Washington State Health Care Authority

Report to the Legislature

Behavioral health assessment and diagnosis for infants and children

Engrossed Substitute Senate Bill 6168; Section 215(62); Chapter 357; Laws of 2020

December 1, 2020

Behavioral health assessment and diagnosis for infants and children

Washington State Health Care Authority

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Background

The Washington State Health Care Authority (HCA) is submitting this reprort to the Legislature as required by Engrossed Substitute Sendate Bill 6168 (2020), Section 215(62):

> *"$31,000 of the general fund—state appropriation for fiscal year 2020, $94,000 of the general fund—state appropriation for fiscal year 2021, and $125,000 of the general fund—federal appropriation are provided solely to conduct an analysis on the impact of changing policy in the apple health program to match best practices for mental health assessment and diagnosis for infants and children from birth through five years of age. The analysis must include cost estimates from the authority and the actuaries responsible for establishing medicaid managed care rates on the annual impact associated with policy changes in assessment and diagnosis of infants and children from birth through age five that at a minimum: (a) Allow reimbursement for three to five sessions for intake and assessment; (b) allow reimbursement for assessments in home or community settings, including reimbursement for clinician travel; and (c) require clinician use of the diagnostic classification of mental health and developmental disorders of infancy and early childhood. The authority must submit a report to the office of financial management and the appropriate committees of the legislature summarizing the results of the analysis and cost estimates by December 1, 2020."*

HCA contracted with Mercer Government Human Services Consulting (Mercer) to conduct an analysis on the impact of changing policy in the Apple Health program to match best practices for mental health assessment and diagnosis for infants and children from birth through five years of age. The Mercer report is attached below as Appendix A.

Appendix A: Mercer behavioral health assessment report

MERCER

Proviso 62 — Behavioral Health Assessment Report

Washington State Health Care Authority
December 7, 2020

welcome to brighter

Contents

1 Introduction

The State of Washington (State or Washington) Health Care Authority (HCA) contracted with Mercer Government Human Services Consulting (Mercer) to conduct an analysis on the impact of changing policy in the Apple Health program to match best practices for mental health assessment and diagnosis for infants and children from birth through five years of age. The Washington Legislature directed HCA to perform this analysis through Proviso 62. Proviso 62 requires an analysis and annual fiscal estimates associated with following policy changes:

a. Allowing reimbursement for three to five sessions of children ages 0–5 for intake and assessment.

b. Allowing reimbursement for assessments in home or community settings, including reimbursement for clinician travel.

c. Requiring clinician use of the diagnostic classification of mental health and developmental disorders of infancy and early childhood (DC:0–5) rather than the Diagnostic and Statistical Manual of Mental Disorders (DSM).

In conclusion, Mercer identified fiscal impacts based on the results of the analysis completed. The fiscal impacts are included in Table 1.

Table 1: Fiscal Impact by Component

Component	Fiscal Impact
Allowing up to 5 Sessions of Intake and Assessments	$73,389
Travel Costs for Existing Utilization	$111,444
Travel Costs for Additional Intake and Assessment Sessions, up to 5	$119,772
Expected Costs for Training Practitioners for DC:0–5	$1,260,000

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Current Apple Health Environment

Apple Health Policy for Intake and Assessments

Existing Apple Health policy allows reimbursement for only one intake and mental health assessment for any individual.[1] All Medicaid-eligible individuals may receive an assessment through a community mental health agency. A diagnosis, specifically a mental health diagnosis, is required by the managed care organizations (MCOs) to process a claim in the Medicaid Management Information System (MMIS). If a clinician is unable to give a diagnosis on the first date that the individual is seen, a provisional diagnosis is given. State Medicaid policy requires the individual to be present for the single assessment session.

