

Commentary: Promoting Health and Well-being in Pediatric Primary Care Settings: Using Health and Behavior Codes at Routine Well-child Visits

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Pediatric primary care provides an optimal setting for the practice of pediatric psychology and the use of health and behavior codes to capture this practice. Pediatric primary care settings provide continuous and comprehensive medical services that are readily accessible to the vast majority of children in the United States and their families (Centers for Disease Control, 2004). These settings are ideally suited to promote optimal development and well-being through the provision of expanded services that address parental concerns, developmental tasks, psychosocial factors, and behavioral health issues in the context of trusting relationships with familiar providers. Pediatric psychologists integrated into primary care settings are able to promote health and well-being of children and families in a manner directly aligned with the mandates and guidelines of the practice of pediatric primary care (American Academy of Child and Adolescent Psychiatry and American Academy of Pediatrics, 2009).

Pediatric primary care is often the only available port of entry into service systems for vulnerable children and their families. Although the American Academy of Pediatrics (AAP) and Bright Futures provide systematic guidelines and outline methods for comprehensive surveillance and screening during well-child checks, most pediatric practices and providers are overwhelmed by the complex risk factors presented during "routine" visits lasting an average of 18 min (Olson et al., 2004) and may be reluctant to solicit information about behavioral and psychosocial matters because they are unable to adequately address them or receive reimbursement for treating them (American Academy of Child and Adolescent Psychiatry and American Academy of Pediatrics, 2009).

Consequently, children facing significant risk factors that impinge upon development and profoundly impact family functioning remain unidentified. Even when risk or early disturbance is identified, families often have difficulty accessing necessary community resources.

Pediatric psychologists in primary care engage in activities that "improve the health-related quality of life of children and their families" (Noll & Fischer, 2004). Such activities include: (a) promoting health and well-being and providing anticipatory guidance during routine well-child visits; (b) screening, early identification, and referral around developmental and behavioral health issues; (c) providing early treatment for issues that, left untreated, could lead to significant impairment; and (d) triaging, referring to, and coordinating with community resources when higher levels of care are necessary. Pediatric psychologists help improve adherence, promote healthy behaviors and reduce behaviors that increase health risks, and improve communication between healthcare providers and the children and families they serve (Noll & Fischer, 2004).

Barriers to Behavioral Health in Primary Care

Unfortunately, substantial barriers exist to creating sustainable behavioral health programs in primary-care settings. Foremost among these are the significant challenges surrounding reimbursement for behavioral health services. In a report on reimbursement of mental health services in primary care, Mauch, Kautz, and Smith (2008) identified seven barriers: (a) insurer limitations on the same-day billing for physical health and mental health services, (b) nonreimbursable time spent in collaborative care and

case management activities, (c) no reimbursement for nonphysician providers, (d) insurer denials of primary care provider bills when mental health diagnosis and treatment are listed, (e) differential reimbursement rates in rural and urban settings, (f) challenges in obtaining reimbursement for behavioral health services in school-based clinics, and (g) lack of incentives for behavioral health screening and prevention efforts. These barriers limit both access to behavioral health services and integrated behavioral health program sustainability.

Children and families receiving behavioral health services in primary-care settings may be seen by medical providers for *medical* diagnoses often without comorbid mental health diagnoses that could be billed under the purview of mental health (Kessler, 2008; Mauch et al., 2008; Miyamoto, 2006). When behavioral health providers bill health and behavior codes in primary-care settings, they generate considerably lower relative value units (RVUs) than if they billed evaluation and management (E&M) or traditional mental health codes (American Academy of Child and Adolescent Psychiatry and American Academy of Pediatrics, 2009). As a result, behavioral health consultations (e.g., assessment, feedback, and collaborative treatment planning) yield lower reimbursement or RVUs despite being integral to patient health and well-being.

Models of Successful Behavioral Health Care in Pediatric Primary Care: Project CLIMB

Project CLIMB (Consultation Liaison in Mental health and Behavior), an integrated mental health program, has successfully served the behavioral health needs of an at-risk population in a high-volume pediatric primary-care clinic and residency training site housed within a large teaching hospital affiliated with a university school of medicine (see <http://www.aap.org/mentalhealth/mh3co.html#Colorado>). Project CLIMB is co-led by a pediatric psychologist and a triple-boarded child, adolescent, and adult psychiatrist. Families served in this clinic have access to seamless and comprehensive care that spans physical and behavioral health in the context of a medical home. Our team also refers and coordinates care with community agencies and resources, when more intensive services are needed. In addition to providing access to mental health services, our team has worked diligently to increase primary care providers' capacity to treat children and families with complex needs in the context of pediatric primary care through educational offerings, training, case collaboration, and precepting (Bunik, Stafford, Rosenberg, & Talmi, 2008).

