

## SUMMARY

### Providers' Behaviors and Beliefs on Prescribing Antipsychotic Medication to Children A Qualitative Study

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#### **Funding Support:**

Passport Health Plans  
Improved Health Outcomes Program

#### **Abbreviations and Acronyms:**

TPB – theory of Planned Behavior

APM – antipsychotic medication(s)

PM – Psychotropic medication(s)

## I. Background

### A. History

- About 20% of U.S. children experience a mental disorder in a given year.
- Functional impairments and developmental delays in academic, emotional, social, or behavioral skills are common.
- Use of psychotropic medications (PM) is increasing.
- Use of antipsychotic medications (APM) in youth has grown more rapidly than any other PM, with a **tripling** of prescriptions for APM over the last 10 to 15 years.
- This growth has disproportionately affected low-income families, minority children, and children with externalizing behavior disorders.
- Concerns arise over quality of care and safety given the lack of evidence for their effectiveness.
- Youth in **foster care** have been shown to receive **three times the rate of PM** than children on Medicaid living with their families.
- Children in foster care typically remain on PM medications for an extended period of time.
- Polypharmacy is also common for children in foster care. One state reported 41% of their children in foster care received 3 or more different classes of medications.
- Preschool-aged children are also vulnerable to the inappropriate use of APM, which is rising rapidly.
- Increasing rates of APM use in children is particularly concerning given their significant side effects. Children and adolescents on atypical antipsychotics are at an increased risk for developing obesity and movement disorders, and experience a three-fold increase in their risk for developing type 2 diabetes mellitus. Polypharmacy involving APM seems to increase this risk. Given these adverse effects, children on APM require close clinical monitoring and appropriate laboratory screening.
- Due to these concerning trends, a number of professional guidelines have been developed and some state Medicaid leaders have developed plans to encourage adherence with these guidelines. These approaches include prior authorizations, formulary restrictions, and improved access to consultative services with child psychiatrists, including through telemedicine. Some these efforts appear to be effective while others have shown mixed results.

### B. Provider prescribing behavior

- Providers' prescription behavior is a critical piece of understanding the use of APM
- little research exists
- Providers face barriers to access mental health services and external pressures may influence their decision to use APM.
- Shortages of mental health professionals have been shown in 77% of U.S. counties and 96% have an unmet need for mental health prescribers. Rural counties and those with low per capita income had higher levels of unmet need.
- Despite professional guidelines, PM, including APM is on the rise, psychosocial therapy is underutilized, and children are not receiving appropriate lab monitoring
- So, understanding provider prescribing behavior is a crucial piece in safeguarding the appropriate use of APM in youth.
- The information gained from our study can inform the development of appropriate interventions.

## II. Approach

- The *Theory of Planned Behavior* (TPB) guided the study
- This theory posits that human behavior is guided by three kinds of consideration:
  - behavioral beliefs - attitudes about a behavior (medication prescribing), which includes a value judgment about that behavior (eg. good or bad; beneficial or detrimental).

- Normative beliefs - individual's perception of social pressures, such as the opinion of an influential peer as to whether one should or should not perform such behavior and whether others like them would perform such a behavior.
- Control beliefs - an individual's views about the presence of factors, (access to care, insurance formularies), that may facilitate or impede performance of the behavior.
- As a general rule, the more favorable the attitude toward behavior and subjective norm, and the greater the perceived behavioral control, the stronger the person's intention to perform the behavior (not prescribing). Finally, given a sufficient degree of actual control over the behavior, people are expected to carry out their intentions when the opportunity arises.
- Provider interviews were conducted using structured and semi-structured interview questions.

### **III. Methods**

#### **A. Procedures**

- The interview study reported here was a part of a larger mixed methods study undertaken to improve the quality and safety of antipsychotic use among at-risk children in Kentucky by collecting data to inform the development of educational and policy interventions for pediatric healthcare providers.
- We conducted interviews with clinicians identified as “high prescribers” of antipsychotic medications in children to elicit beliefs, attitudes, and norms that contribute to the prescribing behaviors of these providers.

#### **B. Sample**

- Using 2013 claims data from Kentucky Medicaid, we classified prescribers as “high prescriber” if they prescribed these medications to children at a rate higher than the median among Kentucky prescribers.
- This sample of 240 “high prescribers” was stratified by eight Kentucky Medicaid regions.
- A random sample was selected from each region.
- Enrollment was monitored throughout to ensure representation by field of practice (primary care providers (PCPs) vs. mental health specialists) and location of practice (urban vs. suburban vs. rural).
- On average, participants ( $n=31$ ) were 51.5 ( $SD = 9.4$ ) years of age, in practice for 18.2 ( $SD = 9.4$ ) years, saw 71.0 ( $SD = 54.2$ ) children per week with 17.7 ( $SD = 19.6$ ) being  $< 5$  years of age. Additional participant and practice characteristics are summarized in Table 1.

#### *Data Collection*

- Interviews consisted of both structured and semi-structured portions, and were designed to elicit beliefs, attitudes, and norms contributing to prescribing behaviors as well as perspectives on possible educational and policy interventions.
- Participants were not informed that they were being invited to participate based on their prescribing record.
- A single investigator (WDL) conducted all 31 interviews. Each interview followed the discussion guide, and the interviewer facilitated discussion using standard interview techniques, such as by asking clarifying questions.

#### *Data Analysis*

- Each interview was transcribed and analyzed using standard qualitative analysis methods.
- Descriptive statistics are presented for structured question responses.