Research and Best Practices

While these coverage and billing practices may be appropriate for older adolescents and adults, research suggests that the youngest children needing behavioral health assessments are not well-served by these policies. Instead, properly assessing children from birth through age five with behavioral challenges may require multiple assessment sessions with and without the child present.[2] Different strategies may be necessary to build rapport and engage caregivers, observe the child and his/her interaction with caregivers, survey/interview the caregivers separately from the child and determine child functioning across settings/caregivers. For complete young child assessments, a provider agency may need multiple practitioners with different specialties or practitioners may need to schedule multiple sessions. Often, because behaviors in very young children can have multiple causes, young children may be misdiagnosed if complete evaluation information cannot be gathered by qualified assessors.[3]

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[1] The Apple Health Mental Health services billing guide states that for 90791 and 90792, only one psychiatric diagnostic interview exam is allowed per client, per provider, per calendar year (page 29). The NCCI edit is less strict: 90791 — Use this code only once per day regardless of the number of sessions or time that the provider spends with the patient on the same day. 90792 — Use this code only once per day regardless of the number of sessions or time that the provider spends with the patient on the same day. Codes 90791 and 90792 may be reported once per day and not on the same day as an evaluation and management service performed by the same individual for the same patient. +90785 interactive complexity add on may be added onto the psychiatric evaluation (90791, 90792). +99354–99355 may not be utilized in conjunction with 90791 and 90792.

[2] "A clinician or team needs a number of sessions to understand how an infant/young child is developing in each area of functioning. A few questions to parents or caregivers about each area may be appropriate for screening but not for a full evaluation. A comprehensive evaluation usually requires a minimum of three to five sessions of 45 or more minutes each." ZERO TO THREE (2016). DC:0–5, p. 8.

[3] Spiro L. *The Most Common Misdiagnoses in Children*. Available at: https://childmind.org/article/the-most-common-misdiagnoses-in-children/

Current Diagnosis Classification

Clinicians in the State are currently using a variety of diagnosis manuals, including the DSM-V, the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0–3R) and/or the DC:0–5. Washington clinicians and agencies have expressed support for utilizing a single comprehensive children's diagnostic tool, such as the DC:0–5 that better supports early childhood assessments. Documentation provided by the Washington State Prenatal to Five Relational Health Committee states that the DSM-V is not an appropriate manual for use in very young children. Instead, the Committee recommends use of the DC:0–5 because it is a developmentally aligned diagnostic manual for clinicians to use as a guide for screening, assessment and diagnosis for children from birth through five years of age.

Using the DC:0–5 in Medicaid

In 2018, the National Center for Children in Poverty asked State administrators if their agency or Medicaid policy requires, recommends or allows providers to use DC:0–5 or the previous version DC:0–3R to conduct mental health/behavioral health diagnostic classification for infants and young children through five years.

- 13 states (25%) allow providers to use DC:0–5: Alaska, Connecticut, Delaware, District of Columbia, Idaho, Louisiana, Maine, Massachusetts, Pennsylvania, Tennessee, Vermont, Virginia and Washington.
- 6 states (12%) recommend, but do not require, that providers use DC:0–5: Arizona, Colorado, Michigan, Minnesota, Nevada and Oregon.
- 30 states (59%) reported none of the above.

DC:0–5 is a nationally accepted standard that has been adopted or recommended in six states including Arizona, Colorado, Michigan, Minnesota, Oregon and Nevada[4]. National research shows that the DC:0–5 Diagnostic Classification System helps providers identify and understand mental health conditions that occur in children ages birth through five years of age. The DC:0–5 was developed by a work group comprised of infant–early childhood mental health experts, including specialists within ZERO TO THREE, the organization that sponsored and led the work that created this system.[5] In 2016, the DC:0–5 was published, updating the DC:0–3R by expanding the target age range, extending criteria to younger ages and including all disorders relevant for young children.

