



**Health Evidence Review
Commission's
Behavioral Health Advisory Panel**

September 16, 2015

9:00 AM

**Clackamas Community College
Wilsonville Training Center, Room 210
29373 SW Town Center Loop E, Wilsonville, Oregon,
97070**

Section 1.0

Call to Order

AGENDA
BEHAVIORAL HEALTH ADVISORY PANEL (BHAP)
September 16, 2015
9:00-11:00 AM

Wilsonville Training Center, Room 210

(All agenda items are subject to change and times listed are approximate)

#	Time	Item	Presenter
1	9:00	Call to Order	David Pollack
2	9:05	Purpose of Meeting	Darren Coffman
3	9:10	Prioritized List issues 1) Integration of medical and mental health lines for child abuse and neglect 2) Guideline notes with differential treatment of children by age (GN 20, 25, 28, 42, 45) 3) Possible new line acute substance intoxication and/or withdrawal 4) SOI 3 INTEGRATED CARE	Ariel Smits
4	10:30	Coding/reimbursement issues with integrated care	Denise Taray
5	10:45	Other Business	David Pollack
6	10:55	Public Comment	
7	11:00	Adjournment	David Pollack

MINUTES

Behavioral Health Advisory Panel
Meridian Park Community Health Education Center
19300 SW 65th Avenue, Tualatin, OR
October 23, 2013
10:00 am--12:00 pm

Members Present: David Pollack, MD, Chair; Kathy Savicki; Michael Reaves, MD; Ann Uhler; Gary Cobb (arrived at 10:20)

Members Absent: Seth Bernstein

Staff Present: Darren Coffman (by phone); Ariel Smits, MD, MPH; Jason Gingerich

Also Attending: Ralph Summers, David Fischer, and Denise Taray (DMAP); Tobi Rates (Autism Society of Oregon)

1. CALL TO ORDER

David Pollack called the meeting to order at 10:00 am. Smits explained that HERC staff has identified some issues related to DSM-5 changes from DSM-IV-TR as well as possible issues with the October 2014 prioritized list.

2. REVIEW OF DSM-5 CHANGES

The group discussed the recommendations shown in the meeting materials. Subcommittee recommendations pertaining to these recommendations are shown. (All line numbers referenced are for the April 1, 2014 Prioritized List except where noted.)

- 1) **Intellectual Disability**—There was no discussion.

Recommendation: Add ICD-10-CM F70 to the following lines for the October, 2014 Prioritized List:

- i. 349 NEUROLOGICAL DYSFUNCTION IN COMMUNICATION CAUSED BY CHRONIC CONDITIONS
 - ii. 381 DYSFUNCTION RESULTING IN LOSS OF ABILITY TO MAXIMIZE LEVEL OF INDEPENDENCE IN SELF- DIRECTED CARE CAUSED BY CHRONIC CONDITIONS THAT CAUSE NEUROLOGICAL DYSFUNCTION
- 2) **Autism spectrum disorder**—The subcommittee briefly discussed the staff recommendations. Tobi Rates (Autism Society of Oregon) testified in support of expanding coverage for medically necessary Applied Behavior Analysis (ABA) for children with Autism Spectrum Disorder. In addition, she said that coverage for other therapies covered under OHP is insufficient, giving the example of her 9-year old nonverbal child who she believed was eligible for only eight sessions per year (Editor's note: Coverage for speech therapy is currently limited per Guideline Note 6 to 12

sessions per year for OHP recipients ages 8-12, with an additional 6 visits if there is a change of status). She asked if these therapies are part of the discussion that the Evidence-based Guidelines Subcommittee (EbGS) is having about ABA. Staff explained that ABA is a separate topic from physical, occupational and speech therapy, but the subcommittee agreed that changes to coverage for these therapies could be considered along when any changes related to ABA coverage after the discussion moves to the Value-based Benefits Subcommittee (VbBS). Rates also noted that when calling OHP about these therapies she expressed concern that it is frustrating to get routed back and forth between physical health and mental health areas, since autism is a mental health condition and yet these therapies are often treated as a physical health treatment. Rates said her group would like to see sensory integration, for instance, covered as well. She said there are a whole set of therapies not well covered under the current mental health guideline. This discussion will need further research by staff.

Recommendations:

- i. Rename line 334 (April 2013 list)/line 313 (October 2014 list) AUTISM SPECTRUM DISORDERS.
- ii. For the October 2014 list, add ICD-10-CM code F80.89 to line 349 (NEUROLOGICAL DYSFUNCTION IN COMMUNICATION...) and remove it from DMAP's ancillary file.
- iii. Staff to review physical/occupational therapy coverage for autism and consider recommending changes for future VbBS meeting.

- 3) **Disruptive mood dysregulation disorder**—Subcommittee members expressed concern that some children with this condition may be receiving inappropriate medication because of a diagnosis of bipolar disorder. Pollack said that these children may not have a bipolar disorder diagnosis when they get older, but may instead end up having depressive disorder. Savicki was uncomfortable putting it on the major depression line. Pollack suggested giving this its own line. Smits suggested putting it on the line with Oppositional Defiant Disorder and changing the name, but the group said this condition is different. Savicki said there may be underlying neurological challenges. After reviewing the DSM-5 language the group, in light of the delay in the possibility of creating a new line, discussed whether to put it on the anxiety disorders line or depression line, and decided that line 212 DEPRESSION AND OTHER MOOD DISORDERS, MILD OR MODERATE would be appropriate. Reaves recommended that staff consult with child psychiatry practitioners to confirm that this is appropriate.