Table 1. Frequencies

	Frequency N = 31	Percent
<b>Type of Practitioner</b>		
M.D./D.O.	24	77.4
Nurse practitioner	7	22.6
<b>Specialty</b>		
Pediatric Primary Care	7	22.6
Family Practice/General Practitioner	2	6.5
General Psychiatry	5	16.1
Child Psychiatry	16	51.6
Child Neurology	1	3.2
<b>Practice Location</b>		
Urban	16	51.6
Rural	14	45.2
Suburban	1	3.2
<b>Type of Practice</b>		
Hospital-based office practice	8	25.8
University-affiliated practice	3	9.7
Independent practitioner	10	32.3
Behavioral/mental health community center	5	16.1
Multiple	5	16.1
<b>Distance to nearest child psychiatrist</b>		
≤ 25 miles	19	61.3
26 - 50 miles	4	12.9
51 - 75 miles	4	12.9
> 75 miles	4	12.9
<b>Distance to nearest provider for child or family psychotherapy</b>		
≤ 25 miles	27	87.1
25 - 50 miles	3	9.7
51 - 75 miles	0	0.0
> 75 miles	1	3.2
<b>Estimate of payer mix</b>		
Predominately Medicaid	23	74.2
Predominately private insurance	1	3.2
Evenly mixed	7	22.6

**Results**

*Structured Interview Questions*

Table 2. Providers' attitudes

<b>Medications and other therapies</b>	Frequency N = 31	Percent
<b>How comfortable are you in prescribing antipsychotic medications to children?</b>		
Not comfortable	2	6.5
Comfortable	29	93.5
<b>How accessible are psychosocial therapy services to your patients who are insured by Medicaid?</b>		
Not accessible	15	48.4
Accessible	16	51.6
<b>How accessible are child psychiatrists to your patients who are insured by Medicaid?</b>		
Not accessible	21	67.7
Accessible	10	32.3
<b>Please rate your level of satisfaction with psychosocial therapy services to your patients who are insured by Medicaid?</b>		
Not satisfied	17	54.8
Satisfied	14	45.2
<b>Please rate your level of satisfaction with child psychiatry services for your patients who are insured by Medicaid.</b>		
Not satisfied	13	41.9
Satisfied	18	58.1
<b>Potential Interventions</b>		
<b>Ability to informally and immediately consult a child psychiatrist</b>		
Helpful	30	96.8
Unhelpful	1	3.2
<b>Case management</b>		
Helpful	29	93.5
Unhelpful	2	6.5
<b>Focused CME on antipsychotic medications for pediatric patients</b>		
Helpful	29	93.5
Unhelpful	2	6.5
<b>Standardized formulary across all Medicaid managed care organizations</b>		
Helpful	24	77.4
Unhelpful	7	22.6
<b>Peer-review</b>		
Helpful	21	67.7
Unhelpful	10	32.3
<b>More strict prior authorization</b>		
Helpful	7	22.6
Unhelpful	24	77.4

### *Prescribing Behaviors*

- Table 3 shows a wide array of diagnoses/symptoms for which APM are prescribed to children. A number of terms were used interchangeably as diagnoses and symptoms, indicating in some cases that these terms were being used imprecisely.
- The most frequently cited diagnosis among both PCPs and mental health specialists was autism (or autism spectrum disorders)
- The most frequently cited symptom among both groups was anger/aggressive behavior.
- When asked to name diagnoses or symptoms for which they prescribed APM to children under the age of 6 years
  - Half of mental health providers mentioned autism spectrum disorders and aggression.
  - PCPs most commonly stated aggression, autism spectrum disorders, bipolar disorder, harm to self or others, and mood disorders.
  - Two PCPs and two psychiatrists responded explicitly they would not prescribe APM to children younger than 6 years of age.
- Regarding circumstances under which they have prescribed two or more APM simultaneously:
  - Five PCPs (71%) and eight specialists (33%) stated that they do not prescribe APM in this way.
  - One PCP and eleven specialists stated that they try not to prescribe multiple APM, but gave reasons this sometimes happens.
  - Five specialists reported they do this when cross-titrating from one APM to another; four reported they sometimes do this when a patient is transferred into their care on multiple APM.
  - Only one PCP and specialist each reported the intentional use of a second APM when one APM does not succeed in controlling symptoms.

### *Monitoring Behaviors*

- Providers were also asked to identify concerning adverse effects of APMs
    - Most commonly reported adverse effects by PCPs: gynecomastia (57%) & weight gain (43%).
    - Most common concerns of specialist regarding medication side effects: weight gain (88%), diabetes and/or pre-diabetes (54%), & other metabolic effects including hyperlipidemia (50%).
    - In general, specialists listed a larger number of adverse effects than PCP.
- When asked to describe the clinical monitoring they perform on pediatric patients taking APM:
- The majority of both PCPs and specialists reported that they follow-up with patients at least every 3 months with a number of them citing an even more frequent follow-ups.
  - Providers indicated that the frequency of follow-up varies with the severity of symptoms.
  - Phone follow-up is used by some specialists to supplement in-person monitoring.
- Reported laboratory monitoring of children taking APM varied by provider type.
    - The baseline lab test cited most frequently by PCPs was a complete blood count (CBC).
    - For specialists, the most frequent baseline and follow-up lab mentioned was serum lipids.
    - Two PCPs stated that they do not perform baseline laboratory testing, but both explained that this was primarily because these medications were generally started by psychiatrists who would perform these tests.
    - On the other hand, a few specialists admitted to inconsistent use of laboratory tests.
    - Evaluations/laboratory tests cited by at least two providers included the following: blood sugar (or HgbA1C), CBC, CMP, EKG, growth charts (or calculated BMI), lipids, prolactin level, and thyroid panel.

