

CPT Code and Evaluation and
Management Training
A Training for Medical Staff at
Master Contract Provider
Organizations
March 15, 2013
Handouts

CPT Code & E/M Training for Medical Providers

(Psychiatrists, Advance Practice Nurses & Physician Assistants)

ACBHCS QA 3.2013

AGENDA

- Overarching CPT Code Changes for 2013
- Evaluation & Management Codes
- Initial Psychiatric Diagnostic Procedures
- E/M New & Established clients
- Two Paths to E/M Selection (Time or Elements)
- Counseling and Coordination of Care E/M
- Medical Necessity and General Principles of Documentation
- Add-on Codes (Psychotherapy, Crisis, Interactive Complexity)
- RN/LVN/Psych Tech Code 369
- Psychiatrists, APN, PA non face-to-face Code 367
- Q&A
- Resources

HANDOUTS

- **Section 1: CPT Code & E/M Training – Counseling/Coord. of Care**
 - CPT E/M Codes: New Coding Options
 - Counseling & Coordination Progress Note Templates
 - Interactive Complexity Info Sheet
 - CPT Code Changes FAQ
 - InSyst Master Code Sheet
 - CPT Code Sheet: Crosswalk, Unchanged, New & Deleted Codes
 - Handout for Clinician Gateway Electronic Health Record users from IS
 - Guidelines for Scope of Practice
- **Section 2: E/M Trainings based on Complexity**
 - The National Council: E/M 102
 - AACAP Introduction to E/M Coding (Part 1 & 2)
- **Section 3 Additional Helpful Hand-outs and Readings**

CPT Codes vs. HCPC vs. Procedure Codes

- 3 Types of Codes:
 - **InSyst three digit Procedure Codes are used by our providers for service entry.** These procedure codes translate into HCPC or CPT codes when BHCS bills the service.
 - **CPT codes are used by Medicare** and commercial insurance for billing.
 - **HCPC Codes are used by Medi-Cal** for billing (*behind the scenes*)
- ***You must use both the 3 digit InSyst (County) Procedure codes and the 5 digit CPT codes in your documentation.***
 - **If there is not an associated CPT code—just use the 3 digit InSyst code.**

2013 Modified Psychiatry Code Categories

- **Diagnostic evaluation**
- **Evaluation and management (E/M)**
- Psychotherapy
- Psychotherapy add-on
- Interactive complexity add-on

Deleted Procedure Codes

Old	New	New Code	Description
90862	E/M	N/A	Pharmacologic Management
90857	Group Therapy + Interactive Complexity add-on	456-90853 +491	Interactive Group Therapy
Multiple	Use Non-AB3632 Codes	N/A	AB3632 Codes (except Day Treatment & Day Rehab)
90805 90807	Use E/M + Psychotherapy add-on codes	E/M + +441-90832 +442-90834 +443-90837	Combination codes for Medication Management with Psychotherapy

Changed/New Medical Provider Codes

Old	New	CPT	Description
331/332* 433/434	323 565	90791 90792	Psychiatric Diagnostic Evaluation Psychiatric Diagnostic Evaluation with Medical Services
321/322*	324	96151	Behavioral Evaluation (CFE—usually not Medical Providers)
341/342* 444/447	441 +465	90832 + 90833	Psychotherapy: 30 minutes Psychotherapy add-on to E/M
341/342* 445/448	442 +467	90834 + 90836	Psychotherapy: 45 minutes Psychotherapy add-on to E/M
341/342* 446/450	443 +468	90837 + 90838	Psychotherapy: 60 minutes Psychotherapy add-on to E/M
371/372*	377	90839	Crisis Therapy : 60 Minutes
new	378	+ 90840	Crisis Therapy: each additional 30 Minutes
	641- 643-46	99211- 99215	E/M Established outpatient Visit
new	369	N/A	Meds Management RN/LVN only
new	367	---	Non Face-to-Face Meds Management
new	491	+ 90785	Interactive Complexity add-on (such as for 565-90792)

* Eliminated AB3632 Codes.

Psychiatric Diagnostic Evaluation Procedure Codes: 565-90792

- Two new codes distinguish between:

323--90791: an initial evaluation without medical services includes the following:

- Biopsychosocial assessment including history, mental status and recommendations and may include:
 - communication with family, others, and
 - review and ordering of diagnostic studies

565--90792: an initial evaluation with medical activities provided only by a medical provider includes those services in 90791 and:

- Medical assessment Physical exam beyond mental status (when appropriate)
- May include:
 - communication with family, others,
 - *prescription medications*, and
 - review and ordering of *laboratory* or other diagnostic studies

Psychiatric Diagnostic Evaluation Procedure Codes 565-90792 cont.

