

# PRACTITIONER *Update*

Dear MHN Practitioner,

There is a considerable amount of important information in this February 2021 MHN Practitioner Update. Thank you for taking the time to review it closely.

This issue includes results from both the annual Member and Provider Satisfaction Surveys as well as a reminder about the importance of documenting Informed Consent.

Please also familiarize yourself with our new Provider Directory Accuracy Tool along with updated information about telehealth billing codes and Mental Health Parity.

Regards,  
The MHN QI Department



Nearly every care provider, policy-based behavioral health advocacy group, and research organization has predicted significant increases in the need for mental health and substance use treatment as a result of the COVID-19 pandemic.

[To review Centene Advanced Behavioral Health's White Paper on \*\*The Mental Health and Substance Use Impact of COVID-19\*\*, please click here.](#)

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## MYSTRENGTH\*: A BEHAVIORAL HEALTH DIGITAL RESOURCE

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### **Remember to tell Health Net patients about myStrength\*!**

myStrength is an evidence-based, behavioral health self-help resource. It offers interactive, individually tailored applications that empower members to address depression, anxiety, stress, substance use, chronic pain, and sleep challenges, and has added a new nicotine recovery program and a new pregnancy and early parenting program.

### **Why myStrength?**

myStrength is a personal and dynamic website. Its clinically proven resources are secured via web and mobile technology. Resources include:

1. Techniques to improve mood.
2. Weekly action plans.
3. Step-by-step eLearning modules.
4. Self-help workbooks.
5. Interactive tools.
6. Daily inspirations.

[Health Net Members can access myStrength online by clicking here.](#)

*\*Available only to Health Net members*

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## PUBLIC HEALTH EMERGENCY RENEWAL

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### **Member Cost Share for Telehealth Services**

- For most members, if contracted and billed correctly, for dates of service 3/17/20 to 4/21/21, MHN will cover the member's cost share (co-pay, co-insurance, deductible).

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## 2020 MEMBER SATISFACTION SURVEY RESULTS

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Each year MHN surveys members who received behavioral health services during the previous year for the Commercial, Medicare, Medi-Cal, Cal Medi-Connect and some of MHN's stand-alone lines of business.

The annual member satisfaction survey began in July 2020 with a total survey response period of 13 weeks. The sample included Health Net and Arizona Complete Health members who used MHN services between April 1, 2019 and March 31, 2020. Response rates for all affiliated lines of business ranged from a low of 4.1% for the Health Net Life Commercial Non Marketplace EPO line of business up to a high of 30.6% for Health Net Oregon Medicare members.

Among the highest rated items for most lines of business were physical health after treatment, work situation after treatment, travel distance and rescheduling appointments.

Among the lowest rated items for most lines of business were care coordination; whether their behavioral health provider discussed the importance of coordinating care with the member’s primary care physicians and other behavioral health providers and the member’s ability to get a timely appointment in both urgent, non-urgent and routine situations.

**Please consider the following to help us improve our member satisfaction:**

- [Always keep in mind MHNs Timely Access to Care requirements for behavioral health appointments on pages 20-21 in our Practitioner Manual.](#)
- Make sure to discuss potential medication side effects and how best to address them during treatment

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## 2020 PRACTITIONER SATISFACTION SURVEY RESULTS

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Each year, the MHN Quality Improvement (QI) program administers a Practitioner Survey. In 2020, MHN sent an online survey to contracted practitioners that had claims for 2 or more unique members in the prior year. A total of 3,303 practitioner email addresses were included in the sample. There were 1,630 respondents, giving the survey a response rate of 49.3%, which is 2% lower than the 2019 response rate. The five highest rated items (Table 1) and the five lowest rated items (Table 2) are shown below.