### *Normative Beliefs about APM Use*

- In order to minimize social desirability bias, we asked participants to speculate about why APMs are used so frequently, in general. We did not directly ask participants to explain why they, personally, prescribed APMs.

- The most frequent explanation provided by both PCPs (43%) and specialists (38%) was the perceived efficacy of these medications, especially given the perception that APMs help control symptoms quickly.
- The perceived medical benefit of controlling symptoms rapidly was almost always couched in terms of social or systems constraints.
- In addition to efficacy, a few providers also mentioned a favorable side effect profile.
- Two child psychiatrists, on the other hand, compared APM with mood stabilizers, observing that APM require less laboratory monitoring compared to alternatives.
- Two child psychiatrists suggested that pharmaceutical companies had driven the use of APM by primary care providers through their on-site marketing/education programs.

#### *Perceived Barriers – Evidence-Based Psychosocial Treatment*

- In order to inform the development of strategies to increase the use of psychosocial treatments and minimize APM, we focused on two factors:
  - (1) Current barriers to referral for mental health services
  - (2) External factors that create pressure to utilize pharmacological treatments exclusively.
    - By far the most common barrier identified by both PCPs and specialists that prevents use of psychosocial assessment was limited availability of these services.
    - There are just not consistently good therapists available for the number of kids that are severely impaired.
    - Access challenges seemed to reach far beyond simply having enough providers. Participants frequently reported that even when mental health providers are available, their patients cannot access them.
    - Poor access to psychosocial therapy is frequently described as a reason for using APM. One pediatrician in a rural area reported that she sometimes prescribes APM while patients are on the waiting list to see a mental health provider: “Because access to pediatric psychiatrist is not easy here so I sometimes have to wait 2-3 months.”
    - Providers cite a number of other reasons that they end up using APM rather than psychosocial therapies. The “quick fix” provided APM can be desirable to families and schools; numerous providers reported that they receive pressure from parents and schools to start a medication to control behavior.
    - Providers also observed that experiences with other family members and messages in media can influence the perspectives of parents and others. There’s pressure in the community from teachers, parents, community members who have seen improvements with antipsychotics with family members, relatives, television ads, print ads. Families come in saying I want a medication they saw on TV or someone else is taking it.

#### *Perceived Barriers – Pre-school Aged Children*

- Most providers either denied using APM in children under the age of 6 or emphasized that they only utilize these medications in extreme circumstances.
- Several providers did mention family desperation as an important reason for using these medications.
- One provider mentioned concerns about foster placement had motivated him to use APM in preschool-age children, “...where nothing else was effective, it made the difference of the young child staying in the home or having a placement terminated.
- This emphasis on using APM in younger children only in extreme circumstances also informs the preference for medications rather than psychosocial therapies. One rural child psychiatrist noted the recent case of a 4-year-old with autism who was extremely aggressive in the clinic, “I don’t think there is a whole lot a therapist is going to be able to do with him .....

### *Perceived Barriers – APM Polypharmacy*

- Just as in discussions about the use of APM in preschool children, most providers seemed to recognize that the use of more than one APM at a time in the same child was not desirable.
- Most stated that they do not engage in this practice.
- Others reported that they only use more than one APM for short durations while they are transitioning from one APM to another.
- However, a few isolated comments may provide some indication of barriers to reducing APM polypharmacy. One child psychiatrist practicing in an urban, hospital-based practice identified poor access to inpatient psychiatric care (apparently with reference to insurance restrictions) as one barrier to reducing the number of PM a patient is taking. “It’s difficult to taper those medicines off.... I used to put those individuals in the hospital for a medicine clean out. That’s no longer possible....It’s much more difficult on an outpatient basis.”

### *Perceived Barriers – Clinical and Laboratory Monitoring*

- Most providers in the current study report following-up frequently with patients on APM.
- One child psychiatrist practicing in an urban, hospital-based practice, however, observed that even though he would like to follow-up with patients more frequently, children on APM are disproportionately affected by social issues that cause patients to no-show for clinic visits.
- Access was mentioned as a barrier to appropriate follow-up. For example, one psychiatric nurse practitioner said, “We are in such a rural area; gas money is such a problem for my patients. So we may not be able to see them until 30 days after, so we will talk to them on the phone after 2 weeks.”
- Laboratory monitoring was more variable. Very few providers reported obtaining all of the labs that are currently recommended for children taking APM, but did not identify barriers to their use.
  - PCPs who said they did not do lab monitoring explained that they typically left this monitoring to the child psychiatrists.
  - The child psychiatrists identified family compliance as a barrier.
    - Both reported that they frequently ordered appropriate tests, but families would fail to take their child to the hospital-based lab to have their blood drawn.
    - Both of these providers mentioned that they use the refusal to refill medications as leverage to motivate follow-through on laboratory monitoring.