- What's the Difference?
- 565--90792: an **initial evaluation with medical activities** are documented:
 - Other physical examination elements as indicated
 - Prescription of medications
 - Review and ordering of laboratory or other [medical] diagnostic studies
- Medical thinking
 - Note that this is not specified in the code description, but represents intent during the code development process

Psychiatric Diagnostic Evaluation Procedure Codes 565-90792 cont.

- **Medical Thinking**
 - Medical thinking is likely the main component that differentiates an evaluation by a psychiatrist, APN, or PA from one by a non medical provider
 - Includes *consideration* of:
 - Medical history and comorbidities
 - Medications prescribed by others
 - Further medical work up
 - Medical treatments
 - Integration of signs and symptoms from a medical standpoint
 - Document what you do!

Psychiatric Diagnostic Evaluation Procedure Codes 565-90792 cont.

- Reporting Psychiatric Diagnostic Procedures
 - Each Psychiatric Diagnostic Codes may be reported only once per day (unless seeing the client and significant other separately).
 - 323-90791 Psych Diag Eval may be provided by a non-medical provider on the same day 565-90792 Psych Diag Eval with Medical Component is provided by a medical provider (psychiatrist/ANP/PA).
 - Cannot be reported with an E/M code on same day *by same individual provider*.
 - Cannot be reported with psychotherapy service code on same day *by any provider*.
 - May be reported more than once for a client when *separate diagnostic evaluations* are conducted with the *client* and *other collaterals* (such as family members, guardians, and significant others).
 1. Diagnostic evaluation for child with child.
 2. Diagnostic evaluation for child with caretaker.
 - Use the same codes, for later reassessment, as indicated.

Evaluation and Management (E/M) Codes

- Psychiatric services now may be reported with the same range of complexity and physician work as has long been available to all other medical specialties
 - Code starts with “99” and comprised of 5 digits
 - Used to report a medical service rendered during a client visit
 - The level of service is indicated by the last digit.
 - Level 1 is the least complex
 - Level 5 is greater complexity (outpatient) or Level 3 (inpatient)
 - Used by all physicians and (MD, DO) and other qualified health care professionals (APN, PA)
 - In addition, E/M codes typically pay more for the same service

Medicare Payments

Code	Payment	Difference	% Increase
90862	\$58.54 (prev. 30")	Baseline	Baseline
99211	\$19.74 (1-7")		
99212	\$42.55 (8-12")		
99213	\$70.46 (13-20")	Additional \$11.92	20% Increase
99214	\$104.16 (21-32")	Additional \$45.62	78% Increase
99215	\$139.89 (33"+)		

CPT E/M New client Definition—CBO's Only

- 545-549/99201-99205. A new client is one who has not received any professional services from
 - the medical provider or another medical provider of the same specialty or sub-specialty
 - **who belongs to the same group practice (same Tax ID Number (TIN))**
 - **within the past three years.**
 - Each ACBHCS Contracted Community Based Organization (all sites) is it's own group practice.
- ***New client Codes ONLY FOR CBO PROVIDERS***
- ***County Medical Providers use 565—90792 Psychiatric Diagnostic Evaluation with Medical Component***

CPT E/M Established Client Definition

- 641/643--46/99211—99215. An established client is one who has received professional services from
 - the medical provider or another medical provider of the same specialty or sub-specialty*
 - who belongs to the same group practice (same TIN),
 - **Either a specific CBO, or**
 - **any of the ACBHCS County Owned & Operated Clinics**
 - within the past 3 years

*Psychiatric subspecialty's include: Child & Adolescent, Geriatric, Addiction, Forensic & Psychosomatic Medicine.

Two Paths to E/M Selection

- PATH ONE

- Basing the code on **Time**
 - Counseling and Coordination of Care are 50% or > of time.
 - The only exception to this if you are using an add on psychotherapy code, you cannot use time as the basis of selecting the code for the E/M portion of the work.
 - **In the Community MH setting it is often found that the majority of E/M services are based on time.**

- PATH TWO

- Basing the code on the **Elements**
 - History
 - Exam
 - Medical Decision Making

Path 1: Choosing the E/M Code Based on Time: Counseling & Coordination of Care

- **Time shall be the key controlling factor used for the selection of the Level of the E/M Service**
 - when counseling or coordination of care dominates the encounter more than 50 percent
 - **Face-to-face time for office visits**
 - Unit time for facility visits
 - **EXCEPT time cannot be the factor for selection of the level when done in conjunction with a psychotherapy visit.**

Path 1: Choosing the E/M Code Based on Time: Counseling & Coord. of Care cont.

