PAINWEEK®

Treating the Whole Patient: Updates in Behavioral Health Tracking and Reimbursement

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Title & Affiliation

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Disclosure

- Consultant for VERTOS (MILD Procedure)
- Consultant for NEVRO (Spinal Cord Stimulator Company)
- Consultant for Abbott (Spinal Cord Stimulator Company)
- Will be discussing Neuroflow platform
  - I have no financial relationship with the company

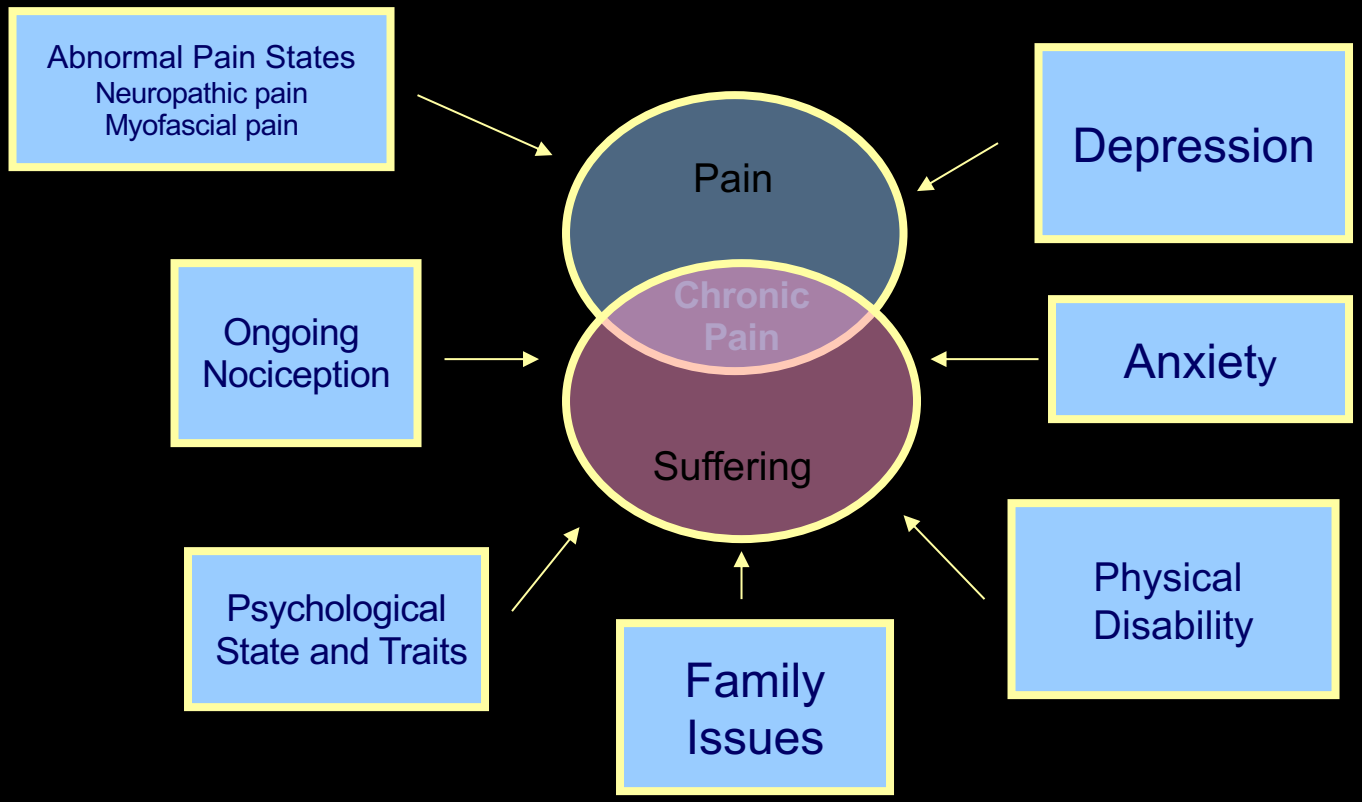
Learning Objectives

- Review the association between chronic pain and coexisting psychiatric pathology
- Review CDC guidelines for prescribing opioids and recommendations in those guidelines to track psychometric measures
- Review CPT code 99484, its reason for introduction, and current reimbursement
- Explore current platforms available for physicians/patients to better address psychiatric needs in the chronic pain population

Curriculum Vitae

- Franklin and Marshall College
- Robert Wood Johnson Medical School
- University of Pennsylvania
  - Assistant Professor
- Private Practice
  - Relievus

Multifactorial Nature of Chronic Pain



The impact of mental health on pain management is **massive & costly**

46%

pain malpractice claimants had depression diagnoses

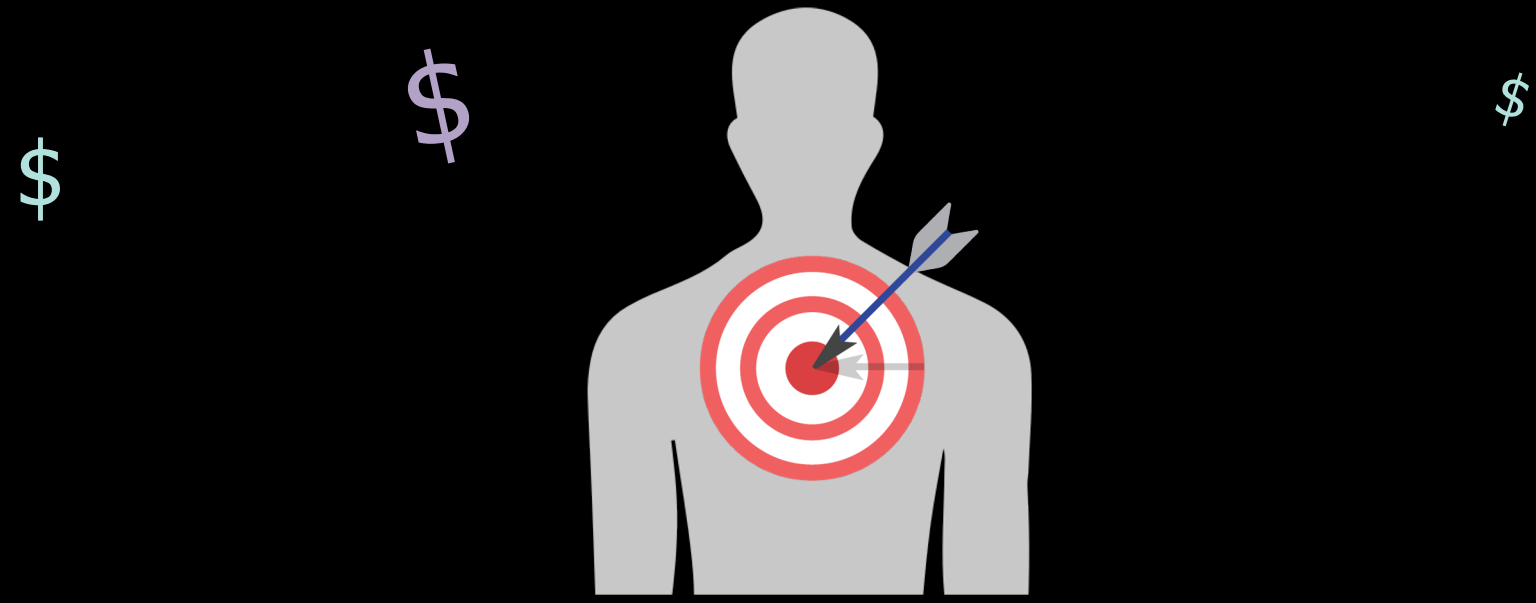
1 in 5

people in the US have a behavioral health disorder

$174,000

is the median malpractice settlement for pain providers

Dermot R. Fitzgibbon, M.D.; James P. Rathmell, M.D.; Edward Michna, M.D et al. Malpractice Claims Associated with Medication Management for Chronic Pain. Anesthesiology. April 2010. Vol.112, 948-956