**Table 1: Highest Rated Performance Indicators**

Performance Indicator	% Positive Response	
	2019	2020
Availability of interpreter services for patients during treatment/evaluation with you	97.2%	97.6%
Availability of interpreter services for members inquiring about services with you	97.0%	97.3%
Ease of access to MHNs 24-hour clinical call center to support your patients	93.7%	96.9% ▲
Availability of MHN case management services to assist your patients	91.4%	96.6% ▲
Distribution of clinical guidelines and/or protocols endorsed by MHN	95.4%	96.5%

**Table 2: Lowest Rated Performance Indicators**

Performance Indicator	% Positive Response	
	2019	2020
Usefulness of information received from PCPs about your patients	83.7%	82.1%
Care Coordination with PCPs on patient's behalf	80.6%	81.2%
Information provided to you on your patients leaving a hospital setting	83.4%	80.7%
Ease of resolution of claims problems	73.7%	80.6% ▲
Amount of time to resolve claims problems	71.1%	78.4% ▲

▲ indicates a statistically significant increase over prior year

The results from the practitioner survey are reviewed each year by the Quality Improvement Department and other appropriate MHN departments. When warranted, workgroups are formed and corrective action plans or quality improvement initiatives are implemented to improve practitioner satisfaction.

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***IN CASE YOU MISSED IT!***  
**REMINDER ABOUT TELEHEALTH BILLING CODES**

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There are three CPT codes available for individual psychotherapy—90832, 90834 and 90837. A review of MHN claims over the past year indicates that provider billing patterns have shifted toward an increase in the use of 90837 versus 90834 for a typical 50-minute session. We are also seeing more telehealth claims submitted under 90837 as a percentage of claims. As a reminder, these codes were developed to capture ranges of time spent in therapy as follows:

90832- 16-37 minutes

90834- 38-52 minutes

90837- at least 53 minutes

Billing under these codes should only be for the time spent face-to-face (either in-person or virtual) on clinical discussion and therapy, not administrative discussions such as collecting fees, scheduling, or documentation. Time spent retrieving clients from the waiting room or setting up video connections are also not billable under these codes. **The typical 50-minute therapy session should be billed as a 90834, because less than 53 minutes are spent on clinical discussion and therapy.** If you do conduct a 53 minute or longer psychotherapy session with an MHN member and choose to bill 90837 for that service, be sure that your documentation reflects sufficient content for an encounter of that length.

As a reminder, MHN reserves the right to conduct record audits to ensure that providers comply with these guidelines. If you have further questions, [please email a Provider Relations Representative here](#) or call Toll Free at (844) 966-0298.

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# DOCUMENTATION OF INFORMED CONSENT

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## **INFORMED CONSENT: Why it's important for the patient and provider alike**

The main purpose of the informed consent process is to protect the member receiving service. A consent form is a legal document that ensures an ongoing communication process between you and your client.

If adult patients are mentally able to make their own decisions, care cannot begin unless they give informed consent. The informed consent process makes sure that you, the health care provider, have given the patient information about his/her condition along with alternative treatment options so that they can make an informed decision as to whether or not to begin treatment with you. The informed consent process also fosters a collaborative relationship between provider and patient from the outset, indicating to the client that decision-making in the therapeutic relationship will be shared.

## **4 Principles of Informed Consent** *(Source: eMedicineHealth.com)*

There are 4 principles of informed consent:

1. The patient must have the capacity (or ability) to make the decision.
2. The provider must disclose information on the treatment, test, or procedure in question, including the expected benefits and risks, and the likelihood (or probability) that the benefits and risks will occur. Alternative treatment options when applicable must also be provided.
3. The patient must comprehend the relevant information.
4. The patient must voluntarily grant consent, without coercion or duress.

In emergencies, when a decision must be made urgently, the patient is not able to participate in decision making, and the patient's surrogate is not available, providers may initiate treatment without prior informed consent. In such situations, the provider should inform the patient/surrogate at the earliest opportunity and obtain consent for ongoing treatment in keeping with these guidelines.

**All MHN providers are expected to obtain informed consent from our members, (or their permitted surrogate) for all treatment, following the 4 principles outlined above. The signed and dated consent forms must be included in each member/patient's record and available for review should MHN require to do so, along with any other patient records (most often done in the case of retro-reviews and treatment audits).**

MHN believes that our [Clinical Record Form](#) can help practitioners meet [MHN's Treatment Record Documentation Standards](#) and possibly improve outpatient documentation and clinical quality. We encourage practitioners to consider using it and other forms available at [www.mhn.com](http://www.mhn.com) under "Working with MHN - Clinical Operations Practices".

