

Rapid Rounds: Clinical Essentials for Perinatal Mental Health Webinar Series



Beyond Baby Blues: Screening & Reimbursement

Tuesday, January 6, 12:15 – 1:00 PM

Speakers: Erin Bider, MD and Tara Chettiar, MD, PMH-C, FACOG

**KANSAS
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Funding and Partnerships

Kansas Connecting Communities is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling \$3,750,000 with 10% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government.

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Mental Health
Consultation
& Resource
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KCC Program Components

Training



- Didactic and case-based learning led by a collaborative and multi-disciplinary training team
- Monthly virtual training on treatment, medication management, and special topics in perinatal behavioral health
- On-demand modules, webinars, and additional custom training options available
- Training scholarship opportunities and up to 6 free CME/CEs offered annually

Consultation Line

- Psychiatric consultations with perinatal behavioral health team
- Resources and referral support
- Connection to training and technical assistance services
- Information about best practices, recommendations and research, and Medicaid billing and reimbursement



Technical Assistance



- Support to implement substance use and mental health screening in clinic, hospital, public health, and community settings
- Coaching to build a referral network and improve care coordination between referral partners.
- Assistance developing custom policies, workflows, and administrative support tools for screening and referrals

Access services to support your work with perinatal clients

Registered KCC Providers Receive

- **Early registration** access to trainings and PSI scholarships
- Up to six hours of **free CEs** (continuing education credits)
- Access to a **consolidated hub** of KCC and KSKidsMAP (pediatric program) services



1-800-332-6262

- Streamline use of the Mental Health Consultation & Resource Network



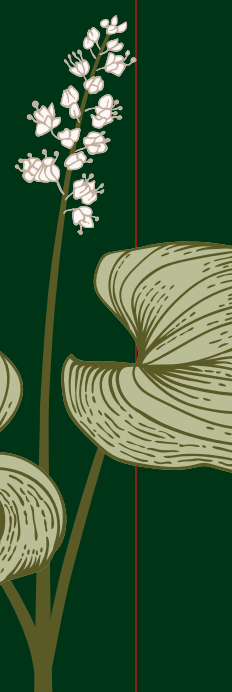
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Beyond Baby Blues

Screening and Reimbursement

Erin N Bider, MD and Tara N Chettiar, MD



Disclosures

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Objectives

- 1. Discuss the epidemiology and differential diagnosis of perinatal mental health disorders.
- 2. Understand the risks of untreated mental illness during the perinatal period.
- 3. Review clinical implementation of maternal depression screening, including the Kansas Medicaid billing and reimbursement policy.

Part 1: Baby Blues vs Perinatal Mental Health Conditions

Presentation and assessment
during the postpartum visit



Epidemiology

- About 85% of women in the US are pregnant at least once by age 44¹
- Women are 2–3x more likely than men to experience depressive and anxiety disorders²
- About 15–20% of pregnancies in the US are affected by mental health conditions³





The State of Kansas

Kansas Pregnancy Risk Assessment Monitoring System (KDHE) surveys women who have given birth in the last 6 months

21% reported depression during pregnancy

15% exhibited symptoms of postpartum depression

14% felt that they needed treatment for their symptoms but did not get it (either counseling or medications)

Among women who smoked during the perinatal period:

- 38.5% reported worsening depression as a barrier to quitting
- 54% reported worsening anxiety as a barrier to quitting

Kansas Maternal Mortality Review Committee



- 51.6% of pregnancy-associated deaths occurred between 43–365 days postpartum
- 27.7% were caused by homicide, suicide, mental health conditions, or unintentional poisoning/overdose
- Mental health conditions contributed to 22.9% and substance use disorders (SUD) contributed to 26.7%
- 68.1% that had SUD as a contributing factor *also* had co-occurring mental health disorders as a contributing factor

Who is at greatest risk?

- Previous or current mental health symptoms
- Victims of intimate partner violence
- Those with financial stress/women of lower SES
- Women who have less social support during and after pregnancy
- Women with medical complications during pregnancy
- Women whose babies are in the NICU after delivery
- Unplanned or not desired pregnancies
- Women with infertility struggles





Impact

Poorer adherence to prenatal care

Poorer nutrition during pregnancy

Small or large babies

Preterm delivery

Difficulty with breastfeeding

Higher rates of substance use

Suicide

Infant mental health

“The ability of the child from birth to age three to experience, regulate, and express emotions; form close and secure interpersonal relationships; and explore the environment and learn – all in the context of family, community, and cultural expectations for young children”

–Zero to Three Infant Mental Health Task Force Steering Committee 2001





Infant attachment

- Attachment between infants and caregivers is a dynamic process through the early year(s) of a child's life that forms the bedrock of social, cognitive, and emotional development
- Attachment can be severely disrupted by poorly treated maternal mental health symptoms
- Infants develop secure attachment patterns when caregivers can reliably and warmly meet their needs
- Important factors are eye contact, facial expressions, and tolerance of the infant's negative emotions
- Insecure or disorganized attachment in the first few years of life is associated with^{6,7}
 - Negativity in early childhood
 - Slower cognitive development
 - Behavioral problems in adolescence
 - Higher cortisol responses to stress
 - Higher rates of mental illness by young adulthood
 - More difficulty forming stable relationships in adulthood