- **> 50% of the Time is Spent Discussing with the client, or Family, Any of the Following (Counseling):**
 - Prognosis
 - Test Results
 - Compliance/Adherence
 - Education
 - Risk Reduction
 - Instructions
- **The time & counseling activities must be thoroughly documented.**

Path 1: Choosing the E/M Code Based on Time: Counseling & Coord. of Care cont.

- Document:
 - Length of time of the encounter and of the time spent in counseling and coordination of care
 - **AND the counseling and/or coordination of care activities**

Path 1: Choosing the E/M Code Based on Time: Counseling & Coord. of Care cont.

- Codes & Timeframes**

NEW client VISIT TIME—CBO's		ESTABLISHED client VISIT TIME	
CODE	MINUTES	CODE	MINUTES
545-99201	10 (6 – 15")	641-99211	5 (1—7")
546-99202	20 (16 – 25")	643-99212	10 (8--12")
547-99203	30 (26 – 37")	644-99213	15 (13 – 20")
548-99204	45 (38 – 52")	645-99214	25 (21 – 32")
549-99205	60 (53" +)	646-99215	40 (33" +)

Path 1: Choosing the E/M Code Based on Time: Counseling & Coord. of Care cont.

- **Counseling:** Discussion with a client or the client's family concerning one or more of the following issues:
 - Diagnostic results, Prior studies, Need for further testing
 - Impressions
 - Clinical course, Prognosis
 - Treatment options, Medication Issues, Risks and benefits of management options
 - Instructions for management and/or follow-up
 - Importance of compliance with chosen management options
 - Risk factor reduction
 - client and education

Path 1: Choosing the E/M Code Based on Time: Counseling & Coord. of Care cont.

- Although CPT considers “counseling” as separate and distinct from psychotherapy, psychiatrists typically include counseling (as defined by CPT) as part of their regular treatment.
- Many of the components of “Supportive Psychotherapy” may be considered as overlapping with “Counseling” (as defined by CPT).
 - *“From the clinician’s objectives—to maintain or improve the client’s self-esteem, to minimize or prevent recurrence of symptoms, and to maximize the client’s adaptive capacities.”**
 - *“From the client’s goals—to maintain or reestablish the best-possible level of functioning given the limitations of his or her personality, native ability, and life circumstances...”**
 - *An Introduction to Supportive Psychotherapy published by the American Psychiatry Press, Inc.

Path 1: Choosing the E/M Code Based on Time: Counseling & Coord. of Care cont.

CPT Elements of Counseling	Corresponding Elements of Supportive Psychotherapy*
Diagnostic results, impressions, and/or recommended diagnostic studies	Advice and Teaching
Prognosis	Reassurance & Encouragement
Risks and benefits of management (treatment) options	Advice and Teaching, Rationalizing and Reframing
Instructions for management (treatment) and/or follow-up	Anticipatory Guidance, Reducing and Preventing Anxiety Naming the Problem Advice and Teaching
Importance of compliance with chosen management (treatment) options	Expanding the client's Awareness
Risk factor reduction	Naming the Problem Expanding the Client's Awareness Advice and Teaching

**Introduction to Supportive Psychotherapy, Amer. Psych. Press, Inc. 2004*

Path 1: Choosing the E/M Code Based on Time: Counseling & Coord. of Care cont.

- **Coordination of care:**

- Services provided by the medical provider responsible for the direct care of a client when he or she **coordinates or controls access to care or initiates or supervises other healthcare services** needed by the client.
- outpatient **coordination of care must be provided face-to-face with the client.**
- *Coordination of care with other providers or agencies without the client being present on that day is reported with the non face-face code 367.*

Example 2 of Counseling & Coordination of Care—Outpt.

- A client returns to a psychiatrist's office for a medication check.
- The encounter takes a total of 25 minutes, during which time more than 12.5 minutes is spent explaining to the client about how a newly prescribed medication works, how to establish a routine so that no doses will be missed, and the possible side-effects of the medication and what to do if they occur.
- The appropriate E/M code would be 99214 (office or outpatient service for an established client), based on the 25-minute time rather than on a detailed history and examination and moderately complex medical decision making that would be required to use this code if counseling and coordination had not taken up more than 50 percent of the time.
- The psychiatrist documents the extent of the counseling/coordination of care in the daily progress note.

Medical Necessity—CMS

- The Center for Medicare and Medicaid (CMS) defines medically necessary services as those that are
 - *“reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member”*
 - In short, services must be clinically appropriate for the client’s condition

General Principles of Documentation

- Complete and legible
- Include:
 - Reason for the encounter and relevant history, physical examination findings and prior diagnostic test results
 - Assessment, clinical impression or diagnosis
 - Plan for care
 - Date and legible identity of the observer

General Principles of Documentation cont.