Health and Behavior Codes in Pediatric Primary Care

Our use of health and behavior codes typically involves associating services with the medical diagnosis of "Routine infant or child health check" (ICD-9 Code V20.2). Many of the children and families with whom our behavioral health team is asked to consult do not have existing mental health diagnoses and would not meet criteria upon further evaluation. However, pediatric providers frequently request consultations to help address behavioral or developmental difficulties that are interfering with a child's ability to optimally engage in age-appropriate activities. Behavioral health services for well-child visits, acute illness visits, and management of chronic disease (e.g., obesity, asthma) include psycho-education, anticipatory guidance, promoting adherence and compliance, and enhancing the relationship between pediatric primary care providers and the children and families they serve. A case study illustrating behavioral health consultations with an infant and his mother during well-child visits may be accessed online.

Medical chart reviews were completed on all patients seen by a behavioral health provider during a 1-year period (2010) using an existing, de-identified dataset with IRB approval. Additionally, we reviewed financial and billing records from 2010 through 2011. Medical record abstraction yielded detailed information related to health and behavior code usage and medical diagnoses assigned for each visit. In 2010, of the ~20,000 total clinic visits, 2,018 included behavioral health consultations (10%). Of these behavioral health consultations, 987 (49%) were conducted during "routine" visits (i.e., well-child checks) and 51% during medical visits, with medical diagnoses of failure to thrive, unspecified disturbance of conduct, and asthma listed most frequently. The psychiatrist saw 17% of the behavioral health patients, of whom 46% carried an ADHD diagnosis.

Table 1 details health and behavior code billing and finance data for 2010 and 2011, including RVU equivalents, units billed, RVUs generated, and FTE (full-time equivalent) calculations by code. Clinical productivity (RVUs) is based on an institutional standard of 2,100 RVUs annually for a full-time pediatric psychologist. The national standard is 2,300 RVUs (Academic Psychiatric Benchmarking Survey, 2011). As can be seen from these data, the majority of visits in 2010 (77%) and 2011 (69%) were for initial assessment (CPT code 96150). In our clinic, patients receive an average of 1.8 behavioral health consultations. Many consultations are one-time assessment and triage visits for specific behavioral health concerns.

Table 1. *Health and Behavior RVU and FTE Data for 2010 and 2011*

CPT codes (RVU value)	2010			2011		
	Units billed	Total RVU	FTE	Units billed	Total RVU	FTE
96150 (0.5)	917	458.5	0.22	841	420.5	0.20
96151 (0.58)	241	139.8	0.07	1	0.6	0.00
96152 (0.46)	14	6.4	0.00	346	159.2	0.08
96154 (0.45)	18	8.1	0.00	24	10.8	0.01
Total	1,190	612.8	0.29	1,211	591.0	0.28

Each year, health and behavior code billing yielded sufficient RVUs to cover ~30% of a pediatric psychologist’s salary.

In our institution, code-based reimbursement data are not available. The hospital collects reimbursement data by encounter (i.e., clinic visit), not by billing code. At present, it is not possible to determine how much actual revenue is generated when health and behavior codes are billed in the context of pediatric primary-care encounters. According to preliminary reports from the Colorado State Department of Health Care Policy and Finance (HCPF), it appears as though the State has not reimbursed any health and behavior code billing through Medicaid. This is likely due to a Colorado Medicaid rule that automatically rejects psychologist health and behavior code bills as “unauthorized provider type” when billed in pediatric primary care because psychologists are not physicians and, therefore, are not “authorized” providers within a primary-care setting.

Policy Recommendations to Promote Reimbursement

Advocate for systems changes where health and behavior codes are: (a) routinely used by behavioral health professionals to document the services provided in pediatric primary care and (b) universally covered benefits in pediatric health insurance plans. Although the development and implementation of health and behavior codes has created a mechanism by which to bill for behavioral health services provided in medical settings, numerous barriers to billing and reimbursement significantly limit their utility. Mental health benefits are often “carved out,” and medical providers are excluded from the network of professionals able to bill for mental health services (Mauch et al., 2008). Health and behavior billing enables pediatric psychologists to document their efforts at integrating physical and mental health, but actual reimbursement for such efforts is inadequate or non-existent. Mental health services that are reimbursable by private insurers in the primary-care setting generally include screening, assessment, and/or medication management; however, only 60% of Medicaid programs reimburse for

screening and assessment and a very limited number of insurers reimburse nonphysician providers for these services (National Institute for Health Care Management, 2009; National Governor’s Association, 2005).