HCA does not currently require clinicians to utilize any specific diagnostic criteria or manual, but is one of 13 state Medicaid agencies that allows providers to use the DC:0–5 Diagnostic Classification System. Washington providers have built limited capacity around the state for utilizing DC:0–5 in limited geographic areas. During a virtual meeting on August 25, 2020 between HCA, the Washington

[4] Although specific language about DC:0–5 was removed from the Medicaid State Manual in a recent revision, the Nevada Division of Child and Family Services and some clinicians continue to use the DC:0–5 and crosswalk the DC:0–5 disorders to the 10th edition of the International Classification of Diseases and Related Health Problems (ICD-10) for eligibility and billing purposes. Source: https://www.zerotothree.org/resources/2764-nevada-advances-infant-and-early-childhood-mental-health-assessment-diagnosis-and-treatment

[5] Smith S, Granja MR, Nguyen U, Rajana K. (2018). *How States Use Medicaid to Cover Key Infant and Early Childhood Mental Health Services: Results of a 50-State Survey* (2018 Update). New York: National Center for Children in Poverty, Mailman School of Public Health, Columbia University.

State Prenatal to Five Relational Health Committee and Mercer, the Committee reported that the training is limited to small geographic areas only and an estimated 30%–40% of providers in King County have participated in the initial two-day training on DC:0–5. One reason contributing to the limited training among providers is that the training costs have needed to be financed outside of Medicaid.

Current Billing Patterns

To properly diagnose a young child, clinicians may conduct two to five intake and mental health assessment sessions. Washington Medicaid billing policy limitations limit assessments to billing a single unit. Providers report that they must instead bill subsequent sessions for assessment using individual or family therapy codes. According to the Policy Brief from the Washington State Prenatal to Five Relational Health Committee, the difference between billing an assessment using evaluation codes versus an individual or family therapy code can be up to $50.00 per session, depending on the billing codes and negotiated fees.[6]

Mercer examined the fees outlined for mental health and psychology services fee schedules and specialized mental health services for July 1, 2020 (updated October 20, 2020). Because the provider fees negotiated between the MCOs and providers are not known, Mercer assumes that some combination of the fees/unit costs shown below approximate the actual fees received by providers. Appendix A includes further information on interactive complexity add-on codes.

Table 2: Washington Medicaid Billing Comparison Allowed Fees/Unit Costs if Practitioner Bills Evaluation Codes versus Therapy Codes[7]

Service code	Fee-for-service (FFS) Base Fees (Maximum Allowable)[8]	FFS Specialized Fees (Maximum Allowable)[9]
Allowed fees/unit costs if provider bills Evaluation Codes (3 combinations)		
Evaluation Code Combination #1:		
Evaluation (90791)	$71.40 per session (Facility) $81.80 per session (non-Facility)	$106.58 per session
Interactive Complexity Add-on (90785)	$7.80 per session (Facility) $8.80 (non-Facility)	Not priced on FFS fee schedule
Total Fee Allowed if billing 90791	$79.20 per session (Facility) $90.60 per session (non-Facility)	$106.58 per session
Evaluation Code Combination #2:		

[6] Policy Brief: Provide Developmentally Appropriate Mental Health Services for Children 0-5. Proposal from the Prenatal to Five Relational Health Committee.

[7] Source: https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules

[8] HCA Mental Health and Psychology Services Fee Services, Effective July 1, 2020, updated October 20, 2020.

[9] HCA Specialized Mental Health Fee Schedule, Effective July 1, 2020.