And the current dynamic is leaving pain specialists vulnerable and **targeted as the villain, or worse, with a lawsuit.**

Depression: Brief Overview

- Depression affects between 5% and 10% of individuals in primary care, but is only recognized in around 50% of cases

- Depression is associated with personal suffering and poor quality of life and functioning

G E Simon , M VonKorff. Recognition, management, and outcomes of depression in primary care. Archives of Family Medicine. 1995; 4:99-105

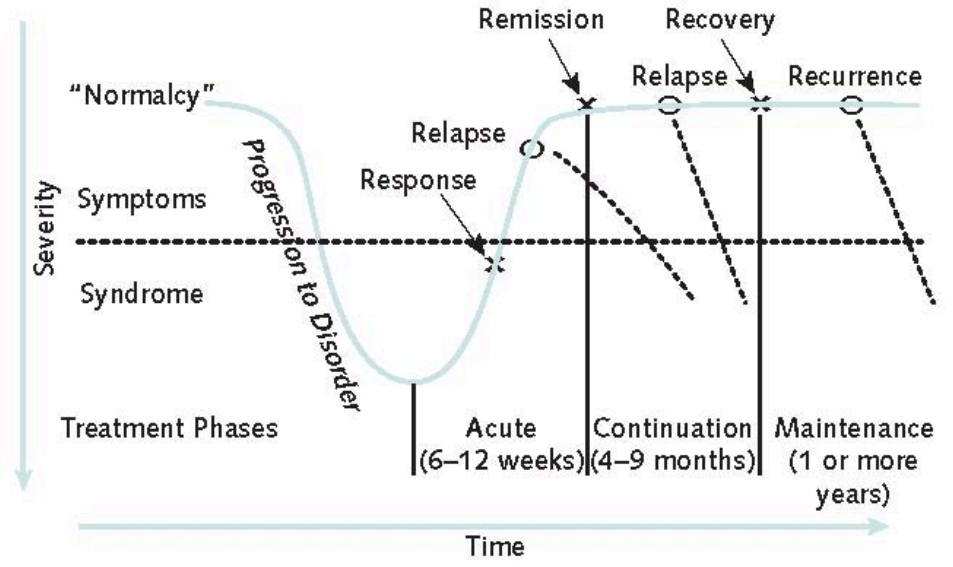
K B Wells , A Stewart, R D Hays, M A Burnam et al. The functioning and well-being of depressed patients. Results from the Medical Outcomes Study. JAMA 1989; 262:914-919

Depression: Brief Overview

- Depressive disorders are serious disabling illnesses that affect 16% of adults in the US during their lifetime
- Depressive disorders include:
  - Major depressive disorder (MDD)
  - Dysthymia
  - Subsyndromal depression

Amir Qaseem , Vincenza Snow, Thomas D Denberg et al. Using second-generation antidepressants to treat depressive disorders: a clinical practice guideline from the American College of Physicians. Annals of Internal Med 2008; 149: 725-733

Figure. Phases of treatment of major depression.



Reproduced with permission from Physicians Postgraduate Press (Kupfer DJ. Long-term treatment of depression. J Clin Psychiatry. 1991;52 Suppl:28-34. [PMID: 1903134]).

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Depression: Brief Overview

- Patients with unrecognized depression consult with their physician more frequently and consume greater health care resources.

- The presence of depression in conjunction with physical illness adversely affects the outcomes of both disorders.

Gregory E Simon , Daniel Chisholm, Michael Treglia et al. Course of depression, health services costs, and work productivity in an international primary care study. Gen Hosp Psych 2002; 24:328-335

Wayne Katon , Paul Ciechanowski. Impact of major depression on chronic medical illness. J Psychosom Res 2002; 53:859-863

Depression: Diagnosis

- A clinical syndrome that lasts at least 2 weeks during which the patient experiences either depressed mood or anhedonia plus at least 5 of the following:
  - Depressed mood most of the day, nearly every day
  - Markedly diminished interest or pleasure in most activities most of the day
  - Significant weight loss or gain or appetite disturbance
  - Insomnia or hypersomnia
  - Psychomotor agitation or retardation
  - Inappropriate guilt
  - Diminished ability to think or concentrate or indecisiveness
  - Recurring thoughts of death, including suicidal ideation

Amir Qaseem , Vincenza Snow, Thomas D Denberg et al. Using second-generation antidepressants to treat depressive disorders: a clinical practice guideline from the American College of Physicians. Annals of Internal Med 2008; 149: 725-733

The Key Issue

- Chronic pain has high associated co-morbidity with:
  - Depression
  - Anxiety disorders
  - Sleep disorders
- All significantly impact function and quality of life
- Addressing these issues is critical for optimal outcome of pain treatment

Prevalence of Psychiatric Illness in Chronic Pain

- Varies with population:
  - Community samples
  - Primary care
  - Sports medicine clinics
  - Nursing homes
  - Pain clinics

- Illness symptoms overlap
  - Symptoms of chronic pain resemble psychiatric disorder

Psychiatric Illness in Chronic Pain

- 200 CLBP patients beginning functional restoration program
- Structured Clinical Interview/DSM-III-R
  - 59% had current symptoms of >/= 1 psychiatric DXx
- Most common:
  - major depression (45%)
  - substance abuse (19%)
  - anxiety disorders (16%)

P B Polatin , R K Kinney et al. Psychiatric illness and chronic low-back pain. The mind and the spine--which goes first? Spine. 1993 Jan;18(1):66-71

Mood Disorders in Chronic Pain: Diagnostic Problems

- Sensitivity and specificity of diagnosis
- Response bias: patients deny psychological symptoms
- Confounding issue:
  - Physical factors (pain, co-existing illness, medications, drugs and withdrawal) cause psychological symptoms

PHQ9

- 9 question self-administered questionnaire
  - Derived from the DSM-IV classification system to document:
    - Anhedonia
    - Depressed mood
    - Trouble sleeping
    - Feeling tired
    - Change in appetite
    - Guilt or worthlessness
    - Trouble Concentrating
    - Feeling slowed down or restless
    - Suicidal thoughts