- Rationale for ordering ancillary services should be easily inferred
- Past and present diagnoses should be accessible
- Appropriate health risk factors should be identified
- Document the client's response to, changes in treatment, and revision of diagnosis
- The CPT and ICD-9-CM (required in Medicare Progress Note) codes reported should be supported.

Risk Management: How Are You Selecting Codes?

- **CAUTION!**
 - “We’re going to instruct our people to only use 645-99214 for established client visits.”
 - “Our back office staff will select the codes after reviewing the documentation.”

General Audit Issues

- Upcoding
- Downcoding
- Meet E/M criteria
- Medical necessity
- Red flags
 - High use of highest level code
 - Exclusive use of one level code

Path 1: Choosing the E/M Code Based on Time: Counseling & Coord. of Care

- CMS: Most Frequently Missed Items in E/M Documentation:
 - Time Based Codes
 - In choosing a code based upon time for counseling and coordination of care, total time may be documented but there is not:
 - quantification that more than 50 percent of the time was spent on counseling and there is also
 - no documentation of what the coordination of care was or what the counseling was.

Path 1: Choosing the E/M Code Based on Time: Counseling & Coordination of Care

- **Choosing Level of E/M Based on Time:**

AUDITOR'S WORKSHEET	Yes	No
Does documentation reveal total time (Face-to-face in outpatient setting; unit/floor in inpatient setting) and indicate > 50% of the total time was counseling and coordination of care services?		
Does documentation describe the content of counseling or coordinating care?		
Does (extent of) documentation support that more than half of the total time was counseling or coordinating of care?		

Note. If all answers are yes, select level based on time.

Path 2: Choosing the E/M Code Based on the Elements

- **History**
 - Chief Complain
 - History of Present Illness (HPI)
 - Past, Family and/or Social History (PFSH)
 - Review of Systems (ROS)
- **Exam**
 - Number of system/body areas examined
 - “Bullets” or elements completed within specific systems
- **Medical Decision Making**
 - Number of Diagnoses or Management Options
 - Amount and/or Complexity of Data to be Reviewed
 - Risk of Significant Complications, Morbidity, and/or Mortality

Each line impacts kind of History, Exam, and MDM

Path 2: Choosing the E/M Code Based on the Elements cont.

- Medical Providers should train by reading the CPT Manual (see additional training resources at conclusion of presentation) and by attending trainings such as these webinars:
 - http://www.thenationalcouncil.org/cs/cpt_codes
 - [http://www.aacap.org/cs/business_of_practice/reimbursement for practitioners](http://www.aacap.org/cs/business_of_practice/reimbursement_for_practitioners)
 - <http://www.apaeducation.org/ihtml/application/student/interface.apa/index.htm>

outpatient/OFFICE PSYCHIATRIC PROGRESS NOTE
COUNSELING AND/OR COORDINATION OF CARE

client's Name: _____ Date of Visit: _____

Interval History: _____

Interval Psychiatric Assessment/ Mental Status Examination:

Current Diagnosis: _____

Diagnosis Update: _____

Current Medication(s)/Medication Change(s) – No side effects or adverse reactions noted or reported

Lab Tests: Ordered Reviewed : _____

Counseling Provided with client / Family / Caregiver (circle as appropriate and circle each counseling topic

Discussed and describe below:

Diagnostic results/impressions and/or recommended studies Risks and benefits of treatment options
Instruction for management/treatment and/or follow-up Importance of compliance with chosen treatment options
Risk Factor Reduction client/Family/Caregiver Education Prognosis

Coordination of care provided (with client present) with (circle all appropriate and describe below):

Coordination with: Nursing Residential Staff Social Work Physician/s Family Caregiver

Additional Documentation (if needed): _____

Duration of face to face visit w/client: _____ min. Start Time _____ Stop Time _____ CPT Code _____

Greater than 50% of face to face time spent providing counseling and/or coordination of care:

Psychiatrist's Signature: _____ Date: _____

Choosing the Individual Psychotherapy (including add-on's) and Crisis Procedure Codes Based on Actual Time Spent in Session

- See actual time (f-f or client contact time) to select code below.
- A unit of time is attained when the mid-point of the time period is passed.
- **Always bill exact number of minutes.**

Procedure Code: Therapy	CPT Code	Typical Time Period (minutes)	Actual/F-F Time (minutes)
441/+465	90832/+90833	30	16-37
442/+467	90834/+90836	45	38-52
443/+468	90837/+90838	60	53-beyond
377	90839	60	1-75
+378	+90840	+30	16-45

Claiming for Services in Clinician's Gateway EHR:

- Established client seen for 12" and documentation time was 5".
Total Time = 17"
- Choose code based on face-to-face time (or contact time for phonework).
 - 643-99212 E/M Est OP Prob Focus 10 min (8-12")
- Enter actual face-to-face time into "Primary Face Time" field:
 - 12"
- Then enter Total Time into "Primary Clinician Time" field:
 - 17"

Warning: It is imperative that you select the code based on the face-to-face time & not the total time or Medicare will consider it fraudulent.