Service code	Fee-for-service (FFS) Base Fees (Maximum Allowable)[8]	FFS Specialized Fees (Maximum Allowable)[9]
Evaluation (90792)	$80.20 (Facility) $90.60 (non-Facility)	$149.52 per session
Interactive Complexity Add-on (90785)	$7.80 per session (Facility) $8.80 (non-Facility)	Not priced on FFS fee schedule
Total Fee Allowed if billing 90792	$88.00 (Facility) $99.40 (non-Facility)	$149.52 per session
Evaluation Code Combination #3:		
Mental Health Assessment by non-Physician (H0031)	Not priced on FFS schedule	$156.65 per session
Total Fee Allowed if billing H0031	Not priced on FFS schedule	$156.65 per session
Allowed fees/unit costs if provider bills Therapy codes		
Therapy Code Combination #1:		
Psychotherapy (90837)	$71.20 per session (Facility) $79.60 (non-Facility)	$105.33 per session for 60 minutes
Interactive Complexity Add-on (90785)	$7.80 per session (Facility) $8.80 per session (non-Facility)	Not priced on FFS fee schedule
Prolonged session Add-on (99354)	Not priced on FFS schedule	$106.53 first hour $105.40 each additional 30 minutes (99355)
Total Fee Allowed	$79.00 per session (Facility) $88.40 per session (non-Facility)	$211.86 for 91 minutes
Total Difference between Evaluation and Therapy codes	Evaluation 90791 is $0.20 greater than therapy (Facility) Evaluation 90791 is $2.20 greater than therapy (Non-Facility) Evaluation 90792 is $9.00 greater than therapy (Facility) Evaluation 90792 is $11.00 greater than therapy (Non-Facility)	Therapy is $105.28 greater than 90791 Therapy $62.34 greater than 90792 Therapy $55.21 greater than H0031
Therapy Code Combination #2:		
Family Treatment (90846)	$57.60 (Facility) $58.00 (non-Facility)	$88.66 per session
Total Fee Allowed	$57.60 (Facility) $58.00 (non-Facility)	$88.66 per session

Service code	Fee-for-service (FFS) Base Fees (Maximum Allowable)[8]	FFS Specialized Fees (Maximum Allowable)[9]
Total Difference between Evaluation and Family Treatment codes	Evaluation 90791 is $13.80 greater than treatment (Facility) Evaluation 90791 is $23.80 greater than treatment (Non-Facility) Evaluation 90792 is $22.60 greater than treatment (Facility) Evaluation 90792 is $32.60 greater than treatment (Non-Facility)	Evaluation 90791 is $17.92 greater than treatment Evaluation 90792 is $60.86 greater than treatment Evaluation H0031 is $67.99 greater than treatment
Therapy Code Combination #3:		
Family Treatment (90847)	$59.80 (Facility) $60.00 (non-Facility)	$100.00 per session
Total Fee Allowed	$59.80 (Facility) $60.00 (non-Facility)	$100.00 per session
Total Difference between Evaluation and Therapy codes	Evaluation 90791 is $11.60 greater than treatment (Facility) Evaluation 90791 is $21.80 greater than treatment (Non-Facility) Evaluation 90792 is $20.40 greater than treatment (Facility) Evaluation 90792 is $30.60 greater than treatment (Non-Facility)	Evaluation 90791 is $6.58 greater than treatment Evaluation 90792 is $49.52 greater than treatment Evaluation H0031 is $56.65 greater than treatment

In summary, Mercer observed that providers can receive between $0.20 and $30.60 more per session if they bill evaluation codes instead of therapy and treatment codes under the base fee schedule. However, under the specialized fee schedule, a provider could bill $55.21 to $105.28 more for a 91-minute therapy session compared to an evaluation session. The fiscal impact of allowing providers to bill evaluation codes instead of Individual Treatment Services therapy codes then could range from a cost of $0.20 per session to a savings of up to $105.28 per session. Below, Mercer utilized the relative cost difference in the FFS Base Fee Schedule between the 90791 Non-Facility rate ($81.80), 90837 Non-Facility rate ($79.60) for Individual Treatment Services, and 90846 Non-Facility rate ($58.00) for Family Treatment services. For the fiscal impact, we assumed that providers were not using the interactive complexity codes for therapy visits (even though a second visit for a complex assessment may warrant that coding). The actual cost difference may vary.

Utilization of Intake and Assessments for Children from Birth through Five Years of Age

Mercer summarized managed care encounter data for months of service calendar year (CY) 2019 with paid runout through April 2020 to review existing utilization of Intake for children from birth through five years of age.

