMIS.</p>	<p>No modifications were suggested.</p>	<p>Dorothy will post on web.</p>	<p>ASAP</p>
<p>HSC/OHFB Update</p> <p>Darren Coffman reported that the Health Outcomes Subcommittee (HOSC) last met on June 11, 2009, where the group reviewed miscellaneous items, tweaked some guidelines and added the 70-80 minute inpatient therapy codes. The HOSC members reviewed this subcommittee's recommendations for wording of the Autism Spectrum Disorder (ASD) Guideline carefully and felt that it was too wordy and contained unnecessary language. They suggested the guideline be shortened to read:</p> <p><i>There is limited evidence of the effectiveness of treatment for Autism Spectrum Disorders (ASD). However, effective treatments may be available for co-morbid conditions such as mood disorders. When treating co-morbid conditions, that condition, not an ASD diagnosis, should be the primary diagnosis for billing purposes. The treatment of co-morbid mental health conditions should be consistent with the treatment methods, frequency, and duration normally applied to those diagnoses. Treatment for associated behaviors, such as agitation, that do not meet the criteria for co-morbid mental health diagnoses should be limited in frequency to a maximum of 8 hours of behavioral health service per month, subject to utilization management review by the mental health organization (MHO) or other relevant payer. A functional behavioral assessment conducted by a</i></p>			

TOPIC	ACTION	RESPONSIBILITY	DATE
<p>HSC/OHFB Update (cont'd)</p> <p><i>clinician who has relevant expertise working with this population may be utilized in formulating a differential diagnosis.</i></p> <p>The members present wholeheartedly felt the guideline they crafted at their last meeting is appropriate considering the political climate and should stand. They respectfully disagreed with the HOSC's recommendation and asked that their guideline be presented to the Health Services Commission (HSC) as originally recommended at the next opportunity.</p> <p>Darren further reported that the "2009 Health Services Commission Biennial Report" has been released and distributed copies to the members.</p>	<p>Forward the MHCD's ASD guideline as written to the HSC.</p> <p>Members who were not present will have their copies mailed to them.</p>	<p>Darren/Staff</p> <p>Dorothy</p>	<p>Next HSC meeting August 6, 2009</p> <p>ASAP</p>
<p>AMHD Update</p> <p>David Fischer reports that there are still issues with MMIS's ability to track current encounter data and that there may be changes in the rate structures for the managed care contracts in the near future as AMH finalizes the 2010 contracts. Also, there is discussion about moving forward with a pilot project involving a broader community involvement.</p> <p>There have been issues with screening code T1023 not pairing correctly and therefore kicking out of the system to be hand-reviewed. A solution presented would be to add that code to the diagnostic list, making a pairing unnecessary.</p> <p>T1023 - Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter</p> <p>H0031 - Mental health assessment by non-physician.</p> <p>H0002 - Behavioral health screening to determine eligibility for admission to treatment program</p> <p>90801 - Psychiatric diagnostic interview examination.</p> <p>90802 - Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication.</p> <p>H0001 - Alcohol and/or drug assessment</p> <p>96101 - Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g. MMPI, Rorschach®, WAIS®)</p>	<p>Recommend to the HOSC that codes T1023, H0031, H0002, 90801, 90802, H0001 be added to the diagnostics list.</p> <p>96101 not recommended to be diagnostic. A provisional diagnosis must be made before this type of costly testing can be administered.</p>	<p>David Fischer will send a memo to HSC staff.</p> <p>Darren/staff will present to the HOSC.</p>	<p>ASAP</p> <p>Next HOSC meeting August 6, 2009.</p>