## **Discussion**

### *Problem*

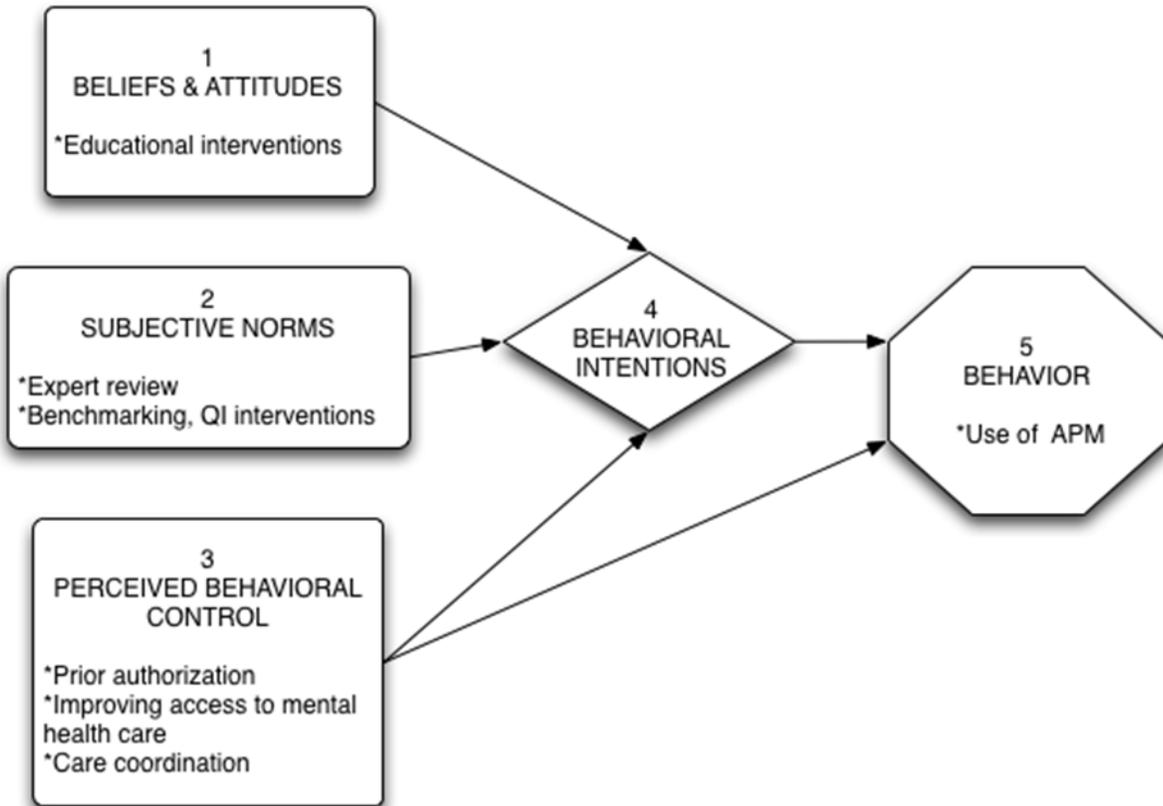
- This study validates issues with the mental health care delivery system of which many providers are already familiar but adds to the literature the use of a well-known theory about the drivers of behavior change that can help to frame solutions to a complex problem.
- Our study sample of primary care providers, child psychiatrists and other subspecialists, and advanced practice nurses across the Commonwealth of Kentucky reported experiencing obstacles that have been well-described in prior assessments of the U.S. mental health system such as being unable to refer patients to mental health experts; uncoordinated services; resorting to medications as a compromise in the face of a failing system of care; and general barriers against accessing health services in rural communities.
- Multiple reports spanning from 1969 to 2003 have similarly outlined the failures of the mental health system serving children, which included fragmented care, lack of available resources to care for children in need, and a lack of progress in developing coordinated community services.
- It has been reported that most children in need of services do not receive them, many who begin treatment terminate services prematurely, poverty status is associated with underutilization of services, and culturally appropriate services are scarce

- The TPB formed the foundation for this qualitative study. The TPB has been applied to behavior change across many types of people and circumstances. According the TPB, in order to change prescribing practices (behavior), one needs to better understand health care providers' beliefs, subjective norms, and perceived control around the use of APM in children.
- Application of the TPB offers potentials targets for policies to safeguard prescribing of APM.
  - Changes in attitudes and beliefs of providers, families, teachers, and other community stakeholders through education.
  - Removal of barriers that influence providers' control beliefs
    - Access to mental health specialists such as child psychiatrists or those providers who can deliver psychosocial therapies.
    - Policies to incentivize individuals to choose careers in child psychiatry and other mental health care specialists.
- Poverty is one of the most challenging issues in Kentucky.
  - Only five Kentucky counties have per capita incomes above the national average.
  - Poverty is a risk factor for the development of mental health disorders in children.
  - Low socioeconomic status in early childhood has been found to be the strongest predictor of emotional problems by age 18 and to account for much of the racial/ethnic disparities in children's social-emotional and behavioral problems.
  - One mechanism by which low income may increase children's vulnerability to mental health and behavioral problems is by increasing their exposure to other risk factors such as life stressors, violence, parental distress, parental depression, and substance abuse, which in turn affect children's behavior and mental development.
  - In one study, youth insured by Medicaid were more than three times as likely as privately insured children to receive an APM and the use of APM is increasing much more rapidly among children on Medicaid than it is among children covered by private insurance.
  - Children with Medicaid generate roughly a quarter of the national child mental health care expenditures.
  - The increased use of APM in Medicaid beneficiaries is multifactorial.
    - Increased risks associated with exposure to toxic stress
    - Frequent moves and changes in eligibility status, which may hinder the continuity of their care and receipt of these services.
    - Providers who serve large proportions of patients insured via Medicaid often perceive not having enough time to conduct proper mental health screenings or delve into complex social determinants of health that may put them at risk for mental illness.
    - Primary care providers may not be adequately informed about children's mental health issues, including risks associated with the use of APM, guidelines for follow-up care, or the delivery of ambulatory-based mental health interventions.
    - Providers may not screen for conditions for which treatment is not available to their patients.
    - Health professionals may not receive adequate reimbursement for these screenings although reimbursement was not a significant theme in our analyses.