Stakeholders reported that providers would perform the activities needed to assess a very young child and either bill multiple assessment codes or bill subsequent visits for assessments using therapy coding. Based on this feedback, Mercer used all available procedure codes for the Intake modality in order to identify all possible intake and assessments. In order to identify potential intake and assessment evaluation claims billed as individual or family therapy, Mercer reviewed all Individual Treatment Services and Family Treatment modality claims within a 60-day period following an Intake modality claim. Table 3 illustrates the procedure codes identified in the managed care encounter data for each modality. Additional information can be found in the Mercer Data Book issued in July 2018.

Table 3: Procedure Codes for Intake, Individual Treatment Services, and Family Treatment

Modality	Procedure Codes
Intake	90791, H0031, 99205, 90792, 99203, 99204, 96130, 96131, 96136, 96137, 96110, 99202, 96101, 96132, 96133, 96102, 96138, 96118, 96139, 99201, 96116, 96121, 96103, 96119, 99356
Individual Treatment Services	90832, 90837, 90834, H0004, H0046, 99354, H2014, 90833, 99355, H2017, 90836
Family Treatment	90846, 90847

Table 4 below includes the count of members from birth through five years of age who received an Intake modality service in 2019 and the proportion of members who received an Individual Treatment Services modality claim within 60 days of an Intake service. There were 5,143 members with at least one Intake claim in 2019 with 830 of those members (16.1%) having more than one claim for the Intake modality. 2,752 members (53.5%) had an Individual Treatment Services or Family Treatment claim within 60 days of a claim for an Intake service. 1,308 members (25.4%) had five or more assessment and treatment service claims.

Table 4: Utilization of Intake Modality for Children from Birth through Five Years of Age

	Count	% of Member Count
Total Member Count	5,143	100.0%
Total Assessments (Intake modality claims)	6,812	N/A
Number of members with multiple assessments (Intake claims)	830	16.1%
Number of members with an Individual Treatment Services or Family Treatment claim within 60 days of an Intake claim	2,752	53.5%
Number of members with 5 or more Intake and treatment claims	1,308	25.4%

Within the procedure codes categorized as the Intake modality, Mercer focused on procedure codes 90791, 90792 and H0031, which are most highly associated with intake and assessment evaluations. Current billing practices limit intake and assessment services for these three codes. As noted above, clinicians may typically conduct multiple sessions of intake and assessment. Under the current Service Encounter Reporting Instructions (SERI), providers can utilize a '53' modifier to indicate evaluations requiring more than one session to complete by a single clinician.[10] Mercer expects that assessments provided by multiple clinicians would be reported separately, but may use the same procedure code.

Table 5 shows the distribution of Intake services reported by procedure code for the proportion of members who have multiple assessments. Note that the counts summarized in this table are not mutually exclusive. The final column shows that 90792, which is a medical/psychiatric evaluation, is typically performed in conjunction with other intake procedure codes. State FFS billing policy does not allow 90792 to be billed for members who also received an Intake service with a 90791 procedure code. However, the data demonstrates that 90792 is often performed in conjunction with 90791. Such a case may occur any time a developmental pediatrician or other physician performs an evaluation on a child at the same time as a psychologist, which is common in the diagnosis of autism for children around the age of three.

Table 5: Utilization of Multiple Evaluation Units for Children from Birth through Five Years of Age

Procedure Code	Total Member Count	Total Assessments (Intake Modality Claims)	% of members with the code including a '53' modifier	% of members utilizing multiple units of the procedure code (with and without '53' modifier)	% of members utilizing other Intake procedure codes in addition to the procedure code
90791	2,646	2,784	1.06%	3.51%	14.29%
H0031	881	922	2.16%	3.41%	10.56%
90792	198	198	0.00%	0.00%	61.11%
All Other Intake Procedure Codes	1,861	2,908	0.00%	15.05%	14.94%