Recommendations:

- i. Move ICD-9-CM code 296.99 from line 32 BIPOLAR DISORDERS to line 212 DEPRESSION AND OTHER MOOD DISORDERS, MILD OR MODERATE (207 on the October 2014 list).
- ii. Add ICD-10-CM code F34.8 to line 212 DEPRESSION AND OTHER MOOD DISORDERS, MILD OR MODERATE and advise DMAP to remove it from the Excluded File
- iii. Staff to consult with a child psychiatrist to confirm whether this placement is appropriate, whether a guideline note would be helpful and whether a new line may be appropriate for the biennial review

4) Premenstrual dysphoric disorder—There was minimal discussion.

Recommendation: Add ICD-9-CM code 625.4 to line 212 and ICD-10-CM code N94.3 to corresponding line 207 on the October 2014 list and remove them from line 581 DYSMENORRHEA (line 562 in October 2014).

5) Trichotillomania—There was minimal discussion.

Recommendation: Move 312.39 to line 487 OBSESSIVE-COMPULSIVE DISORDERS and, in October, 2014, move F63.3 to corresponding line 467.

6) Body dysmorphic disorder

Recommendation: Add F45.22 to line 467 for the October, 2014 list and remove from line 497 SOMATIZATION DISORDER, SOMATOFORM PAIN DISORDER, CONVERSION DISORDER.

7) October, 2014 Line 497, Somatization disorder—The subcommittee discussed how the conditions on this line have a negative connotation for some, and determined that it is inappropriate to have line 497 ranked differently from line 462 FACTITIOUS DISORDERS (on the October 2014 list), noting that factitious disorders do not involve conscious deception. Smits noted that line 462 currently has consultations as the only treatments. Coffman noted that conversion disorder would also be included, and has not previously been covered. Pollack said it should be covered as it is even less conscious than factitious disorders. They also discussed adding the health and behavior assessment codes to enhance care and reduce unnecessary testing and drugs for these conditions. Savicki suggested removing some of the HCPCS codes from line 497. They determined that these changes should be separate from the pending review of fibromyalgia. She said the appropriate codes for these conditions are consultations and medical office interventions (including health and behavior assessments). Once a true mental health diagnosis is arrived at, appropriate treatment can be arranged.

Recommendation: Staff will draft a proposal for merging the conditions and appropriate treatments from line 497 into line 462 and renaming that line “SOMATIC SYMPTOMS AND RELATED DISORDERS”. This line may include consultation, office-based interventions, and health and behavior code group. This proposal will be brought to the VBBS of the HERC.

8) Binge eating disorder—The group reviewed the staff recommendation to move F50.8 to October, 2014 line 385 BULIMIA NERVOSA. Coffman asked if this would mean we would cover treatment of pica (a condition included in F50.8) in adults but not children. Smits proposed a coding specification to exclude coverage of pica from line 385. The group discussed pica in adults, that it is rare but sometimes occurs with pregnancy or in disabled individuals.

Recommendation: Add F50.8 to line 385 BULIMIA NERVOSA to cover binge eating disorder with a coding specification that it is placed on this line for binge eating disorder. It should remain on line 640 PICA for pica in adults and all other subdiagnoses.

- 9) **Reactive Attachment disorder/Disinhibited Social Engagement Disorder**—The subcommittee discussed the latter condition and decided it was appropriately placed on line 454 REACTIVE ATTACHMENT DISORDER OF INFANCY OR EARLY CHILDHOOD. No changes were recommended.
- 10) **Social Anxiety Disorder (Social Phobias)**—Subcommittee reviewed the staff recommendation.

Recommendation: Rename line 463 SIMPLE PHOBIAS AND SOCIAL ANXIETY DISORDER

- 11) **Conduct Disorder and Oppositional Defiant Disorder**—The subcommittee discussed these conditions and determined no changes to the current placement are required. Smits noted that conduct disorder is currently below the funding line and suggested that combining the lines might be appropriate for the biennial review. Initial discussion supported combining the lines. However Coffman noted that the funding line can't be moved up for several years due to Oregon's federal waiver, so anything moved above the funding line would increase costs for the CCO's, and that HERC would need to hear strong reasoning to make a change like this. Savicki said that conduct disorder is expensive to treat with limited effectiveness. After discussion the subcommittee recommended no placement changes be made.
- 12) **Attention Deficit/Hyperactivity Disorder**—The subcommittee discussed the importance of including the slash in between attention deficit and hyperactivity as this highlights that a person may have either attention disorder or hyperactivity or both.

Recommendation:

- i. Rename line 133 (and line 126 on the October, 2014 prioritized list) ATTENTION DEFICIT/HYPERACTIVITY DISORDERS
 - ii. Change Guideline Note 54: replace "attention deficit disorder (ADD)" with "attention deficit/hyperactivity disorder"
- 13) **Separation anxiety disorder**—The subcommittee discussed how this can now apply to adults and is an anxiety disorder, and considered putting it on an anxiety line. However the ICD-10-CM code specifies children. After discussion, the group decided not to make any changes to placement for this code as these lines are ranked in the same area of the list. In 2016 if data supports separating them, then the code could be moved to the anxiety line for adults. The group recommended no coding changes or coding specification for the list.
- 14) **Substance Use Disorders**—The subcommittee agreed with the staff-recommended change to the description of line 5 (line 4 in October 2014) to "SUBSTANCE USE DISORDER," reflecting DSM-5. Pollack and Coffman noted that line 4 may be confusing as it may be confused with October, 2014 line 619 ABUSE OF NONADDICTIVE SUBSTANCES.