Use capitated funding mechanisms to negotiate contracts with behavioral health entities to embed qualified and experienced behavioral health clinicians in primary care. Behavioral health managed care entities with capitated contracts have a vested interest in maintaining or increasing their penetration rates to serve the targeted number of individuals in their catchment areas. Pediatric primary-care settings provide access to large numbers of children and families who can be counted as receiving services under capitated behavioral health plans. Moreover, behavioral health clinicians working in primary-care settings are often highly productive, serving many more children and families than traditional outpatient behavioral health providers can serve.

In Colorado, several behavioral health organizations fund clinicians to deliver integrated mental health services in primary-care settings with rapid expansion of such models over the last few years. For example, the community mental health center designated to provide Medicaid mental health benefits in our county funds a full-time licensed clinician to see patients in our pediatric primary care clinic. By integrating a full-time clinician into our program, the mental health center can serve its target population (county), increase penetration rates, and, thereby, fulfill contractual requirements with Medicaid. Additionally, the on-site clinician creates greater access to care for a population facing considerable barriers to behavioral health services and who would need to access these services through the mental health center.

Reorganize managed care services to reintegrate physical and behavioral health under the auspice of medical home. Health-care reform presents an important opportunity to reconsider how health services are being delivered. In Colorado, the Accountable Care Collaborative (ACC), a Medicaid program developed to improve client health and reduce healthcare costs, assigns members (people insured by Medicaid) to one of seven Regional Care

Collaborative Organizations (RCCOs) statewide and to a primary care medical provider (PCMP; Colorado Department of Health Care Policy and Financing, 2011a). RCCOs provide care coordination, medical management of complex cases, and provider support for resources, referrals, and quality improvement (Colorado Department of Health Care Policy and Financing, 2011b). Medicaid incentivizes RCCOs with a per member/per month rate that is contingent upon the RCCOs ability to deliver coordinated, comprehensive, and cost-effective services.

In order to meet members' needs, RCCOs must continually develop partnerships, streamline services, and create new programs and service delivery models to optimize health and well-being of their members. Individuals struggling with behavioral health issues typically have to access services and resources across two separate systems of care (i.e., physical and mental health) and often have greater and more costly health system utilization. RCCOs that successfully manage both physical and behavioral health services are well-positioned to address the comprehensive needs of their members, improve communication among providers, and ultimately deliver integrated services within a medical home. Since member data are tracked within a single system, these programs could also yield invaluable data on health outcomes in relation to behavioral health services. To date, such data have been difficult to obtain because of the silos in which physical and behavioral health information exist.

Mounting evidence linking behavioral health supports to improved health outcomes and reduced health costs in combination with the RCCOs' focus on creating medical homes and delivering coordinated, comprehensive services may be a catalyst for broad integration of behavioral health services into medical settings. Having RCCOs as the single payers and managers of both physical and behavioral health benefits would eliminate several barriers: (a) reimbursement for behavioral health services would not require preauthorization; (b) all providers would be in network; and (c) billing and reimbursement processes would be internal to the system and not contingent upon external, cross-system approvals, and lengthy waiting periods between billing and collecting revenue. If RCCOs offered integrated behavioral health services as a covered benefit, these services would be sustainable for children insured by Medicaid.

Promote the medical home approach to increase integration of behavioral health services. A medical home is one in which a pediatric provider works in partnership with the family/patient to ensure that all of the medical and

nonmedical needs of the patient are met. Through this partnership, the pediatric provider helps the family/patient access and coordinate specialty care, educational services, out-of-home care, family support, and other public and private community services that are important to the overall health of the child and family (Stille et al., 2010). The medical home approach is a promising framework for incorporating mental health care into primary care, establishing stronger partnerships with families, and improving cross-sector case collaboration (National Institute for Health Care Management, 2009). Behavioral health is an integral component of the medical home approach and as such should be a fundable component.

In Colorado, Family Voices Colorado (see www.familyvoicesco.org) and the Colorado Children's Healthcare Access Program (CCHAP; see www.cchap.org) work together to designate primary care settings as medical homes using site visits, provider and patient surveys, and assessments of practice characteristics. Medical homes are supposed to provide access to and coordination among medical, oral, and mental health services. Those primary-care settings with a medical home designation receive a per member financial incentive from Medicaid. Practices with high patient volumes may consider pooling per member incentives to hire on-site behavioral health providers. Revenue generated from screening efforts (e.g., developmental screening and depression screening) can also be used to fund expanded behavioral health services within a medical home.

