



FINANCING TRAUMA-INFORMED CARE

Overview

Organizations often utilize a combination of funding sources to support their trauma-informed care practices and services. The availability of funding for trauma-informed care varies depending on the state, the service being provided, the type of provider, and other factors. Organizations will need to optimize both direct and abstract revenue to support advancing trauma-informed care in their practices.

Providers can maximize billing opportunities by ensuring they are utilizing all available existing billing codes while doing so accurately and appropriately. Furthermore, providers can overcome barriers to financing by diversifying funding streams and participating in alternative payment models and demonstration projects.

Trauma-informed care could potentially be financed through a variety of funding sources including public insurance (Medicaid and Medicare) programs, commercial insurance, client self-pay, state and federal grants, private philanthropy, and military funding. Additionally, state-based variation in the availability of financing mechanisms exists due to differences in state Medicaid plans, state-specific scope of practice laws, behavioral health resources, and other factors. For many of the direct service components of trauma-informed care, providers deliver billable services to clients and then seek reimbursement using an appropriate billing code. Examples of direct service components could include direct visits for primary care or behavioral health, among others. For non-direct service components, organizations need to review sources of potential abstract revenue, such as quality dollars or engagement to care.

Practice Recommendations

There are several action steps organizations and providers can take to maximize financing opportunities and overcome financial barriers related to implementing comprehensive trauma-informed care across their organizations.

Billing

Provider organizations should ensure that they are maximizing opportunities to gain funding for delivering reimbursable services. Providers should:

- Ensure they are utilizing the range of appropriate billing codes when delivering a service
- Ensure that providers are appropriately and accurately utilizing extender or complexity codes that provide additional reimbursement based on the length or difficulty of a service provided
- Utilize crisis codes where available
- Ensure all providers are credentialed with payers and specifically the payers of their patients.
- Utilize complex care codes for Medicare patients where available.



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As explained above, provider organizations can utilize existing billing codes to seek reimbursement for direct trauma care services. Organizations must use specific billing codes for each specific component of trauma care. For primary care practices with imbedded behavioral health providers utilize billing codes appropriate for services provided. For example, 90791 (psychiatric diagnostic interview without medical services) was reported to be used for a comprehensive behavioral health assessment. Primary care visits addressing trauma histories and related needs with patients often find that the visits meet expanded time and complexity, sometimes commanding higher reimbursement rates.

Table 1. CPT codes and funding mechanisms used for core components of trauma-informed care that organizations may not be familiar with.

BILLING CODE/ FUNDING MECHANISM	SCREENING	ASSESSMENT	GROUP	EVIDENCE-BASED TREATMENTS	WARM HANDOFFS	FOLLOW UP CONTACTS
90791	X	X				
90792	X	X				
96153	X		X		X	
96150,1	X					
99212-5	X	X				
99211	X	X				
90853		X	X	X	X	
90832, 34, 37	X				X	
90839	X	X				
99490	X				X	X
99495	X				X	X
99496	X				X	X

There are several key components to successfully implementing financially sustainable trauma-informed care to optimize revenue, they are:

- Understanding state-based rules and regulations regarding same-day billing, scope of practice laws, supervised billing, etc. The SAMHSA-HRSA Center for Integrated Health Solutions maintains state-level billing sheets that are a helpful resource to providers.



- Maximizing health information technology including electronic health records to ease the documentation and billing burden on individual providers.
- For primary care practices considering imbedding behavioral health to expand trauma-informed care services research needs to be done to ensure understanding of provider credential and license types and related reimbursements.
- Understanding which evidence-based practices are reimbursable and then implementing them.

LEVERAGING SPECIAL PROGRAMS

<p>Health Homes:</p> <p>Many patients with history of trauma are health home eligible based on state requirements. Using health home services allows for potential reimbursement for care coordination, home visits and the extra support patients with trauma may benefit from.</p>	<p>The Patient Protection and Affordable Care Act (ACA) established Health Homes for individuals who receive Medicaid with chronic conditions including a serious and persistent mental health condition. Health Homes provide states with enhanced Medicaid funding to deliver comprehensive care and care coordination for individuals. States have the option of participating in Health Homes and also have flexibility in how the services are financed. Most states that are participating have implemented a per member per month (PMPM) financing model (Nardone & Paradise, 2014). PMPM models allow providers greater flexibility in the services they deliver to clients as compared to fee for service models. Organizations in states participating in Health Homes could potentially provide trauma care services under Health Homes' rate since prevention, care coordination and individual and family supports are often some of the covered services.</p>
<p>Collaborative Care Financing:</p> <p>CPT codes 99494, 99493, 99494</p> <p>Many patients with trauma also experience depression and / or anxiety and are eligible for "high touch" care provided by Collaborative Care, an effective way to not only engage patients in care but finance both the direct care and ancillary telephonic as well as care coordination services patients with trauma benefit from.</p>	<p>Financing strategies for collaborative care vary. In 2017 CMS issued a set of billing codes to support collaborative care for Medicare beneficiaries. These codes reimburse monthly services provided through the Psychiatric Collaborative Care Model (CoCM) (Advancing Integrated Mental Health Solutions [AIMS] Center, 2017b). The CoCM is an integrated care model that adds care management support and regular psychiatric inter-specialty consultation to the primary care team. Care team members include:</p> <ul style="list-style-type: none"> • Treating (billing) Practitioner: physician and/or non-physician practitioner • Behavioral Health Care Manager: a designated individual with formal education or specialized training in behavioral health working under the direction of the billing practitioner • Psychiatric Consultant: a medical professional trained in psychiatry and qualified to prescribe a full range of medications • Beneficiary: the client receiving services is part of the care team <p>A range of services are provided through the CoCM model. These include initial assessment, care planning, treatment, and systematic follow ups. Additionally, a case load review between the primary care team and psychiatric consultant takes place at least weekly (CMS, 2017a). These codes provide Medicare payments for services provided by primary care providers for patients participating in a collaborative care program or receiving integrated behavioral health services.</p>



LEVERAGING SPECIAL PROGRAMS

<p>Medicare Integrated Care Services: CPT 99484</p>	<p>Can be used for patients with behavioral health diagnosis for care coordination and services.</p>
<p>Chronic Care Management Services: Many patients with trauma also have multiple chronic conditions. These services allow for care coordination and extra support which can be helpful for patients with a history of trauma.</p>	<p>In 2015 CMS established billing codes for providers to receive reimbursement for chronic care management services to Medicare beneficiaries. The CPT codes include Chronic Care Management (CCM) and Complex CCM (99490, 99487 and 99489). The CCM code requires at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month for clients who have multiple chronic conditions, chronic conditions that place the patient at risk of death, decompensation or functional decline, and have an established care plan. The Complex CCM code requires a higher level of provider service time (CMS, 2017b). Depression is listed as a qualifying chronic condition per guidance on the use of the codes and many patients with a history of trauma also experience major depressive symptoms and disorder.</p>
<p>Transitional Care Management Services</p>	<p>CMS established codes to provide reimbursement for Transitional Care Management (TCM) services. These CPT codes (99495 and 99496) require providers to provide an interactive contact with a client; provide certain non-face-to-face services; and provide one face-to-face visit within certain time frames (CMS, 2016b). Providers should use these codes when appropriate and available when delivering services to individuals who are receiving Medicare benefits.</p>