In discussion of F55.3 Abuse of steroids and hormones, the group decided to move the code to October, 2014 line 619 ABUSE OF NONADDICTIVE SUBSTANCES as the substance is not physiologically addictive, though it is psychologically addictive. If there is an underlying disorder such as body dysmorphic disorder that could be diagnosed and treated.

The group discussed the staff recommendation for the codes on October 2014 line 478 USE OF ADDICTIVE SUBSTANCES. After discussion, the subcommittee decided to recommend moving the ICD-10-CM codes having a description including the words, "...with other substance induced disorder" to October 2014 line 66 SUBSTANCE-INDUCED MOOD ANXIETY AND DELUSIONAL DISORDERS with no coding specification (in order to cover substance-induced obsessive compulsive disorder). They recommended renaming line 66 to include obsessive compulsive disorders. In addition, they recommended moving the codes for uncomplicated substance use to October 2014 line 658 MENTAL DISORDERS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY. They also recommended renaming line 478 USE OF ADDICTIVE SUBSTANCES as SEXUAL DYSFUNCTION DUE TO SUBSTANCE USE. Then, in the biennial review, they recommended deleting line 478, and moving the codes having a description "...with sexual dysfunction" to line 529 SEXUAL DYSFUNCTION.

Summers asked where methamphetamine-induced dementia fits. Staff explained that this falls on line October 2014 line 205 CHRONIC ORGANIC MENTAL DISORDERS INCLUDING DEMENTIAS.

Recommendations:

- i. Rename line 5 (line 4 in October, 2014) to SUBSTANCE USE DISORDER
- ii. Rename October 2014 line 66 to SUBSTANCE-INDUCED MOOD ANXIETY, DELUSIONAL AND OBSESSIVE-COMPULSIVE DISORDERS
- iii. Move code F55.3 Abuse of steroids and hormones to October 2014 line 619.
- iv. Move the [drug] abuse/ dependence with other [drug] induced disorder ICD-10-CM codes to October, 2014 line 66 (F10.188, F10.288, F10.988, F11.188, F11.288, F11.988, F13.188, F13.288, F13.988, F14.188, F14.288, F14.988, F15.188, F15.288, F15.988, F16.188, F16.288, F16.988, F18.188, F18.288, F18.988, F19.188, F19.288, F19.988).
- v. Move [substance] use, uncomplicated to line 658 (F11.90, F12.90, F13.90, F14.90, F15.90, F16.90, F18.90, F19.90)
- vi. Rename October 2014 line 478 SEXUAL DYSFUNCTION DUE TO SUBSTANCE USE
- vii. In the next biennial review, delete line 478 and move the ICD-10-CM codes for sexual dysfunction due to substance use to line 529 SEXUAL DYSFUNCTION (F10.181, F10.281, F10.981, F11.181, F11.281, F11.981, F13.181, F13.281, F13.981, F14.181, F14.281, F14.981, F15.181, F15.281, F15.981, F16.181, F16.281, F16.981, F18.181, F18.281, F18.981, F19.181, F19.281, F19.981)

15) Smits asked if any of the members noticed anything else in DSM-5 which needs to be corrected on the list. The group discussed line 457 CHRONIC DEPRESSION (DYSTHYMIA) and asked that it be renamed using DSM-5 terminology. The group discussed several other changes which do not require changes to the list. However, Pollack asked that staff review the condition descriptions on the prioritized list to ensure that they match the DSM-5 definitions. The subcommittee also discussed changes to gambling disorders and internet gaming disorder.

Recommendations:

- i. Rename line 457 PERSISTENT DEPRESSIVE DISORDER
 - ii. Staff to review other BHAP lines to ensure that condition descriptions are appropriate for DSM-5 and review it by email with the subcommittee before taking the recommendations to VbBS.
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3. ADJOURNMENT

The meeting was adjourned at 12:15 pm. Staff will refine the recommendations with the subcommittee by email and take them to the Value-based Services Subcommittee for review.

DRAFT

Section 2.0

Mental health treatment for child abuse

Mental Health Treatment for Child Abuse and Neglect

Question: Should the mental health care for child abuse and neglect be combined with the physical health care for these conditions?

Question source: HERC staff

Issue: Medical therapies for child abuse and neglect are included on line 125 ABUSE AND NEGLECT, while mental health therapies are included on line 177 POSTTRAUMATIC STRESS DISORDER Treatment: MEDICAL/PSYCHOTHERAPY. Guideline note 25 applies to the mental health care of children with abuse or neglect and is applied currently to line 177.

Child abuse and neglect diagnoses (ICD-9 995.5x/T74 and T76 series) are included on line 125. Line 177 contains a limited number of these diagnoses (ICD-9 995.52-995.54/ICD-10 T74 and T76 series). The HERC and OHA have been striving to integrate mental and physical health coverage whenever possible.

Currently, GN25 limits certain mental health diagnosis codes for use only in children aged 5 and younger, and limits treatments. The CPT codes not included for treatment include 90839-90840 (psychotherapy for crisis) and 96101 (psychological testing). The ICD-9/10 codes included for treatment are listed below.