Simon Gilbody , David Richards, Stephen Brealey, Catherine Hewitt. Screening for depression in medical settings with the Patient Health Questionnaire (PHQ): a diagnostic meta-analysis. J Gen Intern Med 2007;22:1596-1602

PHQ9

- The PHQ9 has been evaluated for use as a screening tool in the primary care and non-psychiatry care setting

- A meta-analysis evaluated the use of the PHQ9 in 14 published validation studies that included 5,026 patients
  - The results of the PHQ9 had a sensitivity of 0.80 and a specificity of 0.92
    - Using a cut point of ≥ 10

Simon Gilbody , David Richards, Stephen Brealey, Catherine Hewitt. Screening for depression in medical settings with the Patient Health Questionnaire (PHQ): a diagnostic meta-analysis. J Gen Intern Med 2007;22:1596-1602

Key Questions

- Do we do as good a job as we could in diagnosing and treating depression?

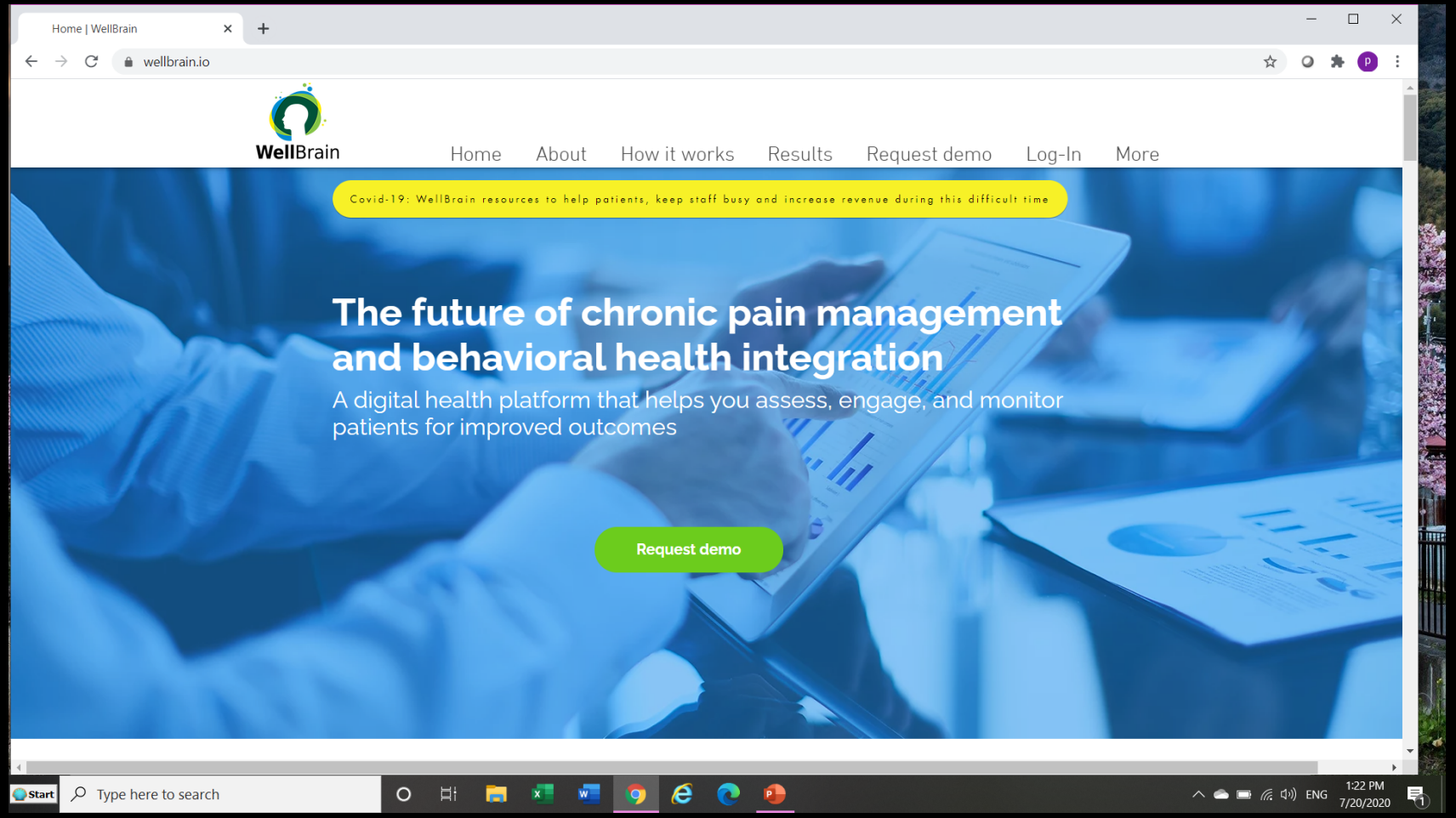
Covid-19 and the Impact of Telemedicine

- Most typical pain practices are not treating depression as well as they could
  - Interventional procedures
  - Medication management
  - Maybe have psychologist/psychiatrist on staff
- How can the gaps in treatment be filled?
  - Telemedicine is ever expanding and allowing for better monitoring of symptoms

Behavioral Health Applications

- Gaining more and more traction and allow for better overall care as other comorbid psychiatric conditions are diagnosed and treated
- Anxiety Reliever, Anxiety Coach, Breathe2Relax, CPT Coach, Happify, Headspace, iCBT App, Live OCD Free, MindShift, Moodkit, MoodTools, Neuroflow, Panic Relief, PE Coach, PTSD Coach, Sanvello, T2 Mood Tracker, WellBrain, WorryWatch
- Some are free, others have monthly subscriptions

WellBrain



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Enabling behavioral health access & engagement in clinical pain settings

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So Where Does This Leave Us as Providers Treating Pain?

You're being asked to **predict patient risk**

You have to **document & measure more**

You're suffering from **bad press & reviews**

You're **not being compensated fairly**

You have a growing need to protect yourself from a lawsuit

CDC Guidelines for Integration of Mental Health in Treatment of Pain

- Psychological distress frequently interferes with improvement of pain and function in patients with chronic pain, thus, using validated instruments such as the **Generalized Anxiety Disorder (GAD)-7** and the Patient Health Questionnaire **(PHQ)-9** to assess for **anxiety, post-traumatic stress disorder, and/or depression** can help improve overall pain treatment outcomes.
- Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Multimodal therapies and biopsychosocial rehabilitation-combining approaches can reduce long-term pain and disability compared with usual care and compared with physical treatments alone. Because patients with **chronic pain often suffer from concurrent depression,** and **depression can exacerbate physical symptoms including pain**, patients with co-occurring pain and depression are especially likely to benefit from antidepressant medication.
- Before starting and periodically during continuation of opioid therapy, **clinicians should evaluate risk factors for opioid-related harms**. Clinicians should incorporate into the management plan strategies to mitigate risk, including history of **substance use disorder, and other mental health considerations**.