TOPIC	ACTION	RESPONSIBILITY	DATE
<p>AMHD Update (Cont'd)</p> <p>per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.</p> <p>The members agreed the codes should be moved to the diagnostics line. Concern was raised that removing the codes makes them less visible to the physicians.</p> <p>Ann asked that A&D screening codes to be placed on the list. .</p> <p>99408 - Alcohol and/or substance (other than tobacco) abuse structured screening, and brief intervention services; 15 to 30 minutes. 99409 -Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes.</p>	<p>Include language on the MHDC extracted lines document that these codes have been moved.</p> <p>Recommend to the HOSC that codes 99408-99409 be added to line 5 (Abuse or Dependence of Psychoactive Substance).</p>	<p>Staff</p> <p>Darren/staff</p>	<p>October's list.</p> <p>Next HOSC meeting August 6, 2009.</p>
<p>Revisit Early Childhood Mental Health Disorder Guideline</p> <p>David Pollack reported that since the last MHCD meeting there had been an inquiry from child psychologists (Nancy Winters and Keith Cheng) who asked that the age restriction for code 296.90 (Unspecified Episodic Mood Disorder) be lifted to include children age 18 and under. They felt that requiring a specific diagnosis for children between the ages of 6 and 18 may lead to misdiagnosis, potential labeling and misuse or over-use of medication therapy.</p> <p>Based on the additional information, the members agreed with these recommendations.</p> <p>Other guidelines: Approve all guideline notes as in meeting materials with exceptions (<i>see Attachment A</i>):</p> <ol style="list-style-type: none"> 1) Add the word "any" in the first sentence of guideline 25, just before "children." 2) For guideline 45, add the phrase, "who have experienced abuse or neglect" to the second sentence. 3) Amend title of guideline 28 to indicate the code is for use in "children 18 and under." 4) Additionally, add a statement to the PTSD line noting the guideline. 	<p>Accept the recommendation and ask that Drs. Winters and Cheng submit their suggestions for amending Guideline Note 28.</p> <p>Email the edited guideline to MHCD members for input before the August HOSC meeting.</p> <p>Forward these recommendations to the HOSC.</p>	<p>Darren/staff will follow up with Drs. Winters and Cheng.</p> <p>Darren/staff</p> <p>Darren/staff</p>	<p>ASAP</p> <p>ASAP</p> <p>Next HOSC meeting August 6, 2009.</p>

TOPIC	ACTION	RESPONSIBILITY	DATE
<p>Appropriate Placement of Services on Chronic Organic Mental Disorders (COMD)</p> <p>Darren presented a cost break down of treatment codes currently on line 210 (Chronic Organic Mental Disorders Including Dementias) (<i>See Attachment B</i>). Members reviewed the information and felt both the usage and costs seem reasonable.</p>	<p>Leave all existing procedure codes on the COMD line.</p>	<p>OHPR Staff has access to the technology and will run reports as requested.</p>	<p>As needed</p>
<p>Public Comment</p> <p>There was no public comment at this time.</p>	<p>None</p>		
<p>Other Business</p> <p>The group discussed requesting a series of annual reports aimed at examining the effectiveness of guidelines for certain conditions/treatments, such as ASD and mental health medication for children. Darren noted that staff have the ability to run reports and can facilitate the data requests.</p> <p>Darren mentioned that DHS's data lag-time is running approximately a year behind; data collected prior to June 2008 is being used as the most current and accessible data.</p> <p>Ann asked to have a discussion about occupational therapy (OT) at the next meeting.</p> <p>David Pollack reviewed health care reform bills for the group's edification.</p> <p>The next meeting was set for Wednesday, September 15th, from 8:30 – 11:15 am, in room 218 of the Wilsonville Training Center.</p>	<p>Place on the agenda to discuss at the next MHCD meeting.</p> <p>Place on the agenda to discuss at the next MHCD meeting.</p> <p>None</p> <p>Send a reminder notice to members.</p>	<p>Darren/Staff</p> <p>Darren/Staff</p> <p>None</p> <p>Dorothy</p>	<p>Next MHCD meeting 9/15/09</p> <p>Next MHCD meeting 9/15/09</p> <p>.</p> <p>August 2009</p>

ATTACHMENT A

Draft Revisions for Review on Guidelines for Early Childhood Mental Health Disorders

GUIDELINE NOTE 20, ATTENTION DEFICIT AND HYPERACTIVITY DISORDERS IN ~~EARLY CHILDHOOD~~ CHILDREN AGE FIVE AND UNDER

Line 134

When using 314.9, Unspecified Hyperkinetic Syndrome, in children age 5 and under, it is appropriate only when the following apply:

- Child does not meet the full criteria for the full diagnosis because of their age.
- For children age 3 and under, when the child exhibits functional impairment due to hyperactivity that is clearly in excess of the normal activity range for age (confirmed by the evaluating clinician's observation, not only the parent/caregiver report), and when the child is very limited in his/her ability to have the sustained periods of calm, focused activity which would be expected for the child's age.