ICD-9 Code	Description
995.52	Child neglect
995.53	Child sexual abuse
995.54	Child physical abuse
995.59	Other child abuse and neglect
ICD-10 Code	Description
T74.02xA/D	Child neglect or abandonment, confirmed
T74.12xA/D	Child physical abuse, confirmed
T74.22xA/D	Child sexual abuse, confirmed
T76.02xA/D	Child neglect or abandonment, suspected
T76.12xA/D	Child physical abuse, suspected
T76.22xA/D	Child sexual abuse, suspected

Mental Health Treatment for Child Abuse and Neglect

Line: 125

Condition: ABUSE AND NEGLECT (See Guideline Notes 64,65)
Treatment: MEDICAL THERAPY
ICD-9: 959.9,994.2-994.3,995.50-995.59,995.80-995.85,V61.11,V61.21,V71.5,V71.81
ICD-10: T73.0xA-T73.0xD,T73.1xA-T73.1xD,T74.01xA-T74.01xD,T74.02xA-T74.02xD,T74.11xA-T74.11xD,T74.12xA-T74.12xD,T74.21xA-T74.21xD,T74.22xA-T74.22xD,T74.31xA-T74.31xD,T74.32xA-T74.32xD,T74.4xA-T74.4xD,T74.91xA-T74.91xD,T74.92xA-T74.92xD,T76.01xA-T76.01xD,T76.02xA-T76.02xD,T76.11xA-T76.11xD,T76.12xA-T76.12xD,T76.21xA-T76.21xD,T76.22xA-T76.22xD,T76.31xA-T76.31xD,T76.32xA-T76.32xD,T76.91xA-T76.91xD,T76.92xA-T76.92xD,Z04.41-Z04.42,Z04.71-Z04.72,Z69.010,Z69.020,Z69.11
CPT: 46700,46706,46707,56800,56810,57023,57200,57210,57415,64505-64530,96127,98966-98969,99051,99060,99070,99078,99184,99201-99239,99281-99285,99291-99404,99408-99412,99429-99449,99468-99480,99487-99498,99605-99607
HCPCS: G0396,G0397,G0406-G0408,G0425-G0427,G0463,G0466,G0467

Line: 177

Condition: POSTTRAUMATIC STRESS DISORDER (See Guideline Notes 25,64,65)
Treatment: MEDICAL/PSYCHOTHERAPY
ICD-9: 309.81,995.52-995.54
ICD-10: F43.10-F43.12,T74.12xA-T74.12xD,T74.22xA-T74.22xD,T76.02xA-T76.02xD,T76.12xA-T76.12xD,T76.22xA-T76.22xD
CPT: 90785,90832-90840,90846-90853,90882,90887,96101,96127,98966-98969,99051,99060,99184,99201-99239,99281-99285,99304-99350,99366,99441-99449,99487-99498,99605-99607
HCPCS: G0176,G0177,G0406-G0408,G0410,G0411,G0425-G0427,G0459,G0463,G0466,G0467,G0469,G0470,H0004,H0017-H0019,H0023,H0032-H0039,H0045,H2010-H2014,H2021-H2023,H2027,H2032,S5151,S9125,S9480,S9484,T1005,T1016

Note: this guideline is shown with changes (placing the ICD-10 codes in numerical order) which are not in the current approved guideline

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

Line 177

ICD-10-CM ~~T76.02xA and T76.02xD (Child neglect or abandonment, suspected)~~, T74.02xA and T74.02xD (Child neglect or abandonment, confirmed), [T74.12xA and T74.12xD \(Child physical abuse, confirmed\)](#), T74.22xA and T74.22xD (Child sexual abuse, confirmed), [T76.02xA and T76.02xD \(Child neglect or abandonment, suspected\)](#), [T76.12xA and T76.12xD \(Child physical abuse, suspected\)](#), T76.22xA and T76.22xD (Child sexual abuse, suspected), ~~or T76.12xA and T76.12xD (Child physical abuse, suspected) or T74.12xA and T74.12xD (Child physical abuse, confirmed)~~ and corresponding ICD-9-CM codes 995.52, 995.53, 995.54 and 995.59, may be used in any children 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 T74.02xA, T74.02xD, T74.12xA, T74.12xD, T74.22xA, T74.22xD, T76.02xA, T76.02xD, T76.12xA, T76.12xD, T76.22xA, T76.22xD, , and corresponding ICD-9-CM codes 995.52, 995.53, 995.54 and 995.59 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: 90791, 90792, H0002, H0031, H0032, T1023

Mental Health Treatment for Child Abuse and Neglect

- Family interventions and supports: 90832-90838, 90846, 90847, 90849, 90887, H0038, H0045, H2021, H2022, H2027, S5151, S9125, T1005
- Individual counseling and therapy: 90785, 90832-90838, 99201-99215
- Group therapy: 90832-90838, 90853, 90857, H2032
- Case Management: 90882, T1016
- Interpreter Service: T1013
- Medication management is not indicated for these conditions in children age 5 and under.

HERC staff recommendations:

- 1) Combine medical and mental health treatments for child abuse and neglect in line 125
ABUSE AND NEGLECT
 - a. Remove diagnosis codes for child abuse and neglect from line 177
POSTTRAUMATIC STRESS DISORDER
 - i. ICD-9 995.52 (Child neglect (nutritional)), 995.53 (Child sexual abuse), 995.54 (Child physical abuse)
 - ii. ICD-10 T74 series, T76 series (child neglect, child abuse, child sexual abuse)
 - iii. All of these codes are already present on line 125
 - b. Add mental health CPT codes to line 125
 - i. CPT 90785 (interactive complexity), 90832-90853 (psychotherapy, including family and group), 90882 (Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions), 90887 (Interpretation or explanation of results of psychiatric, other medical examinations and procedures), 96101 (psychological testing), 96127 (Brief emotional/behavioral assessment)
- 2) Delete GN25
 - a. Staff finds no medical justification for limitations to children 5 and younger
 - b. The first section for suspected abuse treatment is taken care of with the increased specificity in ICD-10 coding.
 - i. Previous ICD-9 codes did not include "suspected" abuse; ICD-10 coding has this as an allowable diagnosis
 - c. The second section allows all code pairings other than crisis therapy, which should also be allowed for these diagnoses. As no limitations in code pairings would exist if crisis therapy was allowed, then there is no need for this portion of the guideline.
 - i. Deletion of the second portion would allow medication therapy for children 5 and under. Consider creating a new guideline to maintain this restriction if there is a medical justifiable reason for this restriction.