General Behavioral Health Integration (99484)

- Used to bill monthly services using models of care other than the Psychiatric Collaborative Care Model (99492-94).
- The core service elements include:
  - Systematic assessment and monitoring with validated screening tools
  - Care plan revision for patients, particularly if condition is not improving
  - Continuous relationship with a designated care team member on staff
- General BHI is a model that does not involve a psychiatric consultant, nor a designated behavioral health care manager - although a care manager may provide these services
- 20 minutes of clinical staff time per month

mln BOOKLET
KNOWLEDGE • RESOURCES • TRAINING
PRINT-FRIENDLY VERSION

BEHAVIORAL HEALTH INTEGRATION SERVICES

TARGET AUDIENCE

Medicare Fee-For-Service Program Providers

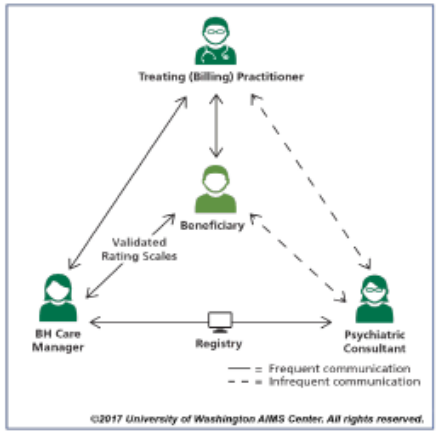
Integrating behavioral health care with primary care ("behavioral health integration" or "BHI") is an effective strategy for improving outcomes for the millions of Americans with mental or behavioral health conditions. As of January 1, 2017, Medicare makes separate payments to physicians and non-physician practitioners for BHI services they furnish to beneficiaries over a calendar month service period. As of January 1, 2018, these services will be reported using new CPT codes, listed below.

PSYCHIATRIC COLLABORATIVE CARE SERVICES (COCM)

CPT codes 99492, 99493, and 99494 are used to bill for monthly services furnished using the Psychiatric Collaborative Care Model (CoCM), an approach to BHI shown to improve outcomes in multiple studies.

What is CoCM? This figure is a model of behavioral health integration that enhances "usual" primary care by adding two key services to the primary care team, particularly regarding patients whose conditions are not improving:

- Care management support for patients receiving behavioral health treatment
- Regular psychiatric inter-specialty consultation
- A team of three individuals provide CoCM: the Behavioral Health Care Manager, the Psychiatric Consultant and the Treating (Billing) Practitioner



General Behavioral Health Integration (99484)

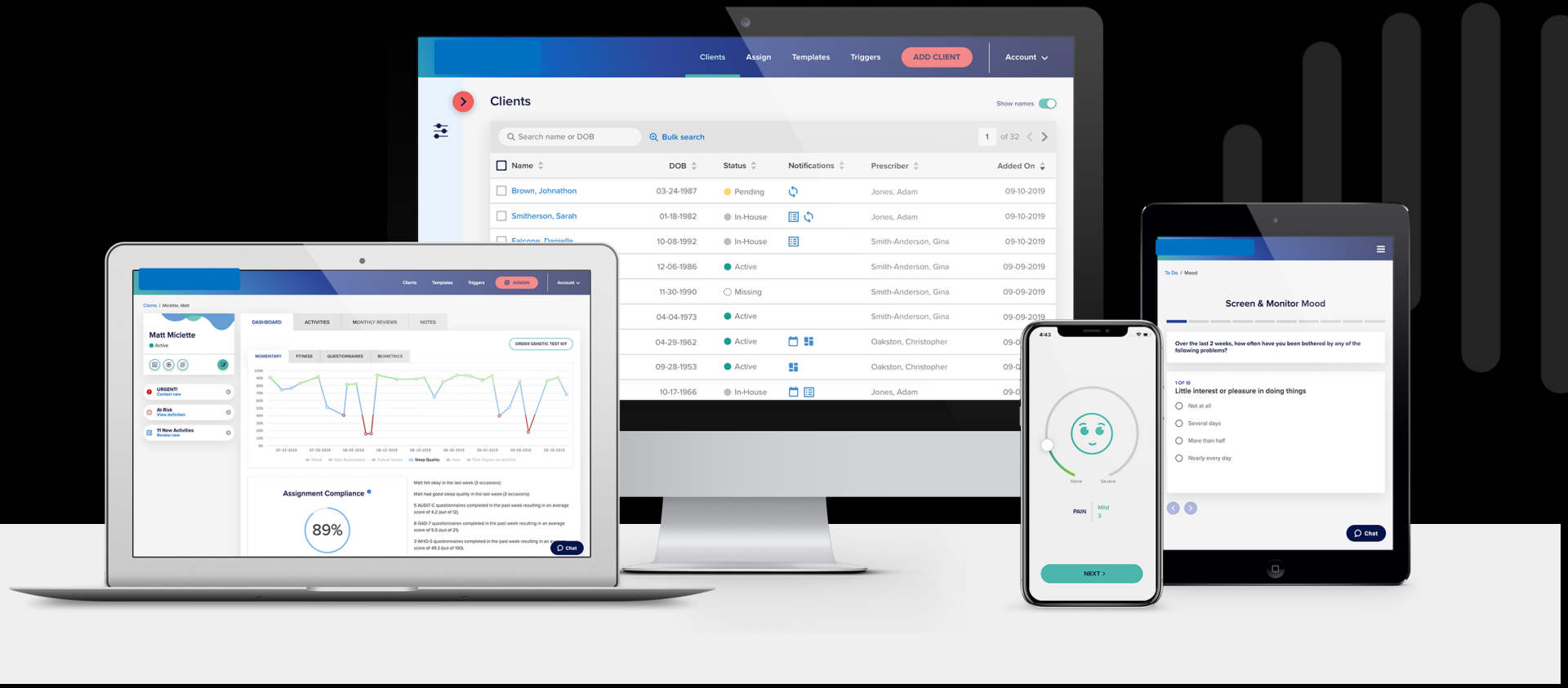
- **Medicare Reimbursement**
  - Medicare reimburses $48.65
  - 20% cost-sharing still applies - meaning CMS will reimburse $38.92
- **Medicaid Reimbursement**
  - Varies greatly by state
  - Currently 13+ states reimbursing
- **Commercial Reimbursement**
  - Reimbursement varies from $10 to $100 every month; ~$50 average
  - Not all commercial payers reimburse; Varies by region
- Aetna, Tricare, United, and others are reimbursing with increasing adoption

General Behavioral Health Integration (99484)

- Applicable Patients
  - Any patient with mental, behavioral health, or psychiatric condition being treated by the billing practitioner, including substance use disorders or chronic pain (“F Codes”) that in the clinical judgment of the billing practitioner warrants BHI services is eligible.

- Why Payers Are Reimbursing
  - Integrating behavioral health care into primary care and other physical health settings is considered an effective strategy for improving outcomes and lowering cost for the millions of Americans with behavioral health conditions.