### *Potential Solutions*

- More stringent prior authorization (least frequently endorsed)
- Expedient consultation with child psychiatry expertise, case management, and standardization in therapeutic choices.
- Based on the TPB, interventions are needed at various levels
  - Education of the provider regarding the care of children with behavioral and mental health issues including the risks associated with the off-label administration of APM and standards for ongoing monitoring of children who are receiving APM.
    - May change their attitudes towards such prescribing practices
    - May change the social norm surrounding such prescribing.
    - Broad-based public health educational campaign is needed to address the social norms around the use of such medications that is targeted toward families, youth, and community advocates.
    - Changing the attitudes of parents, teachers, and child care workers may reduce the pressure that provider may feel to prescribe medication even though he/she is knowledgeable about practice standards.
    - Interventions that increase screening and referral for children exhibiting risk factors for behavioral and mental health issues such as high numbers of adverse childhood experiences, parents with mental health and substance use problems, environmental chaos associated with poverty, and unstable living conditions; to name a few.
    - Providers' perceived and/or actual control over their practice behaviors can be improved through system-level changes that reduce barriers for appropriate prescribing, monitoring, and referral practices to increase providers' access to mental health professionals such as implementation of expert case review and improvements in care coordination, for example.

Figure 1. Guiding Policy Development Using the Theory of Planned Behavior to Safeguard the Prescribing of Antipsychotic Medications



## KENTUCKY MEDICAID POS COVERED VACCINES LIST (without PA)

Managed Care Organization Health Plan Partner	ANTHEM	AETNA Better Health of KY	HUMANA Care Source	PASSPORT	WELLCARE	KY FFS
VACCINE						
FLU MIST				X		
HAEMOPHILUS B POLYSACCHARIDE CONJ VACCINE			X			
HAEMOPHILUS B POLYSAC CONJ-HEPATITIS B (RECOMB) VAC			X			
HEPATITIS A VACCINE			X			
HEPATITIS B VACCINE			X			
HEPATITIS A (INACT)-HEP B (RECOMB) VAC INJ			X			
HUMAN PAPILLOMAVIRUS (HPV) Gardasil		in process	X	X	X	
INFLUENZA VACCINE	X	X	X	X	X	
MEASLES, MUMPS & RUBELLA VIRUS VACCINES			X			
MEASLES-MUMPS-RUBELLA-VARICELLA VIRUS VACCINES			X			
MENINGOCOCCAL VACCINE			X			
MENINGOCOCCAL (C & Y)-HAEMOPHILUS B TET TOX CONJ VAC			X			
PNEUMOCOCCAL VACCINE	X	in process	X	X	X	
PNEUMOVAX	in process	in process	X	X	X	
POLIOVIRUS VACCINE, IPV			X			
ROTAVIRUS VACCINE, LIVE ORAL			X			
TETANUS DIPHTHERIA PERTUSSIS (TDAP)			X	X		
TYPHOID VACCINE CAP DELAYED RELEASE						
VARICELLA VIRUS VACCINE LIVE			X			
ZOSTAVAX		in process	X	X	X	
ZOSTER VACCINE LIVE		in process	X	X	X	

Rx required for all vaccines.

Members < 19 years of age receive vaccines through the Vaccines for Children Program.

(Revised Mar. 2016)

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop C3-01-24  
Baltimore, Maryland 21244-1850



**Office of Financial Management**

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***DPBC Informational Bulletin***

Date: December 1, 2015

To: State Medicaid Directors

From: Catherine Jansto,  Director  
Division of Premium Billing & Collections

Subject: Premium Rates for Medicare Part A and Part B - Effective January 1, 2016

The Centers for Medicare & Medicaid Services (CMS) has announced the new Medicare Part A (Hospital Insurance) and Medicare Part B (Supplementary Medical Insurance) premium rates for calendar year 2016, as released by the CMS Office of the Actuary. Below are the premium rates to be paid under the State Buy-in Program.

**Regular Part A - Hospital Insurance (HI) Premium Rates**

Base Rate	\$411.00
10% Surcharge	\$452.10*

**Reduced Part A - Hospital Insurance (HI) Premium Rates**  
(Individuals with 30-39 quarters of Social Security coverage)

Base Rate	\$226.00
10% Surcharge	\$248.60*

\*NOTE: The 10% surcharge is applied to Part A Group Payer States only.

**Part B - Supplementary Medical Insurance (SMI) Premium Rates**

Base Rate	\$ 121.80
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The Medicare Part A and Part B Summary Accounting Statements for the January 2016 billing period will reflect the rates listed above. If you have any questions, please contact us via email at [DPBCStateBuy-in@cms.hhs.gov](mailto:DPBCStateBuy-in@cms.hhs.gov).



**CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES**

**Matthew G. Bevin**  
Governor

275 E Main St, 6W-A  
Frankfort, KY 40621  
[www.chfs.ky.gov](http://www.chfs.ky.gov)

**Vickie Yates Brown Glisson**  
Secretary

**Lisa D. Lee**  
Commissioner

**MEMORANDUM**

**TO:** Managed Care Organizations  
**FROM:** Lisa D. Lee, Commissioner   
**DATE:** January 7, 2016  
**SUBJECT:** 2017 Rate Development

To assist with the 2017 rate development as it relates to the MS-DRG v33, the Department requests that you provide the following:

1. Is your acute care inpatient facility reimbursement linked to Kentucky Medicaid fee-for-service reimbursements?
2. If yes to 1), please provide the name and Medicaid Provider Number and Medicare Provider Number of all applicable facilities that are paid on a DRG or MS-DRG basis.
3. If yes to 1), please provide the DRG or MS-DRG version(s) used for claims incurred on or after April 1, 2013. If the version your MCO is using has changed since April 1, 2013, please provide the effective dates of all versions used.