[10] Washington State HCA *IMC Service Encounter Reporting Instructions (SERI),* Effective July 1, 2019 (page 40). https://www.hca.wa.gov/assets/billers-and-providers/SERI_v2019-1EffectiveJuly1_2019.pdf

3
Fiscal Impact

Reimbursement for Three to Five Sessions

Table 6 summarizes the utilization impact of including reimbursement for three to five sessions of intake and assessment. Based on stakeholder and provider feedback, Mercer assumes that the observed encounter data reflects the necessary amount of sessions, or claims, needed to complete an assessment for a young child and not every child may require five sessions. As a result, no additional utilization is considered if existing utilization of the Intake modality in combination with treatment modalities is below five claims. If existing utilization of the Intake modality in combination with treatment modalities exceeds five claims, then only the treatment claims up to five claims are priced as an intake and assessment evaluation service in the fiscal impact.

Table 6: Allowing up to Five Sessions of Intake and Assessments

(A)	(B)	(C) = (D) + (G)	(D)	(E)	(F)	(G) = (E) + (F)	(H) = Minimum [5*(B) – (D), (G)]
Number of claims in CY2019	Number of children	Total Claims	Number of claims priced as evaluations (Intake claims)	Number of claims priced as treatment (Individual Treatment Services claims)	Number of claims priced as treatment (Family Treatment claims)	Total Claims Priced as Treatment Services (Individual or Family)	Number of claims that could have been priced as Intake but were priced as Treatment Services (up to 5)
1	2,094	2,094	2,020	43	31	74	74
2	820	1,640	922	490	228	718	718
3	585	1,755	710	653	392	1,045	1,045
4	526	2,104	815	818	471	1,289	1,289
5	366	1,830	643	703	484	1,187	1,187
6	323	1,938	646	817	475	1,292	969
7+	619	5,475	1,056	2,924	1,495	4,419	2,039

In order to model the fiscal impact of allowing reimbursement for three to five sessions, Mercer utilized the relative cost difference in the FFS Base Fee Schedule between the 90791 Non-Facility rate ($81.80), 90837 Non-Facility rate ($79.60) and 90846 Non-Facility rate ($58.00). The rate for 90791 reflects the assumed rate for a session priced as an intake and assessment evaluation service; the rate for 90837 reflects the session priced as an individual therapy claim; the rate for 90846 reflects the

session priced as a family therapy claim. 90791 was selected as the Intake modality procedure code for the relative cost difference due to its significant utilization in the observed encounter data.

Mercer utilized the existing distribution of Individual Treatment Services and Family Treatment claims to determine the proportion of claims that could be priced as Intake once reimbursement is allowed for three to five sessions. Table 7 illustrates breakout by modality.

Table 7: Additional Intake and Assessment Visits by Modality

(A)	(I)	(J)	(H) = (I) + (J)
Number of claims in CY2019	**Expected Individual Treatment Services Claims that can now be priced as evaluations**	**Expected Family Treatment Claims that can now be priced as evaluations**	**Number of claims that could have been priced as Intake but were priced as Treatment Services (up to 5)**
1	43	31	74
2	490	228	718
3	653	392	1,045
4	818	471	1,289
5	703	484	1,187
6	613	356	969
7+	1,349	690	2,039
Total	**4,669**	**2,652**	**7,321**

Using the cost differential and the observed utilization of Intake, Individual Treatment Services and Family Treatment modality claims for Medicaid members from birth through five years of age, Mercer calculated the expected fiscal impact of allowing reimbursement for up to five visits as intake and assessment evaluation visits. Because the providers have been utilizing therapy codes as a substitute for intake and assessment sessions and some providers have been utilizing multiple assessment codes under SERI instructions, the fiscal impact does not include any additional utilization and instead converts some of the observed utilization from treatment services (Individual Treatment Services and Family Treatment modalities) to intake and assessments.

Table 8 summarizes the cost differential and fiscal impact by modality of including reimbursement for three to five sessions of intake and assessment. Based on the selected inputs, the cost associated with allowing reimbursement for three to five sessions of intake and assessment is approximately $73,000.

