Early Childhood Developmental Health Systems | EVIDENCE TO IMPACT CENTER

Unique Needs for Infant and Early Childhood Mental Health Consultation in Primary Care

There are various ways pediatric practices can support the healthy development of young children by integrating mental health into routine care. To do this, collaboration and co-management with mental health professionals are key, but not all practices have direct access to them in their setting. This resource describes consultation in pediatric care and uses case examples to illustrate the screening process, workflow, and billing.

Consultations for Pediatric Primary Care

Child psychiatry access programs (CPAPs) provide consultation, support, and training to pediatric primary care providers. Their goal is to build the capacity of pediatric primary care to better manage the mental health conditions of young children and expand access to mental health care.

In CPAPs, a mental health professional is available by phone to provide consultation around diagnosis, treatment, and community resources. Some CPAPs offer a one-time psychiatric evaluation for more complex cases where additional expertise may be necessary. CPAPs are typically consultation-based and off-site, so they play a supportive role in primary care rather than working directly in the pediatric practice. All 50 states now operate these insurance-agnostic programs, which focus on access for all children and adolescents. Additionally, most CPAPs provide ongoing continuing education opportunities on mental health topics for pediatric providers.

To connect with an individual state CPAP, visit nncpap.org.

Case Examples of Consultation

Case #1 – Aggression and Getting Kicked Out of Daycare

Thomas is a 3-year-old brought in by his mother for his well-child visit, and she wants to discuss his escalating behavior concerns. Over the last six months, his mother reports that he has had intense, frequent tantrums where he screams, destroys objects, and hits or bites caregivers. He is easily frustrated and often acts out when these situations occur. At preschool, he has been hitting, kicking, and biting other children.

Most recently, he threw a book at a teacher when he was frustrated. Despite increased supervision at school, they have issued a formal warning to the family that Thomas will be dismissed if these behaviors continue.

The pediatric provider looks at his screeners from his previous well-child visit and sees some areas of concern on the Preschool Pediatric Symptom Checklist (PPSC), part of the Survey of Well-being of Young Children (SWYC). This visit confirms that the behaviors have escalated since that visit.

The pediatric provider tells the mother about programs where an early childhood mental health consultant visits a childcare center and helps determine a behavioral management plan. The pediatric provider is unsure how to refer the family to the program, so they let the mother know that they will call the local CPAP to learn how.

The CPAP provider assists with the referral and shares how to find a parent-child interaction therapy (PCIT) provider who can offer dyadic therapy for the family. The CPAP provider also recommends asking the mother to complete a two-way release of information, allowing the pediatric provider to talk to the childcare provider about Thomas.

Documentation and Discussion: In the chart, document the screener results, the discussion with the mother, and the next steps for the care plan as decided together.

Workflow Components:

- As part of pre-visit planning, the universal SWYC screen was given for completion at intake for all well-child checks and documented at each well visit. This enabled the pediatric provider to review ahead of this patient's visit.
- Established office protocols helped the provider get the two-way release of information from the family.
- The provider connected with CPAP and nurtured new connections provided by CPAP, which helped create the practice's mental health provider referral base.

Billing:

- 96110: development screening tool
- 96127: social-emotional screening tool, 96160 for social drivers/family strengths, split billing for well-child care, along with a separate evaluation and management (E/M) code for acute behavioral concerns

Case #2 – Autistic Toddler With Sleep Issues

Trevon is a 30-month-old with a new diagnosis of autism by the Childhood Autism Rating Scale (CARS), and he was connected with speech and occupational therapy. Since his last visit, Trevon has experienced sleep issues, and his parents would like more support.

Trevon's parents share that they have great difficulty getting him to sleep. After dinner, he plays with his favorite blocks and likes to run around. He resists and cries when they pick him up to go to bed. They put him down, but he continues crying.

The pediatric provider describes bedtime routines and how they contribute to the gradual extinction of his crying as prompted by a premade dot phrase for Brush, Book, Bed. The pediatric provider then introduces Karen, a social worker on their care team. Karen sees the family for a brief intervention to help them choose a bedtime routine to try. Meanwhile, the pediatric provider contacts the state's CPAP to ask whether melatonin would be appropriate to help with Trevon's sleep. Karen updates the pediatric provider, and the team sets a follow-up visit with Trevon and his family.

Documentation and Discussion: In the chart, the pediatric provider documents the screener results, the discussion with the parents and Karen, and the next steps for the plan.

Workflow:

- A warm handoff with a social worker was completed during the visit.
- The provider called CPAP for consultation from a psychiatrist/D-B pediatrician.
- Karen used a premade dot phrase template that provides guidance on Brush, Book, Bed as part of a nighttime routine structure discussed with the patient.

Billing:

- 99215: E/M of an established patient based on time (40 minutes)
    - The pediatric provider can count all time on the day of service, including the call and conversation with the CPAP line, and may use 99417 in addition if indicated.
- Z73.810: behavioral insomnia of childhood, onset association type R
- Karen codes CPT 90832 for a brief psychotherapy visit.

Case #3 – Preschooler With Attention Deficit Hyperactivity Disorder (ADHD)

The pediatric provider is reviewing patient communications in the electronic health record. One message is from the father of Liam, a 4-year-old patient, regarding concerns about his behavior. He describes that Liam is "constantly on the go" and has difficulty with transitions (e.g., getting dressed, leaving for school), including temper tantrums during these transitions. At preschool, Liam's teachers describe him as "very active." They report that he has difficulty sitting for circle time, often interrupts others, and struggles to follow group instructions. He frequently grabs toys from peers and becomes frustrated when asked to wait for his turn. Over the past six months, his behaviors have become more disruptive and harder to manage.

Liam's father is particularly worried about his safety as he recently ran out into the parking lot at the grocery store and out of the classroom. He is not sure what to do next. The pediatric provider replies to him, asking him to complete the ADHD Rating Scale IV - Preschool version and to schedule a follow-up appointment to discuss.

Two weeks later, the pediatric provider sees Liam and his father. His father brings in the completed ADHD IV scales. The pediatric provider scores the screener, reviews the results, and co-develops next steps with the father.

The pediatric provider reviews the recommendations for treating preschool ADHD and tells Liam's father that behavioral management support would be the first line of treatment before considering medication. The pediatric provider calls the local CPAP to discuss potential parenting support programs in the area and asks about medication options if safety continues to be a concern. The CPAP consultant provides the pediatric provider with the name of a local psychologist who provides PCIT, and the pediatric provider completes a warm handoff.

Documentation and Discussion: In the chart, the pediatric provider documents the results of the screeners, the discussion with the father, and the next steps for the plan.

Workflow:

- Less-utilized, topic-specific screeners were available on paper for ease of use.
- The practice uses a standardized release of information and referral communication pathways to allow for return communication from external providers.
    - For standardized exchange of information, see the HIPAA Privacy Rule and Provider to Provider Communication.

- The provider utilized a warm handoff for this initial external connection and continued to nurture this relationship to create a care management plan.

Billing:

- 99215: E/M of an established patient based on time (40 minutes) and extended time for the visit (99417)
    - The pediatric provider can include the time that the pediatric provider called and spoke with the CPAP line if it was on the day of service.
- 96127: Social-emotional screening tool and extended time for the time of the visit, including the time that the pediatric provider called and spoke with the CPAP line on the day of service (99417)

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