The Department values your partnership and looks forward to future collaborations aimed at increasing the health status of the Commonwealth's most vulnerable citizens. Please do not hesitate to contact me with additional concerns or questions.

**C:** Steve Davis  
File

MAP - 22  
(09/2015)

Commonwealth of Kentucky  
Cabinet for Health and Family Services  
Department for Medicaid Services

MEDICAID  
CHANGE OF ADDRESS

Today's Date \_\_\_\_\_

Name of person reporting address change \_\_\_\_\_

Phone number of person reporting change \_\_\_\_\_

\_\_\_\_\_

Case name (first, middle, last & suffix)

\_\_\_\_\_

(Medicaid Case Number or Social Security Number)

WHEN DID YOUR MAILING ADDRESS CHANGE \_\_\_\_\_

New Mailing Address: \_\_\_\_\_

Street Apt. #

\_\_\_\_\_

City State Zip Code

Home address if different: \_\_\_\_\_

Street Apt. #

\_\_\_\_\_

City State Zip Code

I certify under the penalty of perjury, that the information given by me is true and complete to the best of my knowledge. I give my consent to make any necessary contacts to prove my statement. I understand that if I give false information or conceal information in order to get or keep medical coverage, I will be subject to criminal sanctions under federal law, state law, or both, and I may have to pay back the cost of medical care received.

You may fax this form to the Centralized Mail Center at 1-502-573-2005 or send by US postal service to: Centralized Mail PO Box 2104 Frankfort, KY 40601

Reminder: If you have additional changes to report in your household situation log into the Self-Service Portal at <https://kynect.ky.gov/> or call kynect at 1-855-459-6328 or DCBS at 1-855-306-8959. You may also visit a Department for Community Based Services (DCBS) office. To find a DCBS office near you go to [https://prd.chfs.ky.gov/Office\\_Phone/index.aspx](https://prd.chfs.ky.gov/Office_Phone/index.aspx).

\_\_\_\_\_  
Signature of Medicaid member or authorized representative Date



February 29, 2016

David McAnally  
Branch Manager, Managed Care Oversight  
Department for Medicaid Services  
275 E Main St. 6C-C  
Frankfort, KY 40621

RE: CPT Codes 99213, 99214 and 99215

Dear Mr. McAnally,

Anthem Blue Cross and Blue Shield Medicaid (Anthem) is responding to the inquiry received from the Department for Medicaid Services (DMS) on February 10, 2016. The letter was in regards to CPT codes 99213, 99214 and 99215. DMS requested our plan to reprocess reimbursements to provider claims for these codes.

After extensive review of claims reports and configuration documents, we have found that this reimbursement limit is not configured in our system. We are paying codes 99214 and 99215 at the full allowable amount, regardless of how often it has been billed. We regret that contrary information was communicated previously, including to the Medical Advisory Committee (MAC).

Anthem will follow 907 KAR 3:010. The configuration change is estimated to be complete in the next 30 days.

We will examine these overpayments and recover inappropriate paid amounts in compliance with state guidance. If providers have any questions about the recoupments, or codes 99214 and 99215 denials in general, please direct them to their designated Provider Relations Representative or our Provider Solutions hotline (855-661-2028).

Please contact me with any questions or concerns.

Sincerely,

A handwritten signature in cursive script that reads "Amy Hayden". The signature is enclosed in a thin black rectangular border.

Amy Hayden  
Manager, Regulatory Services  
Anthem Blue Cross and Blue Shield Medicaid



9900 Corporate Campus Dr.  
Suite 1000  
Louisville, KY 40223

February 22, 2016

David McAnally  
Branch Manager  
Managed Care Oversight – Contract Management  
Department for Medicaid Services  
Cabinet for Health and Family Services  
275 E. Main St. 6C-C  
Frankfort, KY 40621

Re: CPT codes 99213, 99214 and 99215

Dear Mr. McAnally:

This letter is in response to your inquiry dated February 10, 2016.

Coventry Cares of Kentucky has met the prior expectations and has not denied these codes in the past. For 2015 claims dates of service, Coventry Cares of Kentucky has done recoveries for those over the limit in the regulation and paid at the 99213 allowable. Aetna Better Health of Kentucky's QNXT system has implemented automated logic to reduce the billings, beyond the regulation limits, to pay at the 99213 rate and recovery will no longer be needed for the claims that meet the criteria moving forward.

Aetna Better Health of Kentucky requires providers that file claims for an evaluation and management service with a corresponding CPT code of 99214 or 99215 submitted in excess of the 907 KAR 3:010 (a) limits, will be reimbursed at the lower rate of CPT code 99213.

Thank you and let us know if you have any questions.

A.J. Oxley  
Senior Compliance Consultant  
Aetna Better Health of Kentucky

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February 22, 2016

**Via Email**

Mr. David McAnally  
Branch Manager Managed Care Oversight – Contract Management  
Cabinet for Health and Family Services Department for Medicaid Services  
275 East Main Street, 6 C-C  
Frankfort, KY 40601

**Re: CPT codes 99213, 99214, and 99215**

Dear Mr. McAnally,

This letter is in response to the Letter of Inquiry received via email on February 11, 2016, regarding a determination of Humana – CareSource's (HCS) plan to reprocess reimbursements to provider claims for CPT codes 99213, 99214, and 99215.