Section 3.0

Mental health guidelines with
differential treatment of kids

Mental Health Guidelines with Differential Treatment of Children by Age

Question: Should the mental health guidelines with differential treatment of children by age be modified?

Question source: HERC staff

Issue: The ACA requires medical justification for differential coverage for persons based on age. Four current mental health guidelines specify different care for children aged 5 and younger (GN 20, 25, 42 and 45). One of these guidelines (GN25) was proposed for deletion as part of another topic for this meeting (merging physical and mental health care for neglect and abuse). One current mental health guideline (GN28) specifies different care for children aged 18 and younger.

On review, the CPT code pairing restrictions in all of these guidelines serve to limit services in children only by restricting pairing with only 3 mental health CPT codes [90839-90840 (psychotherapy for crisis) and 96101 (psychological testing)] which might not be a justifiable restriction based on age. There has been at least one complaint to HSD (DMAP) for lack of coverage for the crisis CPT codes for a diagnosis covered in these guidelines. These coding restrictions have been in place for at least 15 years and the original rationale could not be found in a minutes search or discussion with long term members.

The ADHD guideline (GN20) contains specific developmentally-based restrictions which are allowable under the ACA. However, the second part of this guideline note, which stresses that behavioral therapy should be first line and medication second line, needs to be clarified based on the ADHD coverage guidance.

Guideline Note 28 defines when a vague diagnosis code (unspecified mood disorder) should be used. Approximately 10 years ago, this guideline was amended to allow use in children 18 and younger, changing the previous restriction to children 5 and younger, due to provider complaints. This guideline also contains the CPT code restrictions found to be problematic above.

The conduct disorder guideline (GN 42) may not be required anymore as a new line was created for children with conduct disorder (485 CONDUCT DISORDER, AGE 18 OR UNDER), separating them out from the adult line (425 OPPOSITIONAL DEFIANT DISORDER). New line 485 is the only line containing the ICD-10 diagnosis code limited by GN42 (F91.9 Conduct disorder, unspecified), but is not referenced by the guideline. The ICD-9 code in GN42 (312.9 Unspecified disturbance of conduct) is not on line 485, only appearing on line 425.

Mental Health Guidelines with Differential Treatment of Children by Age

GUIDELINE NOTE 20, ATTENTION DEFICIT/HYPERACTIVITY DISORDERS IN CHILDREN AGE FIVE AND UNDER

Line 126

When using ICD-9-CM 314.9/ICD-10-CM F90.9, Attention deficit/hyperactivity disorder, unspecified type, 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.

First line therapy is "parent-behavior training" (i.e. Triple P (Positive Parenting of Preschoolers) Program, Incredible Years Parenting Program, Parent-Child Interaction Therapy and New Forest Parenting Program). The term "parent" refers to the child's primary care givers, regardless of biologic or adoptive relationship.

Second line therapy is pharmacotherapy.

Use of ICD-9-CM 314.9/ICD-10-CM F90.9 for children age five and younger is limited to pairings with the following procedure codes:

- Assessment and Screening: 90791, 90792, H0002, H0031, H0032, T1023
- Family interventions and supports: 90832-90838, 90846, 90847, 90849, 90887, H0038, H0045, H2021, H2022, H2027, S5151, S9125, T1005
- Group therapy: 90785, 90832-90838, 90853, 99201-99215, H2032
- Medication management: 90832-90838, 99201-99215
- Case Management: 90882, T1016
- Provider/teacher care coordination: 99366, 99367, 99368
- Interpreter Service: T1013

The development of this guideline note was informed by a HERC coverage guidance. See

<http://www.oregon.gov/oha/herc/Pages/blog-treatment-adhd.aspx>

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

Line 207

The use of ICD-10-CM code F39 Unspecified Mood [Affective] Disorder/ICD-9-CM code 296.90, Unspecified Episodic Mood Disorder, is appropriate only for children 18 years old and under who have functional impairment caused by significant difficulty with emotional regulation.

Use of ICD-10-CM F39/ICD-9-CM 296.90 is limited to pairings with the following procedure codes:

- Assessment and Screening: 90791, 90792, H0002, H0031, H0032, T1023

Mental Health Guidelines with Differential Treatment of Children by Age

- Family interventions and supports: 90832-90838, 90846, 90847, 90849, 90887, H0038, H0045, H2021, H2022, H2027, S5151, S9125, T1005
- Individual Counseling and Therapy: 90785, 90832-90838, 99201-99215, H0004
- Group therapy: 90785, 90832-90838, 90853, 99201-99215, H2032
- Medication management: 99201-99215
- Case Management: 90882, T1016
- Interpreter Service: T1013

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

Line 425

The use of ICD-10-CM code F91.9 Conduct disorder, unspecified/ICD-9-CM 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 F91.9/312.9 is limited to pairings with the following procedure codes:

- Assessment and Screening: 90791, 90792, H0002, H0031, H0032, T1023
- Family interventions and supports: 90832-90838, 90846, 90847, 90849, 90887, H0038, H0045, H2021, H2022, H2027, S5151, S9125, T1005
- Individual Counseling and Therapy: 90785, 90832-90838, 99201-99215, H0004
- Group therapy: 90785, 90832-90838, 90853, 99201-99215, H2032
- Case Management: 90882, T1016
- Interpreter Service: T1013
- Medication management is not indicated for these conditions in children age 5 and under.