Claiming for Services for Direct Entry Into InSyst:

- Established client seen for 12" and documentation time was 5".
Total Time = 17"
- Choose code based on face-to-face time (or contact time for phonework).
 - 643-99212 E/M Est OP Prob Focus 10 min (8-12")
- Enter Total Time:
 - 17"

Warning: It is imperative that you select the code based on the face-to-face time & not the total time or Medicare will consider it fraudulent.

Add-On Codes (+)

Add-On (+) codes describe additional services provided within a service. They are added to select, primary codes and demonstrate an enhanced service.

- *Added time increments (crisis therapy—aka intervention)*
- *Added service (interactive complexity and individual psychotherapy add-on)*
- *Add-on (+) codes are never used as stand alone codes*
- *Add-on codes are designated by a + sign*

Note: In addition to Medicare, other Private Insurance Carriers may use these codes. Therefore, ALL clinicians need to code according to the service they are providing, not to the insurance of the client.

Add-On Codes:

- Additional Time Spent: for Crisis Therapy—concept in general.
 - 377-90839 is used for the first 30-75”
 - 378-90840 is used for each additional 16-45”
 - When you go beyond a 377 and use a 378--the 377 is indicated as 60” and the balance moves down to 378.
 - If an additional 378 is needed the earlier 378 indicates 30” and the balance moves down to the next 378.
 - The final 378 includes the actual remaining minutes of f-f time.

Crisis Code 377-90839 (Used Alone)

- **InSyst**
 - Crisis service lasting 45" f-f, 15" doc/travel
 - Based on f-f time choose code 377-90839 (30-75")
 - Enter 60" (45" f-f + 15" doc/travel)
- **Clinician's Gateway**
 - Crisis service lasting 45" f-f, 15" doc/travel
 - Use code 377-90839 for the 45" f-f time.
 - Enter 45" into "Primary f-f Time"
 - Enter Total Time of 60" (1:00) (45" f-f + 15" doc/travel) into "Primary Clinician Time"
 - See screen shot
- **For < 30 minutes can not use Crisis Code (if appropriate use and chart to a different code, e.g. individual psychotherapy, E/M, etc.)**

CRISIS THERAPY FACE TO FACE TIME = 45" (:45)

DOC/TRAVEL TIME = 15" (:15)

TOTAL TIME = 60" (1:00)

Service Entry, Individual

Welcome: R. ANTHONY SANDERS-PFEIFER

Service #: New Title: Clinician's Progress Note

Client: 75087772 LAST FIRST CINDYTWO

Procedures: 371 Crisis Intervention

Service Location: Select Location Emergency? Pregnant?

Primary Clinician: 14219 - SANDERS-PFEIFER, R. ANTHONY Provider: 9999CG - CLINICIAN GATEWAY TEST MHS AD Primary Clinician Time: 1:00

E/M Plus Psychotherapy or Additional Crisis: None

Interactive Complexity: Not Present

Allergies

☐ YES ☒ NO NEW ALLERGIES REPORTED ☐ NO ☐ UNKNOWN

peanuts from adult assessment [10/26/2012: Peterson, Camille E]
dust mites from child assessment [10/26/2012: Peterson, Camille E]
shellfish from phys assessment [10/25/2012: Peterson, Camille E]

Instructions

Respond to problems/goals/objectives of treatment plan and signs and symptoms related to diagnosis. Include treatment interventions and address changes in the client's functioning. If there is little progress, include an explanation of the limited progress.

Primary FF Time 0:45 Hours:Minutes

Services were provided in English by ☐ interpreter or ☐ clinician

Axis I 296.44 Axis II 799.9 Axis III 305.80 Axis IV J Axis V 000

Presenting Problem(s)

Previous Entries: (Select Note)

Crisis Code 377-90839 + 378-90840

- **InSyst**

- Crisis service: 115" F-F Time + 60" Travel/Doc Time = 175" Total Time
 - Select Code 377-90839 for the 1st 60" = 60" duration time
 - Select Code 378-90840 for next 30" = 30" duration time
 - Select Code 378-90840 for the add'l 25" = 85" duration time
 - Includes 25" F-F time + 60" Travel/Doc time
- In paper chart, indicate:
 - "377-90839, +378-90840, +378-90840. F-F = 115", Total Time = 175"
 - OK to also indicate documentation and travel time.