Based upon our research, Humana-Caresource (HCS) has paid all claims submitted with CPT codes 99213, 99214, and 99215 at or above the rates on the KDMS fee schedule for these codes since our inception on January 1, 2013. With the exception of a short period of time from May 2015 through August 2015, HCS has never limited the number of visits that could be billed under these codes. Between May and August of 2015, HCS did implement a two visit limit on codes 99214 and 99215, and visits billed in excess of these limits were denied. When the business decision was made in August 2015 to remove the limits on level 4 and level 5 visits, an impacted claims report was run. As a result, a mass claims adjustment was done in September 2015, and all denied claims for codes 99214 and 99215 were reprocessed and paid according to the KDMS fee schedule without limits to the number of visits. The impacted claims during that time were 5,327. This impacted 1,426 individual providers. HCS has decided not to limit the number of visits for CPT codes 99214 or 99215 as outlined in KAR 3:010, so all future claims submitted with codes 99214 and 99215 will be paid according to the KDMS fee schedule, and without limits placed on the number of visits that can billed for these codes.

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Should you have any questions, please do not hesitate to contact me at [jlayman@humana.com](mailto:jlayman@humana.com)

Kindest regards,

A handwritten signature in black ink, which appears to read "Jeff Layman".

Jeff Layman  
Executive Director, Kentucky Medicaid

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March 3, 2016

Mr. David McAnally  
Branch Manager  
Managed Care Oversight – Contract Management  
Cabinet for Health and Family Services  
Department for Medicaid Services  
275 E. Main Street, 6C-C  
Frankfort, Kentucky 40621

Re: CPT Codes 99213, 99214, 99215

Dear Mr. McAnally,

This is Passport Health Plan's (Passport) response to the Department for Medicaid Services' (Department) Inquiry Letter dated February 10, 2016. Specifically, the Department asked about Passport's plan to reprocess reimbursements to provider claims for CPT codes 99213, 99214 and 99215. Our understanding from the Department's January 8, 2016 letter is that the Department's request for this determination is based on Kentucky regulation 907 KAR 3.010. It is our position that Kentucky regulation 907 KAR 3:010 does not apply to Passport and that we do not practice the activity for which the Department is concerned as set forth below.

907 KAR 3:010 is titled "Reimbursement for physicians services." The preamble to the regulation states in part that "This administrative regulation establishes the method of *reimbursement* for physicians' services *by the Medicaid Program.*" (emphasis added)

Therefore, the purpose of the regulation is to provide rules for payments that are made directly to physicians by the Cabinet for Health and Family Services (Cabinet), not payments that are made by the Cabinet to an MCO pursuant to a managed care contract. As such, the term "reimbursement" would only apply to situations in which the Cabinet makes a payment directly to a physician or to a physician group practice.

This interpretation of the regulation is confirmed by 907 KAR 3:010, Section 2(1) and (2), which provides as follows:

"Section 2. *Reimbursement.* (1) *Reimbursement* for a covered service *shall be made to:*

(a) *The individual participating physician; or*

(b) **A physician group practice** enrolled in the Kentucky Medicaid Program.

(2) Except as provided in subsections (3) to (9) of this section, reimbursement for a covered service shall be the lesser of:

(a) The physician's usual and customary charge; or

(b) The amount specified in the Medicaid Physician Fee Schedule established in accordance with Section 3 of this administrative regulation."

(emphasis added)

Furthermore, this interpretation is confirmed by the following sections in 907 KAR 3:010

**907 KAR 3:010, Section 3(6), which provides as follows:**

"(6) **Reimbursement** for a covered service provided by a physician assistant **shall be:**

(a) **Made to the employing physician; or**

(b) **Included in the facility reimbursement** if the physician assistant is employed by a primary care center, federally qualified health center, rural health clinic, or comprehensive care center."

**907 KAR 3:010, Section 5(1), which provides as follows:**

"Section 5. Supplemental Payments. (1) **In addition to a reimbursement made pursuant to Sections 2 through 4** of this administrative regulation, **the department shall make a supplemental payment** to a medical school faculty physician employed by a state-supported school of medicine that is part of a university health care system that includes a:

(a) Teaching hospital; and

(b) Pediatric teaching hospital.

(2) **A supplemental payment plus other reimbursements made in accordance with this administrative regulation** shall not exceed the physician's charge for the service provided and **shall be paid directly or indirectly to the medical school.**"

(emphasis added)

In addition, this interpretation of the regulation is supported by three additional facts:

First, the preamble to the regulation lists several federal statutes and regulations and several state statutes as "Statutory Authority" for the regulation and as being statutes and regulations that the regulation "Relates To." The cited statutes and regulations do not include the federal or state statutes or regulations governing the provision of Medicaid through MCOs.

Second, the terms “managed care” or “managed care organization” or “MCO” do not appear anywhere throughout the regulation.