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

Line 449

ICD-10-CM code F43.2x/ICD-9-CM 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:

- A) 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.
- B) F43.2x/309.89 is limited to pairings with the following procedure codes:
 - Assessment and Screening: 90791, 90792, H0002, H0031, H0032, T1023
 - Group Therapy: 90785, 90832-90838, 90853, 99201-99215, H2032
 - Family Interventions and Supports: 90832-90838, 90846, 90847, 90849, 90887, H0038, H0045, H2021, H2022, H2027, S5151, S9125, T1005
 - Case Management: 90882, T1016
 - Interpreter Service: T1013

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- Individual Counseling and Therapy: 90785, 90832-90838, 99201-99215
- Medication Management 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.

ICD-10-CM codes Z62.82x (Parent-child conflict) and Z63.4 (Disappearance and death of family member), may only be used as secondary diagnoses to the primary diagnosis of F43.2x, and only for children five years of age or younger. Two ICD-9-CM 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 (Other specified adjustment reactions), and only for children five years of age or younger.

A) When using codes Z62.82x/V61.20, the following must apply:

- 1) Service provision will have a clinically significant impact on the child.
- 2) A rating of 40 or lower has been assessed on the PIR-GAS (Parent-Infant Relationship Global Assessment Scale).
- 3) The same limitations in pairings to CPT and HCPCS codes as given for ICD-10-CM code F43.2x apply, with the only exception being that 90785 cannot be used.

B) When using ICD-10-CM Z63.4 (Disappearance and death of family member)/ICD-9-CM V62.82, the following must apply:

- 1) The child exhibits a change in functioning subsequent to the loss of a primary caregiver;
- 2) The child exhibits at least three of the following eight symptoms:
 - a) Crying, calling and/or searching for the absent primary caregiver,
 - b) Refusing attempts of others to provide comfort,
 - c) Emotional withdrawal manifesting in lethargy, sad facial expression, and lack of interest in age-appropriate activities that do not meet mood disorder criteria,
 - d) Disruptions in eating and sleeping that do not meet criteria for feeding and eating disorders of infancy or early childhood,
 - e) Regression in or loss of previously achieved developmental milestones not attributable to other health or mental health conditions,
 - f) Constricted range of affect not attributable to a mood disorder or PTSD,
 - g) Detachment, seeming indifference toward, or selective "forgetting" of the lost caregiver and/or of reminders of the lost caregiver,
 - h) 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;
- 3) The symptoms in B(2) above are exhibited for most of the day and for more days than not, for at least 2 weeks.
- 4) The same limitations in pairings to CPT and HCPCS codes as given for ICD-10-CM code F43.2x/ICD-9-CM code 309.89 apply.

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

2013 ADHD Coverage Guidance

HERC COVERAGE GUIDANCE

Children under Age 6

For children under 6 diagnosed with disruptive behavior disorders¹, including those at risk for ADHD, specific parent behavior training² is recommended for coverage as first-line therapy (*strong recommendation*).

Pharmacotherapy³ is recommended for coverage as a second line therapy (*weak recommendation*).

Provider consultation with teachers is recommended for coverage (*weak recommendation*).

Children Age 6 and Over

For children 6 and over who are diagnosed with ADHD¹, pharmacotherapy³ alone (*weak recommendation*) or pharmacotherapy³ with psychosocial/behavioral treatment (*strong recommendation*) are recommended for coverage.

Provider consultation with teachers is recommended for coverage (*weak recommendation*).

¹Children with comorbid mental health conditions may require additional or different treatments that are not addressed in this guidance.

²Effective studied types of parent behavior training include: Triple P (Positive Parenting of Preschoolers) Program, Incredible Years Parenting Program, Parent-Child Interaction Therapy and New Forest Parenting Program. The term "parent" refers to the child's primary care givers, regardless of biologic or adoptive relationship.

³Limited to medications that are FDA-approved for the condition

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HERC Staff Recommendations:

- 1) Modify GN20 as shown below
 - a) Remove reference to age in the title
 - b) The first section includes age limits which are appropriate based on developmental rationale
 - c) The second section should be modified to more clearly follow the coverage guidance on ADHD wording. Adding in language regarding children 6 and over clarifies coverage intent.
 - d) Consider clarifying language in the first section
- 2) Modify GN28 as shown below
 - a) Remove the coding restrictions
 - b) Clarifying language that this code can also be used for adults
 - c) Strongly consider deleting guideline altogether as it is unclear if this is a justifiable limitation based on age
- 3) Modify GN42 as shown below
 - a) Move ICD-9 312.9 (Unspecified disturbance of conduct) from line 425 to line 485
 - i) May be moot point if ICD-10 conversion goes ahead and currently scheduled
 - b) Change guideline line reference to line 485 CONDUCT DISORDER, AGE 18 OR UNDER
 - c) Modify the guideline wording to clarify intent
 - d) Consider deleting guideline altogether
- 4) Modify GN45 as shown below
 - a) Deletes CPT code restrictions
 - b) Is there a medically justifiable reason to treat kids 5 and under differently here?
- 5) Note: purple modifications are deletions of ICD-9 codes which will go into effect if the planned ICD-10 conversion goes into effect as scheduled October 1, 2015