Use innovative funding mechanisms to sustain and support behavioral health billing in pediatric primary care. In a recent report, The Urban Institute described two-generation Medicaid billing under which strategies including treating caregiver mental health issues (e.g., perinatal mood and anxiety disorders), creating access to behavioral health services for caregivers in pediatric settings, and increasing insurance options for caregivers and their children are employed to benefit child well-being (Golden & Fortuny, 2011). Initiatives like "Money Follows the Person" (U.S. Department of Health & Human Services, 2011; National Conference of State Legislatures, 2011) also expand the potential for treating behavioral health issues wherever they emerge instead of relying exclusively on traditional mental health service systems. This approach reduces restrictions on the types of services that can be provided in particular settings (e.g., mental health services only at community mental health centers) and enables clients to access services and supports from qualified professionals in settings where they are typically seen (e.g., primary care). Providers, in turn, can get reimbursed for services rendered.

Implications for Pediatric Psychology Practice Health Promotion and Prevention

The hallmark of pediatric practice is anticipatory guidance, which includes conveying information that assists parents in understanding current and future developmentally salient issues with the aim of preventing future disturbance. Recommended topics include injury and violence prevention, family well-being, parent–child relationship issues, sleep issues, school adjustment, and fostering optimal development, all of which can fall under the purview of behavioral health consultation provided during well-child visits (Hagan, Shaw, & Duncan, 2008).

Serving the Early Childhood Population

Research suggests that parents are more likely to turn to their healthcare provider for information regarding parenting and child development than to another specialist (Inkelas, Schuster, Newacheck, Olsen, & Halfon, 2002; Inkelas et al., 2002). Capitalizing on the close succession of visits in the first year, pediatric psychologists working in primary care settings are in a unique position to enhance infant and early childhood mental health by developing strong relationships with caregivers, supporting young children and their families, and providing critical information about development and well-being (Talmi, Buchholz, & Stafford, 2009). Without behavioral health services in primary care, many young children and their families would not be seen or identified until significant disturbance emerged later in development and when they met criteria for mental health diagnoses. Moreover, the comfort, safety, and familiarity of pediatric primary care settings in which caregivers routinely raise concerns and obtain information and resources to address these concerns increases the potential of primary care settings to function as gateways to behavioral health services.

Training Transdisciplinary Professionals to Assess and Address Behavioral Health in Pediatric Populations

The shortage of pediatric behavioral health providers, particularly in rural areas, places an even greater burden on pediatric primary care settings to provide behavioral health services. A competent, high-quality workforce will ensure that the services provided in the context of primary care can appropriately meet the needs of a population whose only access to health and mental health services may be in primary care. Since its inception, our team has developed numerous education and training opportunities for pediatric primary care providers, allied health

professionals, and integrated mental health-service providers. CLIMB clinicians teach preclinic didactics and noon conferences to residents and medical trainees on various topics related to mental health, behavior, and development. These and other presentations are distributed to pediatric and behavioral health providers statewide.

Directions for Future Research

The AAP task force on children's mental health (AAP, 2002) includes among its goals: identifying mental health competencies required for pediatric primary-care clinicians, providing skill building and educational opportunities, changing medical education curricula, and developing new clinical tools (National Institute for Health Care Management, 2009). More research is needed to scientifically validate the outcomes associated with increased training and education about behavioral health on providers' knowledge, attitudes, and practice.

Pediatric primary care providers would benefit from tools and algorithms that promote mental health, identify problems, engage patients and families, determine need for further assessment/evaluation, and assess care options and resources for children with identified problems (AAP, 2008). The AAP policy statement focused on identifying developmental disorders in children 0–3 provides a framework for identification of specific screening tools and information on how to select appropriate tools and CPT codes to use for billing purposes (Council on Children with Disabilities, 2006).

Research efforts must focus on exploring the costs and benefits of integrated models in order to determine the most effective and efficient approach to services. Additionally, more research is needed to empirically compare child and family outcomes for patients served in integrated versus traditional mental health settings. Finally, much of the research and literature has focused primarily on integrative initiatives for adults, for whom mental health and substance use disorders are more prevalent (National Institute for Health Care Management, 2008). Pediatric psychologists are uniquely positioned to demonstrate the benefits of preventive efforts and promotion of development and well-being within integrated pediatric primary-care settings.

Conclusions

Integration of behavioral health services into routine health maintenance activities is critical in providing comprehensive services that include early identification, amelioration

of distress, triage and referral, and the creation of a medical home (AAP, 2002). Although to date, reimbursement for behavioral health services in pediatric settings is negligible, documenting services provided, access to care, and utilization rates is essential in raising awareness and creating momentum for policy changes. In combination with research and policy efforts, routine use of health and behavior codes has the potential to transform models of behavioral and physical health services in the pediatric population. A comprehensive behavioral health approach in pediatric primary care could provide: (a) access to culturally responsive, family-centered resources once issues are identified through screening processes; (b) access to onsite integrated care for those patients who cannot access community services; and (c) continual interaction with primary care providers to enhance case management and care coordination. Using this approach, pediatric psychologists can collaboratively meet the needs of children and families and ultimately improve their health and well-being.

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