Differentiating from Baby Blues

Baby Blues (Postpartum Blues)

- **Onset:** Usually within 2–3 days after delivery
- **Duration:** Lasts 2–4 weeks
- **Symptoms:** Mood swings, crying spells, anxiety, irritability, feeling overwhelmed, difficulty sleeping
- **Treatment:** Self-care, rest, support from family/friends, often self-limited

Postpartum Depression (PPD)

- **Onset:** Can begin up to a year postpartum
- **Duration:** Can persist for months if untreated
- **Symptoms:** More intense and persistent sadness, hopelessness, extreme fatigue, loss of interest, rage, trouble bonding, difficulty caring for self/baby, suicidal thoughts
- **Treatment:** Should be professional help, including psychotherapy, antidepressants, and ruling out other medical issues

Part 2: MDS Billing





Screening Recommendations

Mental Health

- Universal screening in pregnancy, postpartum, and pediatric settings
- Ideal:
- first prenatal visit, once per trimester, first postpartum visit
 - 6- and 12-months PP by OB/PCP
 - 3, 9, 12-month pediatric visits
- Each national group (ACOG, AAFP, AAP, etc...) has slightly different recommendations

KanCare has no cap on reimbursable screens

SUD

- Screening should happen at initial prenatal visit and include nicotine, alcohol, prescription, and illicit drug use
- Patients who screen positive should be offered brief intervention, motivational interviewing, and referral to treatment

KanCare has a cap of 1 screen/year/patient



Screening Tools

- **Edinburg Postnatal Depression Scale (EPDS)**
 - Considered ‘gold standard’
 - Validated for depression and anxiety through pregnancy and 12 months PP for any caregiver, **reimbursable**
 - **PHQ-9 and GAD-7**
 - When used together, cover depression and anxiety
 - Widely used, validated in adults and adolescents.
 - **PHQ-9 is reimbursable**
 - **4Ps/5Ps *will be covered at next talk***
 - Validated for perinatal population
 - Not free to use, **not currently reimbursable through KanCare**
 - **Tobacco, Alcohol, Prescription Medications, and other Substance use (TAPS)**
 - Validated for adults, **reimbursable**
- For more options, see the full SBIRT guidance document.

Maternal Depression Screening Medicaid Policy

- Screenings are reimbursed during the prenatal period under the mother's Medicaid ID. **There is no cap on number of reimbursable screens.**
- Screenings during the 12-months postpartum period under the child's Medicaid ID.
- Screenings can be administered by non-licensed staff (e.g., home visitors, community health workers) who are supervised by licensed professionals.
- More information, including a list of screening tools and billing codes, can be found in the Perinatal Mental Health Toolkit.



Complete Guidance
Document

Maternal Depression Screening Medicaid Policy

- Providers can bill 96160 for MDS administered under the mother's Medicaid ID or 96161 for MDS administered as part of a child's medical visit under the child's Medicaid ID.
- Reimbursement rate is \$21.86 a screen.
- **Policy caveats:** FQHCs and RHCs cannot bill for MDS—it's included in their encounter rate. CCBHCs cannot bill for MDS, but these organizations can bill under their CMHC designation. MDS is not included in the maternity global fee.



Complete Guidance
Document



Perinatal Visit	Screening	Recommendation	Maternal Care Provider	Pediatric Care Provider
First Prenatal Visit	Depression/Anxiety	PSI	\$21.86 (CPT 96160)	
First Prenatal Visit	Substance Use	ACOG	\$24.00 (CPT 99408)	
Second Trimester	Depression/Anxiety	PSI	\$21.86 (CPT 96160)	
Third Trimester	Depression/Anxiety	PSI	\$21.86 (CPT 96160)	
First Postpartum Visit	Depression/Anxiety	PSI	\$21.86 (CPT 96160)	
1-Month Postpartum	Depression	Bright Futures		\$21.86 (CPT 96161)
2-Months Postpartum	Depression	Bright Futures		\$21.86 (CPT 96161)
3-Months Postpartum	Depression/Anxiety	PSI		\$21.86 (CPT 96161)
4-Months Postpartum	Depression	Bright Futures		\$21.86 (CPT 96161)
6-Months Postpartum	Depression	Bright Futures		\$21.86 (CPT 96161)
9-Months Postpartum	Depression/Anxiety	PSI		\$21.86 (CPT 96161)
12-Months Postpartum	Depression/Anxiety	PSI		\$21.86 (CPT 96161)
Annual Well-Woman Exam (6/12-months Postpartum)	Depression/Anxiety	PSI	\$21.86 (CPT 96160)	
Total KanCare Payment Per Patient			\$133.30	\$153.02

Part 3: Q&A



Thank you



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