- **Clinician's Gateway:**

- Crisis service: 115" (1:55) F-F Time + 60" (1:00) Travel/Doc Time = 175" (2:55) Total Time
 - Select code 377-90839 and enter 60" (1:00) in "Primary FF Time" & 60" (1:00) into "Primary Clinician Time"
 - Select code 378-90840 and enter= 55 "in "Secondary FF Time" & 115 (1:55) into "Secondary Total Time" (55" remaining f-f + 60" doc/travel time).
 - *See Screen Shot*

CRISIS THERAPY FACE TO FACE TIME = 76" (1:55)
DOC/TRAVEL TIME = 60" (1:00) TOTAL TIME = 175" (2:55)

Service Entry, Individual

Welcome: R. ANTHONY SANDERS-PFEIFER

Service #: New Title: Clinician's Progress Note

Client: 75087772 TEST CINDYTWO

Procedures: 371 Crisis Intervention

Service Date: 3/12/2013

Utilization review date: 4/7/2007

Client Plan due date: 11/26/2010

Primary Clinician: 14219 - SANDERS-PFEIFER, R. ANTHONY

Provider: 9999CG - CLINICIAN GATEWAY TEST MHS AD

Primary Clinician Time: 1:00

2nd FF Time: 0:55

2nd Tot Time:

1:55

Interactive Complexity: Not Present

Allergies

YES NO UNKNOWN

peanuts from adult assessment [10/26/2012: Peterson, Camille E]
dust mites from child assessment [10/26/2012: Peterson, Camille E]
shellfish from phys assessment [10/25/2012: Peterson, Camille E]

Instructions

Respond to problems/goals/objectives of treatment plan and signs and symptoms related to diagnosis. Include treatment interventions and address changes in the client's functioning. If there is little progress, include an explanation of the limited progress.

Primary FF Time 1:00

Hours:Minutes

Services were provided in English

by interpreter or clinician

Episode Diagnosis Information

Axis I	Axis II	Axis III	Axis IV	Axis V
296.44	799.9	305.80	J	000

Presenting Problem(s)

Previous Entries: (Select Note)

Add-On Code for Additional Service Provided: **Interactive Complexity**

Refers to specific communication factors *during* a visit that complicate delivery of the primary psychiatric procedure:

- **Typical clients:**
 - Have others legally responsible for their care, such as minors or adults with guardians
 - Request others to be involved in their care during the visit
 - Require the involvement of other third parties, such as child welfare agencies, parole or probation officers, or schools

Add-On Code for Additional Service Provided: **Interactive Complexity cont.**

4 specific communication factors *during* a visit that complicate delivery of the primary psychiatric procedure:

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.
- Vignette (reported with 90834, Psychotherapy 45 min)
 - *Psychotherapy for an older elementary school-aged child accompanied by divorced parents, reporting declining grades, temper outbursts, and bedtime difficulties. Parents are extremely anxious and repeatedly ask questions about the treatment process. Each parent continually challenges the other's observations of the client.*

Add-On Code for Additional Service Provided: **Interactive Complexity cont.**

4 specific communication factors *during* a visit that complicate delivery of the primary psychiatric procedure:

2. Caregiver emotions or behaviors that interfere with implementation of the treatment plan
- Vignette (reported with 90832, psychotherapy 30 min)
 - *Psychotherapy for young elementary school-aged child. During the parent portion of the visit, mother has difficulty refocusing from verbalizing her own job stress to grasp the recommended behavioral interventions for her child.*

Add-On Code for Additional Service Provided: **Interactive Complexity cont.**

4 specific communication factors *during* a visit that complicate delivery of the primary psychiatric procedure:

3. Evidence or disclosure of a Sentinel Event and mandated reporting to a 3rd party (e.g., abuse or neglect with report to state agency) *with* initiation of discussion of the sentinel event and/or report with client and other visit participants
- Vignette (reported with 90792, psychiatric diagnostic evaluation with medical services)
 - *In the process of an evaluation, adolescent reports several episodes of sexual molestation by her older brother. The allegations are discussed with parents and report is made to state agency.*

Add-On Code for Additional Service Provided: **Interactive Complexity** cont.