For children age 3 and under, it is especially important that psychosocial interventions, including parent skills training and/or parent-child therapy, and environmental modifications, be tried prior to medication. For children over the age of 3, psychosocial interventions are important, whether the child is on medications or not.

Use of 314.9 for children age five and younger is limited to pairings with the following procedure codes:

- Assessment and Screening: 90801, 90802, H0002, H0031, H0032, T1023
- Family interventions and supports: 90846, 90847, 90849, 90887, H0038, H0045, H2021, H2022, H2027, S5151, S9125, T1005
- Group therapy: 90853, 90857, H2032
- Medication management: 90862
- Case Management: 90882, T1016
- Interpreter Service: T1013

GUIDELINE NOTE 25, MENTAL HEALTH PROBLEMS IN ~~EARLY CHILDHOOD~~ CHILDREN AGE FIVE AND UNDER RELATED TO NEGLECT OR ABUSE

Line 181

995.52, Child Neglect (Nutritional), 995.53, Child Sexual Abuse, and 995.54, Child Physical Abuse, may be used in any children age five and younger when there is evidence or suspicion of abuse or neglect. These codes are to be used when the focus of treatment is on the alleged child victim. This can include findings by child welfare of abuse or neglect; or statements of abuse or neglect by the child, the perpetrator, or a caregiver or collateral report. Although these diagnoses can be used preventively, i.e. for children who are not yet showing symptoms, presence of symptoms should be demonstrated for interventions beyond evaluation or a short-term child or family intervention.

The codes 995.52-995.54 may be used in children age five and younger and, in these instances only, is limited to pairings with the following procedure codes:

- Assessment and Screening: 90801, 90802, H0002, H0031, H0032, T1023
- Family interventions and supports: 90846, 90847, 90849, 90887, H0038, H0045, H2021, H2022, H2027, S5151, S9125, T1005
- Individual counseling and therapy: 90810, 90812
- Group therapy: 90853, 90857, H2032
- Case Management: 90882, T1016
- Interpreter Service: T1013
- Medication management, 90862, is not indicated for these conditions in children age 5 and under.

GUIDELINE NOTE 28, MOOD DISORDERS IN ~~EARLY CHILDHOOD~~ CHILDREN AGE EIGHTEEN AND UNDER

Line 213

The use of 296.90, Unspecified Episodic Mood Disorder, is appropriate only when the following apply:

- For children ~~five~~ 18 years old and under.
- In the presence of significant difficulty with emotional regulation that causes functional impairment.

Use of 296.90 ~~for children five years old and under~~ is limited to pairings with the following procedure codes:

- Assessment and Screening: 90801, 90802, H0002, H0031, H0032, T1023
- Family interventions and supports: 90846, 90847, 90849, 90887, H0038, H0045, H2021, H2022, H2027, S5151, S9125, T1005
- Individual Counseling and Therapy: 90810, 90812, H0004
- Group therapy: 90853, 90857, H2032
- Medication management: 90862
- Case Management: 90882, T1016
- Interpreter Service: T1013

ATTACHMENT A

Draft Revisions for Review on Guidelines for Early Childhood Mental Health Disorders

GUIDELINE NOTE 42, DISRUPTIVE BEHAVIOR DISORDERS IN ~~EARLY CHILDHOOD~~ CHILDREN AGE FIVE AND UNDER

Line 439

The use of 312.9, Unspecified Disturbance of Conduct, is appropriate only for children five years old and under who display sustained patterns of disruptive behavior beyond what is developmentally appropriate.

- Interventions should prioritize parent skills training in effective behavior management strategies or focus on other relational issues.