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## NEW MHN PROVIDER DIRECTORY ACCURACY TOOL

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The MHN Provider Relations Department is proud to introduce our contracted clinicians to VerifyHCP®, a quick and easy clinician directory verification portal developed by LexisNexis® Risk Solutions. **To make attestation more efficient for you and your staff, VerifyHCP enables practices to validate or update pre-populated directory information in one place across all participating health plans.**

Updated practice information allows us to provide patients with current directory information so they can select in-network providers, choose health plans, and ultimately access care. Our goal is to make this process as easy as possible for clinicians and their practices and to receive 100% response to outreach requests. Clinicians who do not respond to verification requests may face delayed claim reimbursements and removal from directories.

### Clinician and practice outreach

Outreach to confirm and update directory information began in early January. Several outreach methods are being used including email, fax, and phone, with email being the primary method. Clinicians and practices will be directed to register and log in to the Verify Health Care Portal to confirm their directory information on file is accurate. The Portal is a secure, free website for clinicians and their staff to use to confirm directory information, as required by CMS and various state laws. Contact [LexisNexis Risk Solutions Tech Support here](#) or the VerifyHCP Portal Help Desk phone number, 1-888-245-461, if you have questions about their portal.

### Additional information

Providers are encouraged to access the [MHN Provider Portal](#) for real-time information, including eligibility verification, claims status and more. If you have further questions, please [email a Provider Relations Representative](#) or call us Toll Free at (844) 966-0298.

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## MENTAL HEALTH PARITY IN CALIFORNIA: SB855

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On September 25, 2020, California Governor Gavin Newsom signed into law, SB855. The reform strengthens mental health parity statutes by expanding the California Mental Health Parity Act of 1999. The Act of 1999 required coverage of medically necessary treatment for nine listed severe mental illnesses (SMI), as well as serious emotional disturbances (SED) of a child. SB855 repeals and replaces this section of the Health and Safety Code (Section 1374.72), as well as the California Insurance Code (Section 10144.5), with a new requirement to cover medically necessary treatment of all mental health and substance use disorders listed in the mental and behavioral disorders chapter

of the most recent edition of the international Classification of Diseases or Diagnostic and Statistical Manual of Mental Disorders.

The revised statute (Health and Safety Code Sections 1374.72 and 1374.721; CIC Sections 10144.5 and 10144.52) provides a standard definition for “medically necessary” and “generally accepted standards of mental health and substance use disorder care” for purposes of medical necessity and conducting utilization review.

Effective 1/1/2021, California health plans and insurers are required to base medical necessity determinations or utilization review criteria on current generally accepted standards of mental health and substance use disorder care as defined in the statute. Health plans and insurers must apply the most recent criteria and guidelines developed by the nonprofit professional association for the relevant clinical specialty when conducting utilization review of treatment of mental health and substance use disorders including service intensity, level of care placement, continued stay and transfer or discharge decisions. MHN has selected Level of Care Utilization System (LOCUS) and Child and Adolescent Level of Care Utilization System (CALOCUS) criteria for mental health care. By 3/1/2021, utilization review of requests for children 0-5 years of age will be conducted with the Early Childhood Service Intensity Instrument (ECSII). Also by 3/1/2021, Substance use disorders for any age will utilize the criteria and guidelines provided by the American Society of Addiction Medicine (ASAM).

When utilization review criteria for a specific specialty is not available through a nonprofit professional association, MHN will utilize criteria that are developed in accordance with “generally accepted standards of mental health and substance use disorder care” as defined by the statute. These may be internally developed by our board certified medical directors or purchased through an outside vendor such as InterQual (pursuant to Section 1374.721(d)) upon verification of compliance with the statute.

The revised statute does not apply to policies or plans outside of California, any Administrative Services Only (“ASO”) plans, or California’s Medi-Cal, Medicare and CalMediConnect plans.

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## **2019 CA DMHC TIMELY ACCESS REPORT IS NOW ONLINE!**

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[The California Department of Managed Health Care \(DMHC\) Timely Access Report for Measurement Year 2019 can be viewed now by clicking here.](#) This report summarizes and compares provider appointment availability data submitted to the DMHC by full service and behavioral health plans in California. Please review the Behavioral Health Plan data starting on page 24 of the report to see how MHN performed compared to other behavioral health plans.

**The next Practitioner Update is scheduled for May 2021**