One Reimbursable Tool That Can Help



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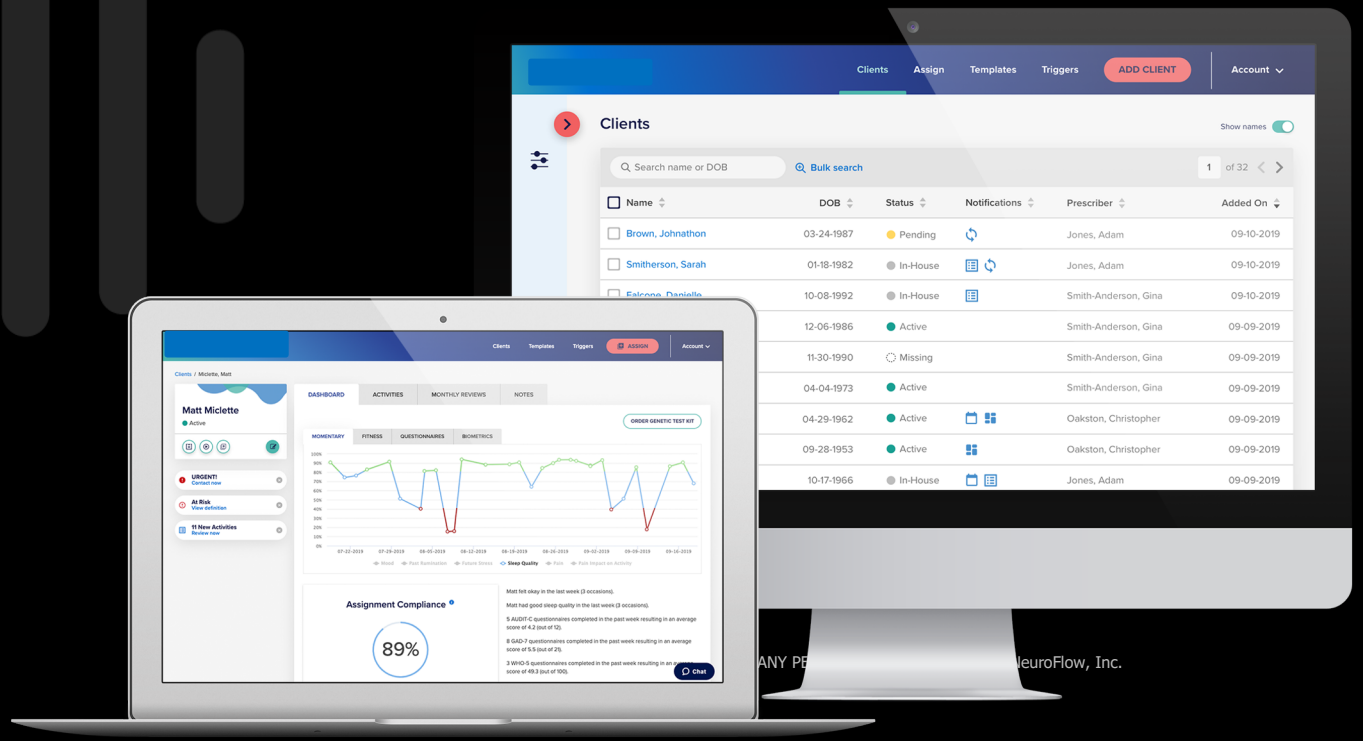
Provider-Facing Platform

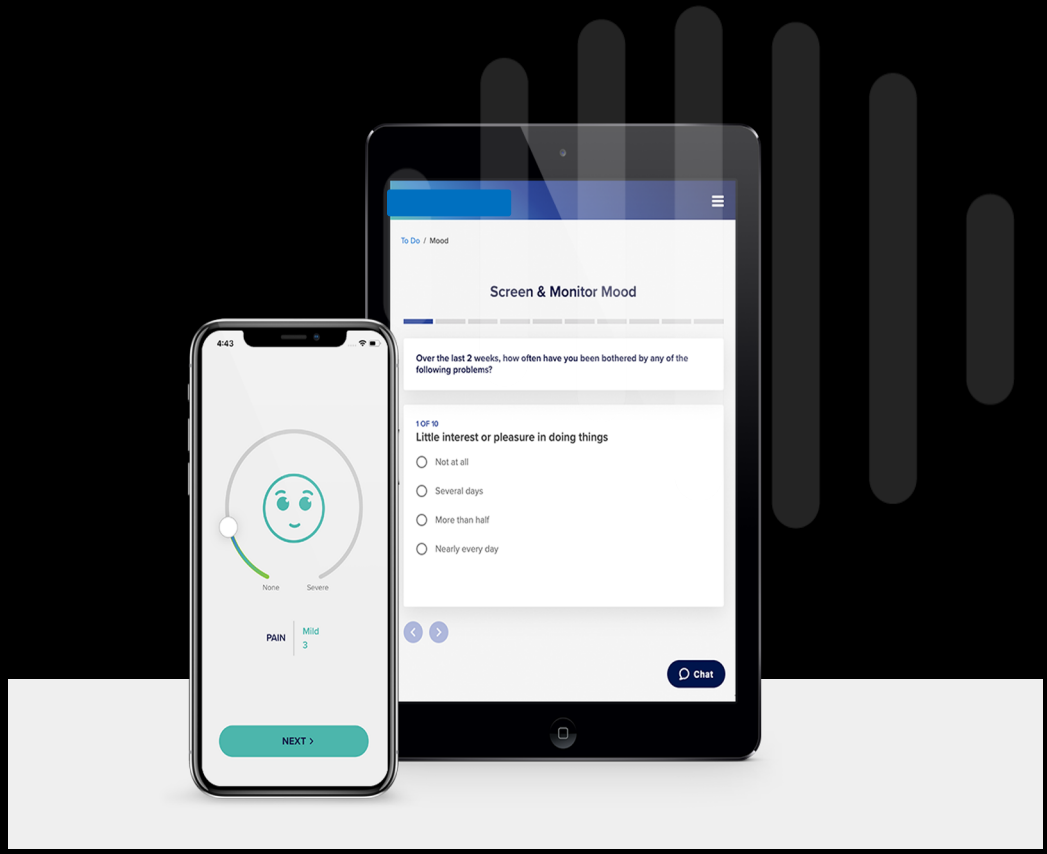


Cover your bases by consistently tracking and monitoring your patients

Patient-Facing App

Your patients use an App:

- Take clinically validated assessments
- Track longitudinal subjective data like pain, mood, and sleep
- Access educational and motivational content and activities