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

Line 126

When using ~~ICD-9-CM 314.9~~/ICD-10-CM F90.9, Attention deficit/hyperactivity disorder, unspecified type, 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 under age 6 diagnosed with disruptive behavior disorders, including those at risk for ADHD, first line therapy is "parent-behavior training" (i.e. Triple P (Positive Parenting of Preschoolers) Program, Incredible Years Parenting Program, Parent-Child Interaction Therapy

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and New Forest Parenting Program). The term “parent” refers to the child’s primary care givers, regardless of biologic or adoptive relationship. Second line therapy is pharmacotherapy.

For children age 6 and over who are diagnosed with ADHD, pharmacotherapy alone or pharmacotherapy with psychosocial/behavioral treatment are included on this line for first line therapy.

~~Use of ICD-9-CM 314.9/ICD-10-CM F90.9 for children age five and younger is limited to pairings with the following procedure codes:~~

- ~~• Assessment and Screening: 90791, 90792, H0002, H0031, H0032, T1023~~
- ~~• Family interventions and supports: 90832-90838, 90846, 90847, 90849, 90887, H0038, H0045, H2021, H2022, H2027, S5151, S9125, T1005~~
- ~~• Group therapy: 90785, 90832-90838, 90853, 99201-99215, H2032~~
- ~~• Medication management: 90832-90838, 99201-99215~~
- ~~• Case Management: 90882, T1016~~
- ~~• Provider/teacher care coordination: 99366, 99367, 99368~~
- ~~• Interpreter Service: T1013~~

The development of this guideline note was informed by a HERC coverage guidance. See <http://www.oregon.gov/oha/herc/Pages/blog-treatment-adhd.aspx>

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

Line 207

~~The use of~~ When using ICD-10-CM code F39 Unspecified Mood [Affective] Disorder ~~/ICD-9-CM code 296.90, Unspecified Episodic Mood Disorder, is appropriate only~~ for children 18 years old and under, the child must ~~who~~ have functional impairment caused by significant difficulty with emotional regulation.

~~Use of ICD-10-CM F39/ICD-9-CM 296.90 is limited to pairings with the following procedure codes:~~

- ~~• Assessment and Screening: 90791, 90792, H0002, H0031, H0032, T1023~~
- ~~• Family interventions and supports: 90832-90838, 90846, 90847, 90849, 90887, H0038, H0045, H2021, H2022, H2027, S5151, S9125, T1005~~
- ~~• Individual Counseling and Therapy: 90785, 90832-90838, 99201-99215, H0004~~
- ~~• Group therapy: 90785, 90832-90838, 90853, 99201-99215, H2032~~
- ~~• Medication management: 99201-99215~~
- ~~• Case Management: 90882, T1016~~
- ~~• Interpreter Service: T1013~~

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

Line ~~425, 485~~

The use of ICD-10-CM code F91.9 Conduct disorder, unspecified/~~ICD-9-CM 312.9, Unspecified Disturbance of Conduct~~), may be used for any age child. However, when using ~~is appropriate only~~ for children five years old and under, ~~the child must who~~ display sustained patterns of disruptive behavior beyond what is developmentally appropriate. ~~[delete indent of the following sentence]~~ Interventions should prioritize parent skills training in effective behavior management strategies or focus on other relational issues.

~~Use of F91.9/312.9 is limited to pairings with the following procedure codes:~~

- ~~• Assessment and Screening: 90791, 90792, H0002, H0031, H0032, T1023~~
- ~~• Family interventions and supports: 90832-90838, 90846, 90847, 90849, 90887, H0038, H0045, H2021, H2022, H2027, S5151, S9125, T1005~~
- ~~• Individual Counseling and Therapy: 90785, 90832-90838, 99201-99215, H0004~~
- ~~• Group therapy: 90785, 90832-90838, 90853, 99201-99215, H2032~~
- ~~• Case Management: 90882, T1016~~
- ~~• Interpreter Service: T1013~~
- ~~• Medication management is not indicated for these conditions in children age 5 and under.~~

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

Line ~~449~~

ICD-10-CM code F43.2x/~~ICD-9-CM 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: [delete indent and have wording directly follow]~~

- A) ~~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.
- B) ~~F43.2x/309.89 is limited to pairings with the following procedure codes:~~
 - ~~• Assessment and Screening: 90791, 90792, H0002, H0031, H0032, T1023~~
 - ~~• Group Therapy: 90785, 90832-90838, 90853, 99201-99215, H2032~~
 - ~~• Family Interventions and Supports: 90832-90838, 90846, 90847, 90849, 90887, H0038, H0045, H2021, H2022, H2027, S5151, S9125, T1005~~
 - ~~• Case Management: 90882, T1016~~
 - ~~• Interpreter Service: T1013~~
 - ~~• Individual Counseling and Therapy: 90785, 90832-90838, 99201-99215~~
 - ~~• Medication Management 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

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symptoms, parental guidance around enhancing safety and stability in the child's environment, and therapeutic support for the parents.