Third, Section 6 of the regulation provides for the right to appeal from the application of the regulation by (1) department decisions regarding a Medicaid recipient, (2) department decisions regarding Medicaid eligibility of an individual, and (3) department decisions regarding a Medicaid provider. In the case of decisions regarding a Medicaid provider, Section 6 states that the appeal shall be in accordance with 907 KAR 1:560. The latter regulation deals with Medicaid provider participation, the withholding of overpayments to providers, and related issues. One example of a provider overpayment under the latter regulation is provided in Section 2(2) of such regulation as follows: “Departmental adjustments of the *reimbursements* rates, and differences between estimated and actual costs a provider incurred in determining *reimbursements*, may create situations where a provider was *overpaid*.” (emphasis added)

However, the appeals process set forth in this regulation for a provider overpayment would not apply to a dispute between an MCO and a provider regarding payment or overpayment, because such a dispute would be governed by the appeals process that has been created by the MCO in accordance with 907 KAR 17:015, Section 11, which requires an MCO to have written policies and procedures for provider grievances and appeals, including “an appeal with an MCO regarding a provider payment issue.”

In addition to the non-applicability of 907 KAR 3:010, Passport does not practice the activity for which the Department is concerned. In response to previous Department inquiries, we confirmed that Passport does not limit the number of times CPT codes 99214 or 99215 can be billed per member during a 12-month period thereby limiting payment to the level of 99213.

In summary, Kentucky regulation 907 KAR 3:010 does not apply to Passport and does not limit the number of times CPT codes 99214 or 99215 can be billed per member during a 12-month period. Therefore, Passport respectfully requests that the Department issue a communication to Passport that states Passport is not required to reprocess reimbursements to provider claims for CPT codes 99213, 99214 and 99215.

Sincerely,



David Henley, JD, CCEP, CHIE, FLMI  
Vice President and Chief Compliance Officer

cc: Mark Carter, CEO, Passport Health Plan  
Stephen P. Miller, Commissioner, Department for Medicaid Services  
Catherine York, Office of Legal Services, Central Office Attorney  
Cindy Arflack, Director, Division of Program Quality and Outcome



**Rebecca Randall**  
Director, Regulatory Affairs

David McAnally  
Branch Manager  
Managed Care Oversight  
Department of Medicaid Services  
275 E. Main St. 6W-A  
Frankfort, Kentucky 40621

March 1, 2016

RE: CPT Codes 99213, 99214, and 99215

Dear Mr. McAnally:

On behalf of WellCare of Kentucky, Inc., ("WellCare") I would like to provide the following information regarding the Department's letter concerning reimbursement for CPT codes 99213, 99214, and 99215.

By way of background, WellCare has never instructed providers to bill with a downgraded evaluation and management (E/M) code (99213) if the service administered by a provider was at the duration and complexity of CPT codes 99214 or 99215. Additionally, WellCare does not deny claims that exceed the limits set forth within 907 KAR 3:010 Section 4:

Section 4. Reimbursement Limitations. (1)(a) With the exception of chemotherapy administration to a recipient under the age of nineteen (19) years, reimbursement for an evaluation and management service with a corresponding CPT code of 99214 or 99215 shall be limited to two (2) per recipient per twelve (12) months.(b) Any claim for an evaluation and management service with a corresponding CPT code of 99214 or 99215 submitted in excess of the limit established in paragraph (a) of this subsection shall be reimbursed as an evaluation and management service with a corresponding CPT code of 99213.  
(c) A claim for an evaluation and management service of moderate or high complexity in excess of the limit established in paragraph (a) of this subsection shall be reimbursed at the Medicaid rate for the evaluation and management service representing medical decision making of low complexity.

Upon receipt of the Department's memo in January 2016, WellCare undertook an initiative to review our claims processing edits for E/M codes to ensure appropriate adjudication of claims for such services. From 2011 through December 2014, WellCare used a systematic front-end edit to "down code" the E/M code to the lower level and issue reimbursement to providers accordingly in instances where the regulatory limit was met. In 2015, WellCare used a new process for claims billed at the higher level E/M codes (99214 and 99215). Instead of automatically "down coding" claims billed at these E/M codes, we reimbursed providers upfront at the full contracted rate with a post payment recovery mechanism in

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**Rebecca Randall**  
Director, Regulatory Affairs

place to recover overpayments, minus the amount the provider would have been reimbursed at the lower level. Refund requests were sent to providers for these services (minus the amount that would have been paid for the lower level code) which afforded providers an opportunity to dispute our findings.

As a result of the Department's guidance and the findings of our internal analysis, WellCare has deployed the following step actions to fully comply with applicable provisions of the Department's request and the requirements of 907 KAR 3:010:

- 1) WellCare is amending its policy to "down code" E/M services to a lower level when the regulatory limit is met at the point of claim adjudication rather than perform post-payment recoveries from providers for overpayments (minus the amount that would have been paid for the lower level code).
- 2) WellCare has ceased all recovery efforts for overpayments to providers whose claims were not automatically "down coded" for exceeding the regulatory limit.
- 3) WellCare will reinstate the front-end edit within our claims system to automatically "down code" claims that have reached the regulatory limit. We expect this edit to be fully deployed by March 21, 2016.

Our internal analysis does not show WellCare denied claims or instructed providers to bill claims inappropriately, thus we do not believe a claims reprocessing project is necessary at this time, but welcome further guidance from the Department on this matter. We trust that this information gives assurance to the Department that we are actively engaged in assuring our claims processing policies and procedures adhere to both our contractual and regulatory obligations. If there are any further questions or concerns, please let me know.

Sincerely,

A handwritten signature in cursive script that reads "Rebecca Randall".

Rebecca Randall  
Director  
Regulatory Affairs

Cc: Kelly Munson, Senior Vice President, Division President and Product  
Ben Orris, COO Kentucky  
Cindy Arflack, Director, Division of Program Quality & Outcomes



**Rebecca Randall**  
Director, Regulatory Affairs