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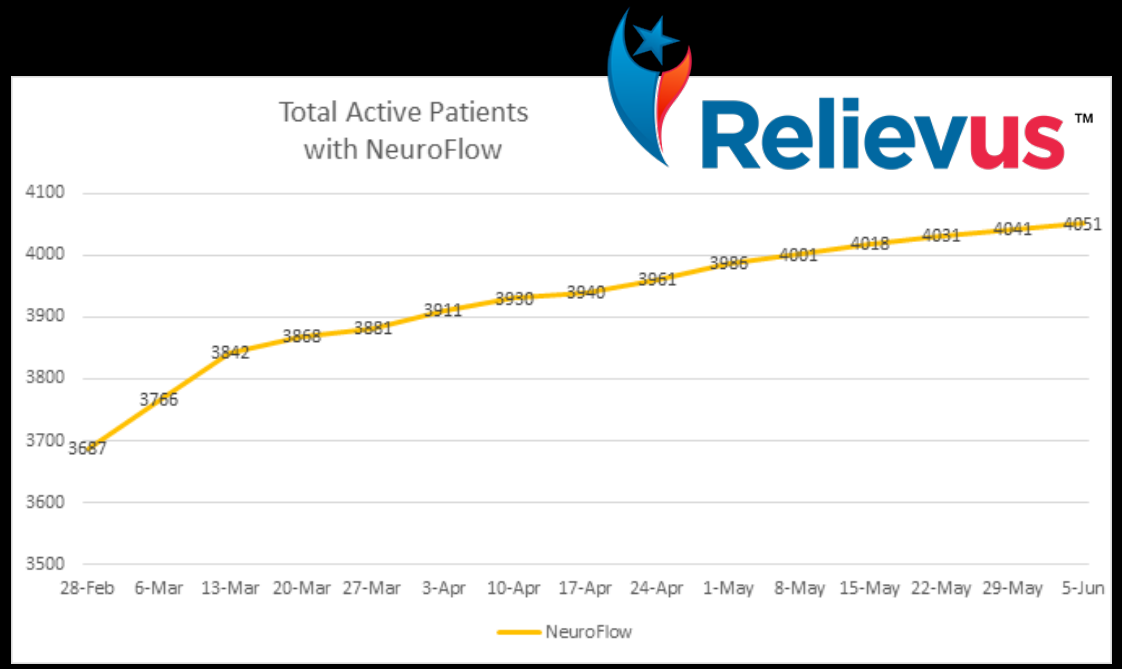
My Practice Uses Neuroflow to Monitor And Treat The Whole Patient; Now With Over 4,000 Patients

Improved outcomes with 75% of patients measuring a reduction in depression and anxiety

Safely prescribing opioids accounting for the *whole* patient

Sustainable through reimbursement codes for behavioral health integration



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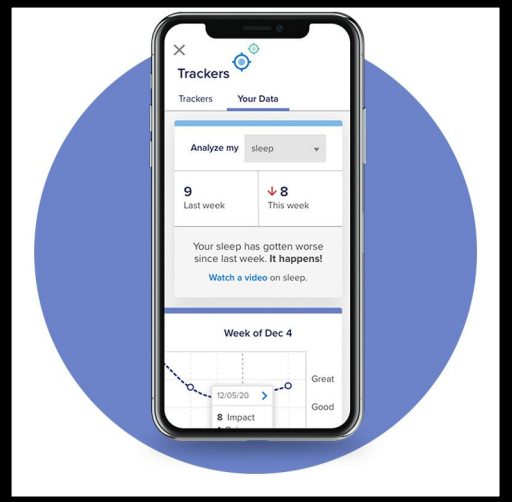
Apps Help Your Patients & Your Practice Monitor And Provide Better Care

Measure

Measurement-Based Care to remotely track and risk stratify your population

Manage

Adjust treatment plans with integrated, coordinated care

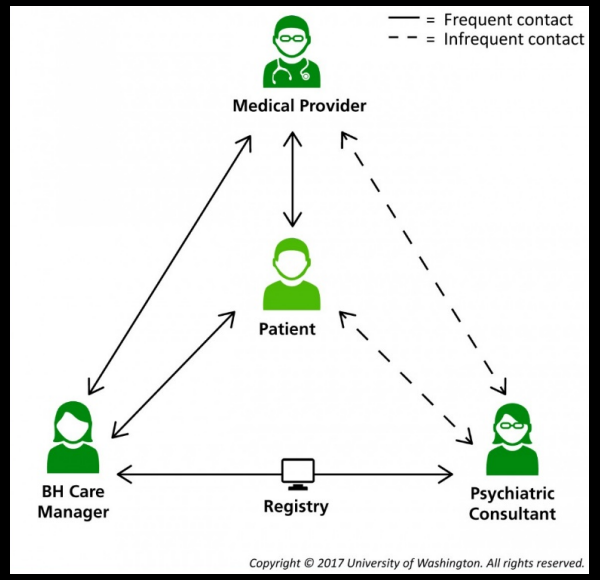


Motivate

Deliver evidence-based, personalized tools and resources

Integrating Behavioral Health Without Technology Can Be Cumbersome and Expensive

CMS Model for Behavioral Health Integration (BHI) and Psychiatric Collaborative Care (CoCM)



This platform enables this evidence-based model to occur efficiently at scale with automated workflows

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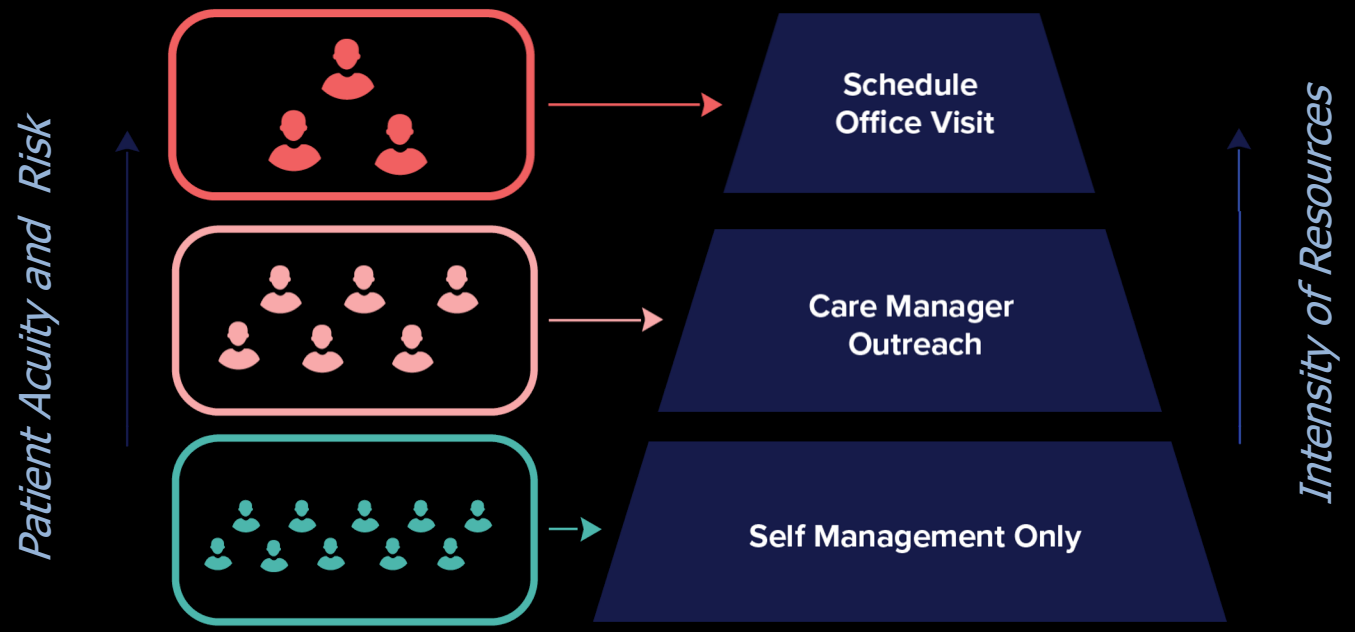
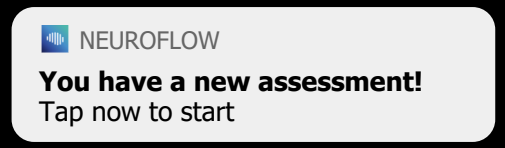
Allocate Resources Efficiently During Outbreaks