ICD-10-CM codes Z62.82x (Parent-child conflict) and Z63.4 (Disappearance and death of family member), may only be used as secondary diagnoses to the primary diagnosis of F43.2x, and only for children five years of age or younger. ~~Two ICD-9-CM 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 (Other specified adjustment reactions), and only for children five years of age or younger.~~

- A) When using codes ~~Z62.82x/V61.20~~, the following must apply:
- 1) Service provision will have a clinically significant impact on the child.
 - 2) A rating of 40 or lower has been assessed on the PIR-GAS (Parent-Infant Relationship Global Assessment Scale).
 - 3) The same limitations in pairings to CPT and HCPCS codes as given for ICD-10-CM code F43.2x apply, with the only exception being that 90785 cannot be used.
- B) When using [code](#) ICD-10-CM Z63.4 (Disappearance and death of family member) ~~/ICD-9-CM V62.82~~, the following must apply:
- 1) The child exhibits a change in functioning subsequent to the loss of a primary caregiver;
 - 2) The child exhibits at least three of the following eight symptoms:
 - a) Crying, calling and/or searching for the absent primary caregiver,
 - b) Refusing attempts of others to provide comfort,
 - c) Emotional withdrawal manifesting in lethargy, sad facial expression, and lack of interest in age-appropriate activities that do not meet mood disorder criteria,
 - d) Disruptions in eating and sleeping that do not meet criteria for feeding and eating disorders of infancy or early childhood,
 - e) Regression in or loss of previously achieved developmental milestones not attributable to other health or mental health conditions,
 - f) Constricted range of affect not attributable to a mood disorder or PTSD,
 - g) Detachment, seeming indifference toward, or selective "forgetting" of the lost caregiver and/or of reminders of the lost caregiver,
 - h) 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;
 - 3) The symptoms in B(2) above are exhibited for most of the day and for more days than not, for at least 2 weeks.
 - 4) ~~The same limitations in pairings to CPT and HCPCS codes as given for ICD-10-CM code F43.2x/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.

Section 4.0

Substance intoxication and withdrawal

Substance Intoxication and Withdrawal

Question: Should a new line for acute intoxication and withdrawal be created?

Question source: HERC staff

Issue: Diagnosis codes for substance intoxication and withdrawal have appeared on the equivalents of both line 66 SUBSTANCE-INDUCED MOOD, ANXIETY, DELUSIONAL AND OBSESSIVE-COMPULSIVE and line 69 SUBSTANCE-INDUCED DELIRIUM in the past. During the ICD-10 review, all codes for substance intoxication and withdrawal were consolidated onto line 69. However, this consolidation involved only ICD-10 codes; ICD-9 codes appear on line 66 currently. With the ICD-10 review, line 66 was renamed SUBSTANCE-INDUCED DELUSIONAL AND MOOD DISORDERS; ~~INTOXICATION~~ to reflect that the intoxication diagnoses were now no longer on that line. Line 69 contains all of the substance withdrawal diagnoses.

Both lines contain the full range of CPT codes for psychotherapy. HCPCS codes for ambulatory acute withdrawal treatment (H0005, H0010-H0016, H0020) were added to line 66 and 69 in 2011. Acute inpatient detoxification treatment is Ancillary.

HERC staff are seeking clarity on the prioritization of substance intoxication and withdrawal.

HERC staff recommendations:

- 1) Clarify that line 69 contains all substance intoxication and withdrawal diagnoses
 - a. Rename line 69 SUBSTANCE-INDUCED DELIRIUM; SUBSTANCE INTOXICATION AND WITHDRAWAL
 - b. Add H0005 (Alcohol and/or drug services; group counseling by a clinician) to line 69
 - c. Remove drug intoxication ICD-9 codes from line 66 and add to line 69
 - i. 291.4 Idiosyncratic alcohol intoxication
 - ii. 292.2 Pathological drug intoxication
 - iii. 303.0x Acute alcoholic intoxication in alcoholism
 - iv. Note: this change will be moot if the ICD-10 conversion occurs as scheduled on October 1, 2015
 - d. Remove the HCPCS codes for substance withdrawal treatment (H0005, H0010-H0016, H0020) from line 66
- 2) Consider creation of a new line for substance intoxication and withdrawal for the 2018 Biennial Review Prioritized List
 - a. Medical only line
 - b. Prioritized in a similar range to current location

Section 5.0

BH integration statement of
intent (SOI)

Statement of Intent 3 INTEGRATED CARE

Question: Should Statement of Intent (SOI) 3 be deleted or modified?

Question source: HERC staff

Issue: SOI3 is out of date given the current HERC and OHA emphasis on integrating mental and physical health. The SOI3 wording actually is causing issues with the CCOs, as this SOI requires use of certain types of psychiatric rehabilitation codes to provide chronic disease health management. HERC staff feels that SOI3 should be deleted, to allow ongoing rapidly evolving mental/physical health integration work to continue.

HERC staff is interested in BHAP's assistance in identifying any other work that can be done with the Prioritized List to assist in integrating behavioral and physical health.

STATEMENT OF INTENT 3: INTEGRATED CARE

Recognizing that many individuals with mental health disorders receive care predominantly from mental health care providers, and recognizing that integrating mental and physical health services for such individuals promotes patient-centered care, the Health Evidence Review Commission endorses the incorporation of chronic disease health management support within mental health service systems. Although such supports are not part of the mental health benefit package, mental health organizations (MHOs) that elect to provide these services may report them using psychiatric rehabilitation codes which pair with mental health diagnoses. If MHOs choose to provide tobacco cessation supports, they should report these services using 99407 for individual counseling and S9453 for classes.

HERC staff recommendation:

- 1) Delete Statement of Intent 3