Table 8: Fiscal Impact for Allowing up to 5 sessions of Intake and Assessments

Modality	Price of evaluations (based on 90791 Non-Facility)	Price of treatment modality	Differential cost of evaluations compared to treatment	Expected Treatment Claims that can now be priced as evaluations	Total additional cost of pricing up to five visits as evaluations
Individual Treatment Services	$81.80	$79.60 (based on 90837)	$2.20	4,669	$10,272
Family Treatment	$81.80	$58.00 (based on 90846)	$23.80	2,652	$63,118
			Total:	**7,321**	**$73,389**

Reimbursement for Travel

In order to allow for reimbursement for assessments in home or community settings, including reimbursement for clinician travel, Mercer evaluated the impact of lost billable productivity and the direct costs for transportation. Mercer estimates the additional cost associated with travel to reflect 20% of the provider rate. Table 9 illustrates the impact of increased travel cost for the existing assessments.

Table 9: Travel Costs for Existing Utilization

Increased cost of travel and productivity decreases	Number of claims priced as evaluations (Intake claims)	Additional cost due to travel for existing evaluation visits
$16.36	6,812	$111,444

Table 10 illustrates the impact of increase travel cost for allowing reimbursement for the additional three to five intake and assessment sessions from the calculations above.

Table 10: Travel Costs for Additional Intake and Assessment Sessions, Up to Five

Increased cost of travel and productivity decreases	Number of claims that could have been priced as Intake but were priced as Treatment Services (up to 5)	Additional cost due to travel for allowing up to five intake and assessments
$16.36	7,321	$119,772

Costs for Unifying Diagnosis Classification Criteria

National Training costs

The official DC:0–5 training costs $549.00 per person plus the $80.00 manual fee. Discounts are available with a ZERO TO THREE membership, which ranges from $100 for a one-year digital membership to $306 for a three-year print and digital membership. The training requires 10.50 hours for individual practitioners to complete. Persons who have completed the training are able to apply for consideration to become a trainer. Training to become a trainer requires an additional 12 hours of coursework. ZERO TO THREE also offers seminars and overview trainings though less intense of one to two hour workshops or webinars, half-day trainings or full day overview that can be tailored to specific audiences or topic concentrations.[11]

Washington State Training Costs

Stakeholders with the Washington State Prenatal to Five Relational Health Committee reported there are trainers within the State that offer the DC:0–5 training for a fee of approximately $500.

A cross-agency team from the State that represented public and non-profit sectors participated in a project focused on Medicaid financing policy for Infant-Early Childhood Mental Health (IECMH) assessment. Referenced in the findings from the IECMH Professional Development Survey (2019), there is an estimated 650 practitioners who could benefit from a full or refresher DC:0-5 training and up to an additional estimated 500 practitioners who could benefit from an overview training or subset of the training to expand their skillset and provide services to young children.[12]

Table 11 illustrates the total expected costs for training practitioners for DC:0–5, with a per-practitioner cost of:

- $1,400 based on the costs above, including an expected lost productivity assumption of $900 for full or refresher training.
- $700 based on a mix of expected lost productivity and direct training costs for an overview training or subset of training.

Table 11: Expected Costs for Training Practitioners for DC:0–5

Practitioners	Estimated Training Costs	Total Estimated Fiscal Impact
650 practitioners who could benefit from a full or refresher training	$1,400	$910,000
500 practitioners who could benefit from an overview or subset of the training	$700	$350,000
	Total:	**$1,260,000**

[11] ZERO TO THREE. *DC:0–5 Training Offerings*. https://www.zerotothree.org/resources/2218-dc-0-5-training-offerings

[12] Summary of draft survey results and estimated providers who could benefit from DC:0-5 training shared during a HCA workgroup meeting with Mercer on November 19, 2020.