Support providers as immense pressure is being put on our health systems

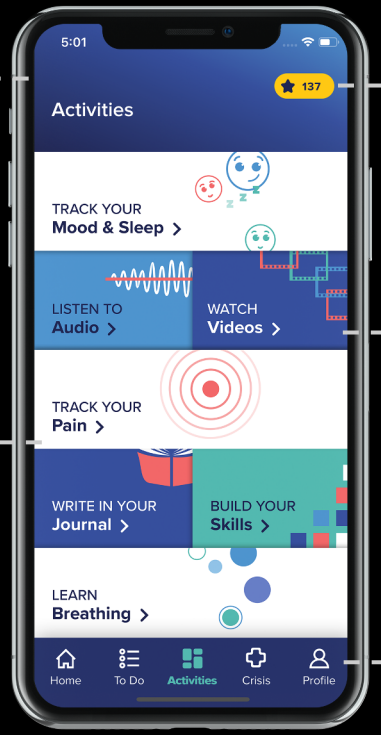


Collect Data Remotely While Offering Resources

Automated prompts for your patients to do assessments



Quantitative tracking so you and your patients can see progress



Patients receive **rewards incentives** at no additional cost to you

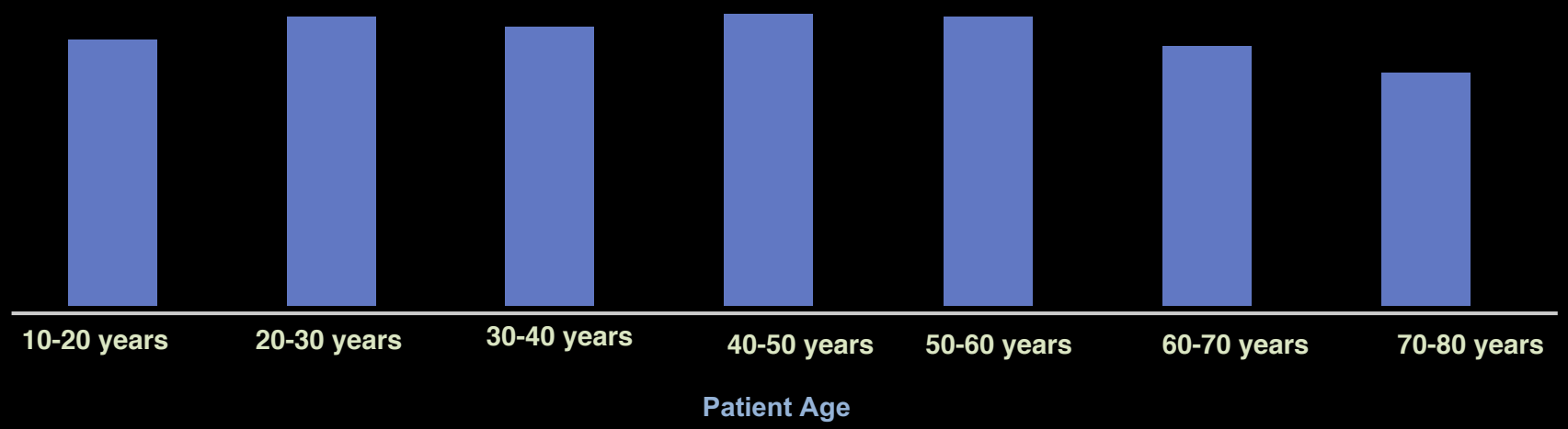
Content libraries with educational information and evidence-based activities

Easy sign up with automated text invitations

Consistent Engagement Across Age Groups

51%
of users are between 45-70 years old

40-60
highest monthly engagement



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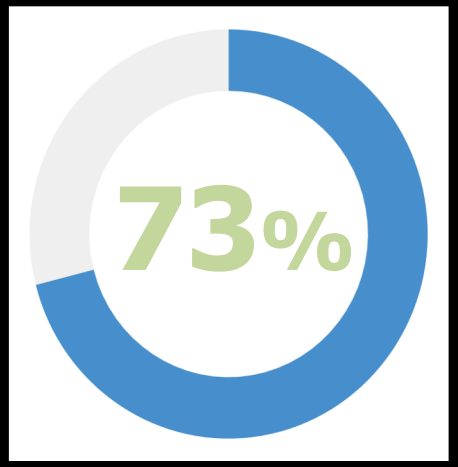
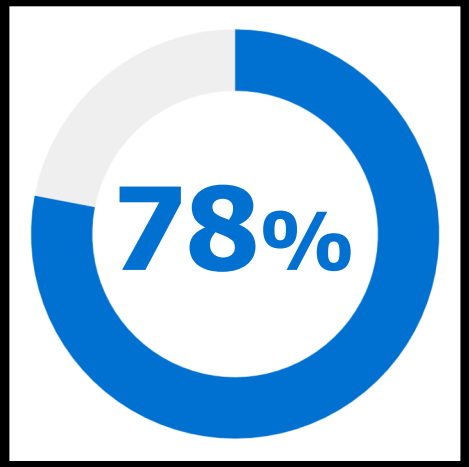
Improve Outcomes, Overall Wellness, & Revenue

ENGAGEMENT



of patients remain engaged on the platform after 1 month

OUTCOMES



of patients report a reduction in depression or anxiety symptoms

PROTECTION

$ 174k

median cost of malpractice settlement

REIMBURSEMENT

10+

supported CPT codes **averaging $48 per patient per month (all remote work)**

PainWeek®

With Mental Health Apps, You Have The Ability To:

Get paid for providing better care

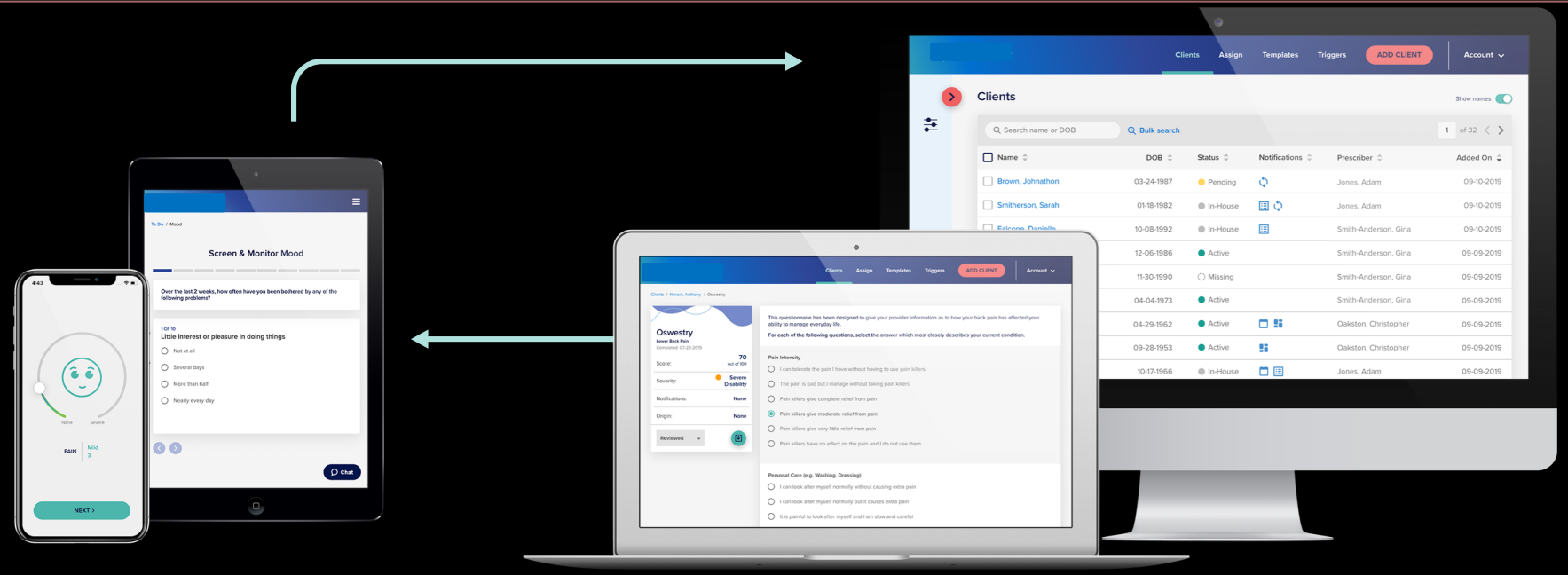
- Increase Access & Engagement for Mental Health Services
- Increase Revenue Through Reimbursable BHI Activities
- Integrate Collaborative, Holistic Care Into Your Practice

Easily gather data from your patients

- Track Measurable Outcomes For Patients
- Enhance Care & Treatment Plans with Actionable Data
- Stratify Patients to Identify the Most Urgent Individuals

Provide a better patient experience

- Automate Provider Workflows for Remote Patient Monitoring
- Reduce Patient Costs & Gaps in Care
- Drive Patient Experience Metrics (CSAT & NPS)


Clients
Assign
Templates
Triggers
ADD CLIENT
Account
Screen & Monitor Mood
Oswestry
Patient-facing app
Provider-facing platform

PAINweek®

Backed by Evidence-based Psychology

The tools are derived from proven treatments such as

Cognitive Behavioral Therapy (CBT) and mindfulness-based interventions

Psychoeducation

Relaxation training

Mindfulness meditations

Cognitive restructuring

Coping skills training

Behavioral activation

Relevant reporting for patient risk stratification

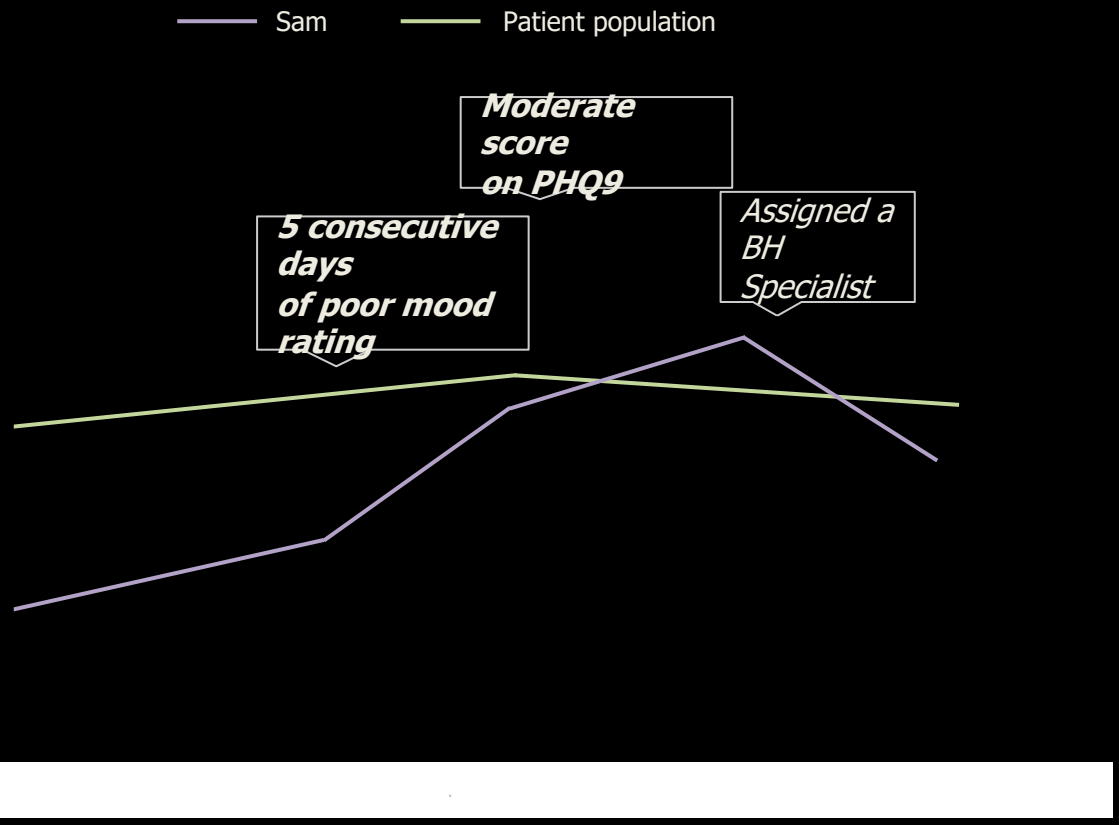
Proprietary risk algorithm developed by data scientists

PAIN PATIENT

Sam, 47

Nov. Severity Rating	**Moderate**
Compared to users in your organization	65%

**risk level is at 65th percentile of patient population*



QUESTIONS?