Use of 312.9 is limited to pairings with the following procedure codes:

- Assessment and Screening: 90801, 90802, H0002, H0031, H0032, T1023
- Family interventions and supports: 90846, 90847, 90849, 90887, H0038, H0045, H2021, H2022, H2027, S5151, S9125, T1005
- Individual Counseling and Therapy: 90810, 90812, H0004
- Group therapy: 90853, 90857, H2032
- Case Management: 90882, T1016
- Interpreter Service: T1013
- Medication management, 90862, is not indicated for these conditions in children age 5 and under.

GUIDELINE NOTE 45, ADJUSTMENT REACTIONS IN CHILDREN AGE FIVE AND UNDER

Line 462

ICD-9-CM code 309.89 can be used for individuals of any age. However, when using it for children five years of age or younger, who have experienced abuse or neglect, the following must apply:

1. The child must demonstrate some symptoms of PTSD (such as disruption of his or her usual sleeping or eating patterns, or more increased irritability/lower frustration tolerance) but does not meet the full criteria for PTSD or any other disorder.
2. 309.89 is limited to pairings with the following procedure codes:
 - Assessment and Screening: 90801, 90802, H0002, H0031, H0032, T1023
 - Group Therapy: 90853, 90857, H2032
 - Family Interventions and Supports: 90846, 90847, 90849, 90887, H0038, H0045, H2021, H2022, H2027, S5151, S9125, T1005
 - Case Management: 90882, T1016
 - Interpreter Service: T1013
 - Individual Counseling and Therapy: 90810, 90812
 - Medication Management, 90862, is not indicated for this condition in children five years of age or younger.

Note: Cessation of the traumatic exposure must be the first priority. Infants and toddlers may benefit from parental guidance regarding management of the child's symptoms, parental guidance around enhancing safety and stability in the child's environment, and therapeutic support for the parents.

Two V-codes, V61.20 (Counseling for Parent-Child Problem, Unspecified) and V62.82 (Bereavement, Uncomplicated), may only be used as secondary diagnoses to the primary diagnosis of 309.89, and only for children five years of age or younger.

1. When using V61.20, the following must apply:
 - a. Service provision will have a clinically significant impact on the child.
 - b. A rating of 40 or lower has been assessed on the PIR-GAS (Parent-Infant Relationship Global Assessment Scale).
 - c. The same limitations in pairings to CPT and HCPCS codes as given for ICD-9-CM code 309.89 apply, with the only exception being that 90810 and 90812 cannot be used.
2. When using V62.82, the following must apply:
 - a. The child exhibits a change in functioning subsequent to the loss of a primary caregiver;
 - b. The child exhibits at least three of the following eight symptoms:
 - i. Crying, calling and/or searching for the absent primary caregiver,
 - ii. Refusing attempts of others to provide comfort,
 - iii. Emotional withdrawal manifesting in lethargy, sad facial expression, and lack of interest in age-appropriate activities that do not meet mood disorder criteria,
 - iv. Disruptions in eating and sleeping that do not meet criteria for feeding and eating disorders of infancy or early childhood,
 - v. Regression in or loss of previously achieved developmental milestones not attributable to other health or mental health conditions,
 - vi. Constricted range of affect not attributable to a mood disorder or PTSD,
 - vii. Detachment, seeming indifference toward, or selective "forgetting" of the lost caregiver and/or of reminders of the lost caregiver,
 - viii. Acute distress or extreme sensitivity in response to any reminder of the caregiver or to any change in a possession, activity, or place related to the lost caregiver;

ATTACHMENT A

Draft Revisions for Review on Guidelines for Early Childhood Mental Health Disorders

GUIDELINE NOTE 45, ADJUSTMENT REACTIONS IN CHILDREN AGE FIVE AND UNDER (Cont'd)

- c. The symptoms in 2(b) above are exhibited for most of the day and for more days than not, for at least 2 weeks.
- d. The same limitations in pairings to CPT and HCPCS codes as given for ICD-9-CM code 309.89 apply.

Note: Intervention should include persons significantly involved in the child's care and include psychoeducation and developmentally-specific guidance.