4
Disclosures and Limitations

This report is intended to support HCA efforts to respond to Proviso 62 developed by Washington State Legislature as part of ongoing budget planning. This report is intended to be relied upon solely by HCA and other State stakeholders and is not intended to be distributed broadly. Mercer disclaims any use beyond the intended purpose. The analyses presented in this report are based on readily available managed care data, publicly available information and Mercer's experience in other state programs.

This report relies on data provided by the HCA as part of separate engagements. Mercer acknowledges that the suppliers of data are solely responsible for its validity and completeness. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit it.

All estimates are based upon the information and data available as of the date of this report and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely and potentially wide range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use. To the extent additional information becomes available that may impact the anticipated structure of the programs, the recommendations and accompanying fiscal analyses may need to be revised accordingly.

The State understands that Mercer is not engaged in the practice of law or in providing advice on taxation matters. This report, which may include commenting on legal or taxation issues or regulations, does not constitute and is not a substitute for legal or taxation advice. Accordingly, Mercer recommends that the State secure the advice of competent legal and taxation counsel with respect to any legal or taxation matters related to this report or otherwise.

To the best of Mercer's knowledge, there are no conflicts of interest in performing this work. Mercer expressly disclaims responsibility, liability or both for any reliance on this communication by third parties or the consequences of any unauthorized use.

Appendix A
Interactive Complexity

Source:
https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/business_of_practice/cpt/Interactive_Complexity_Guide_2012.pdf

www.psychiatry.org

Interactive Complexity

Revised 11/3/12

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY
WWW.AACAP.ORG

Definition

A new concept in 2013, interactive complexity refers to 4 specific communication factors *during* a visit that complicate delivery of the primary psychiatric procedure. Report with CPT add-on code **90785**.

Code Type

Add-on codes may be reported in conjunction with specified "primary procedure" codes. Add-on codes may never be reported alone.

Replaces

Codes for interactive diagnostic interview examination, interactive individual psychotherapy, and interactive group psychotherapy are deleted.

Use in Conjunction With

The following psychiatric "primary procedures":

- Psychiatric diagnostic evaluation, 90791, 90792
- Psychotherapy, 90832, 90834, 90837
- Psychotherapy add-on codes, 90833, 90836, 90838, when reported with E/M
- Group psychotherapy, 90853

When performed with psychotherapy, the interactive complexity component (90785) relates only to the increased work *intensity* of the psychotherapy service, and does not change the *time* for the psychotherapy service.

May Not Report With

- Psychotherapy for crisis (90839, 90840)
- E/M *alone*, i.e., E/M service *not* reported in conjunction with a psychotherapy add-on service
- Family psychotherapy (90846, 990847, 90849)

Typical Patients

Interactive complexity is often present with patients who:

- Have other individuals legally responsible for their care, such as minors or adults with guardians, or
- Request others to be involved in their care during the visit, such as adults accompanied by one or more participating family members or interpreter or language translator, or
- Require the involvement of other third parties, such as child welfare agencies, parole or probation officers, or schools.

Interactive complexity is commonly present during visits by children and adolescents, but may apply to visits by adults, as well.

Report 90785

When at least one of the following communication factors is present during the visit:

1. The need to manage maladaptive communication (related to, e.g., high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicates delivery of care.
2. Caregiver emotions or behaviors that interfere with implementation of the treatment plan.
3. Evidence or disclosure of a sentinel event and mandated report to a third party (e.g., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.
4. Use of play equipment, physical devices, interpreter or translator to overcome barriers to diagnostic or therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language.

Per the Center for Medicare and Medicaid Services (CMS), "90785 generally should not be billed solely for the purpose of translation or interpretation services" as that may be a violation of federal statute.

Complicating Communication Factor Must Be Present *During* the Visit

The following examples are ***NOT*** interactive complexity:

- Multiple participants in the visit with straightforward communication
- Patient attends visit individually with no sentinel event or language barriers
- Treatment plan explained during the visit and understood without significant interference by caretaker emotions or behaviors

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