4 specific communication factors *during* a visit that complicate delivery of the primary psychiatric procedure:

4. Use of play equipment, physical devices, ~~interpreter or translator~~ ** to overcome barriers to diagnostic or therapeutic interaction with a client 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.
 - Vignette (reported with 90853, group psychotherapy)
 - *Group psychotherapy for a young child who requires play equipment to participate in the group therapeutic interaction*

****Per CMS, 491 should not be used to bill *solely* for translation or interpretation services as that may be a violation of federal statute.**

Add-On (+) Procedure Code for Interactive Complexity (491) + 90785

Can only be used with these codes:

- **323-90791 & 565-90792 Psychiatric Diagnostic Eval.**
- **441-90832, 442-90834, 443-90837 Psychotherapy**
- **E/M+465-90833, E/M+467-90836, E/M+468-90838 E/M with + Psychotherapy add-on**
- **456-90853 Group Psychotherapy**

Cannot be used with Crisis Therapy, Family Therapy, or with other E/M codes when no psychotherapy was provided.

Interactive Complexity (+) 491-90785 Add-on in InSyst & CG

- Select primary procedure code and indicate minutes (into InSyst or Clinician's Gateway) as previously described.
- Select Interactive Complexity Add-on Code (no associated minutes).
 - InSyst, Select code 491-90785 and enter one (1) minute
 - Clinician's Gateway, Select "Interactive Complexity: Present"

Interactive Compl Add-on (+) in CG

http://cg/CG/serviceentry/IndivSvcEdit.aspx?SERVICE_NUMBEI Clinician's Gateway ... x

File Edit View Favorites Tools Help

x Google Search Share More » Sign In

ALCOWEB Administration 2000 Emb... Clinician's Gateway versio... Breach Notification Rule Department of Mental He...

Welcome: **Kyree Klimist** Home Help Log Out

Service #: 1267229 Title: Clinician's Progress Note

Client: Number: Unknown Last Name: test1 First Name: [X] [...]

Procedures: 442 90834 Psychotherapy 45 min Service Date: 1/30/2013 [12] [PM]

Utilization review date: Client Plan due date: Med. Compliant: N/A Side Effects: N/A

Primary Clinician: 7636 - Klimist, Kyree Provider: Select Provider Primary Clinician Time: 0:45

E/M Plus Psychotherapy or Additional Crisis: None Time: Interactive Complexity:

90785 Present

Allergies

☐ YES **NKA** ☒ NO ☐ UNKNOWN

☐ NO NEW ALLERGIES REPORTED

Instructions

Respond to problems/goals/objectives of treatment plan and signs and symptoms related to diagnosis. Include treatment interventions and address changes in the client's functioning. If there is little progress, include an explanation of the limited progress.

Face To Face Time: 0:40 Hours:Minutes Services were provided in: English

by ☐ interpreter ☐ or ☐ clinician

Episode Diagnosis Information

Axis I Axis II Axis III Axis IV Axis V

Presenting Problem(s) Previous Entries: (Select Note)

Documenting Add-On (+) Codes

- Medicare/CMS requires that add-on (+) codes are indicated in the chart note.
- When documenting for an add-on (+) code, be sure that the note content reflects the service and/or time frame of the add-on (+).

Medication Support: RN/LVN only (Not an add-on)

369-Meds Management by RN/LVN/PT Only

This procedure code was developed for RN's and LVN's who provide medication management but who can not bill Medicare. Medi-Cal billable only.

- This code should be used when doing medication injections and providing medication support.
- The expectation is that time spent would be 15-30 minutes. *If service is provided beyond 30 minutes, the documentation must emphasize the need for that level of service.*

Medication Support: Medical Providers (MD, DO, NP, PA, CNS) **(Not an add-on)**

- This procedure code was developed for non face-to-face, and therefore non billable to Medicare, Medication Services
 - 367—Medication Training and Support
 - Used ONLY for Non face-to-face services

Elimination of AB3632 procedure codes

- *All AB3632 procedure codes (except Day Tx/Rehab codes) have been eliminated beginning with January 2013 dates of service.*
- *AB 3632/ERHMS now uses the same codes as non-AB3632/ERHMS (except Day Tx codes).*
- All children in the ERMHS program must be identified in the ERMHS database maintained by BHCS Children's Specialized Services.

Contact Us:

- For questions on coding, please contact Quality Assurance at (510)567- 8105.
- If you feel that you are missing a procedure code that should be included in your RU (per contract), please call Provider Relations at (800) 878-1313.
- For Clinicians Gateway questions, please contact IS at (510)567-8181.
- *For questions regarding your agency contract, please contact the Network Office at (510) 567-8296*

Resources:

- *CPT Handbook for Psychiatrists*, American Psychiatric Press Inc., Third Edition, 2004
- American Psychiatric Association: <http://www.psych.org>
- American Academy of Child & Adolescent Psychiatrists: www.aacap.org
- 1997 Documentation Guidelines for Evaluation and Management Services <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf>
- Center for Medicare and Medicaid Services (CMS) <http://www.cms.gov/Medicare/Medicare.html?redirect=/home/medicare.asp>

Resources continued:

- AMA Code Book www.amabookstore.com or 1-800-621-8335
- National Council webpage dedicated to the CPT changes with resources such as:
 - 2012-2013 Crosswalk
 - Frequently Asked Questions
 - Free training resources
- *Compliance Watch*, new CPT series
 - www.TheNationalCouncil.org/CS/Compliance_Watch_Newsletter

SECTION 1: COUNSELING AND COORDINATION OF CARE

Click links below:

1. CPT E/M CODES: NEW CODING OPTIONS
2. PROGRESS NOTE TEMPLATES
3. INTERACTIVE COMPLEXITY
4. CPT CODE CHANGES FAQ
- 5.INSYST MASTER CODE SHEET
6. CPT CODE CROSSWALK
7. CLINICIAN'S GATEWAY USERS CPT GUIDE
8. SCOPE OF PRACTICE GUIDELINES

CPT E/M Codes: New Coding Options for Psychiatrists

INTRODUCTION

This memorandum will focus on the impact of significant enhancements announced by CMS in June, 2006, to the Work Relative Value Units assigned to certain CPT[®] Evaluation & Management Codes (99xxx)¹ effective January 1, 2007. These enhanced Evaluation & Management codes will have substantially higher Medicare reimbursement than comparable psychiatry codes. Psychiatrists can use these enhanced Evaluation & Management codes for Medicare services provided in office and in hospital instead of psychiatry codes. Use of these enhanced Evaluation & Management codes requires familiarity with CPT[®] coding and documentation requirements and the special rules regarding providing counseling and/or coordination of care as the primary Evaluation & Management service.

BACKGROUND

The changes in the Work RVU resulted from recommendations from the AMA Relative Value Update Committee (RUC). The RUC recommended and CMS approved increases in 35 E&M codes. Of potential importance to psychiatrists are the increases to RVUs for the following E/M services:

- | | |
|------------------------|--|
| • 99205 | Office visit for a new patient |
| • 99213, 99214 & 99215 | Office visit for an established patient |
| • 99222, 99223 | Initial Hospital Care |
| • 99232 & 99233 | Hospital visits for established patients |
| • 99243, 99244 & 99245 | Office consultations |
| • 99253, 99254 & 99255 | Initial inpatient consultation |

These proposed increases in the RVUs for these codes are significant for psychiatry for the following reasons:

- these E/M codes in 2007 will have significantly higher RVU values and, therefore, higher Medicare reimbursement than certain key psychiatric codes - 90805, 90807, 90817, 90819 and 90862
- these E/M codes with higher reimbursement may be an appropriate alternative coding option for psychiatrists when properly documented
- these E/M codes may also be used when billing health plans other than Medicare.

¹ CPT 2007, American Medical Association 2006. CPT[®] is published annually by the AMA. CPT 2007 can be purchased from AMA at www.amapress.com or by calling 1-800-621-8335

Because of the statutory requirement for budget neutrality, CMS implemented a 10% reduction in the Work RVU for all 7,700 CPT[®] codes to offset the proposed reimbursement increases in Medicare payments for the targeted E/M codes. This RVU reduction was imposed on all psychiatric codes – none of which received an RVU enhancement. CMS is also phasing in an adjustment in the Practice Expense RVU which will also adversely affect psychiatric codes. Finally, although Congress did take action to prevent a 5% reduction in the Medicare Conversion Factor (a result of problems in the statutory algorithm used to determine the annual update), Congress merely rolled the 2006 conversion factor forward for 2007 with no cost-of-living adjustment.

IMPACT OF THE E/M RVU ENHANCEMENTS AND THE REDUCTIONS IN THE PSYCHIATRIC FEES

Psychiatric fees in 2007 will drop in all settings – by an average of 9% for inpatient and outpatient hospital services and by an average of 6% for office visits. The key E/M management codes targeted for enhanced Work RVUs will increase in all settings by as much as 12%. A review of the fee schedules that follow this memorandum will demonstrate why psychiatrists may wish to consider a change in coding for Medicare services.

The substantial decreases in Medicare reimbursement for every psychiatric code (908xx) and the substantial increases in key office and hospital E/M will have the same impact whether a psychiatrist is participating or non-participating in Medicare and will impact the Medicare limiting charge to the same degree.

WHEN IS IT APPROPRIATE TO USE THESE E/M CODES INSTEAD OF THE 908xx CODES?

Normally, under CPT[®], in order to bill for each successive higher level E&M code in a specific series (e.g., office visit for an established patient 99211-99215), a physician must document that the higher level of service in question involved a higher level of history obtained, examination performed, and the complexity of medical decision-making. The time values assigned to E/M codes in CPT[®] are included only as a guidance, but never as the basis for selecting the proper level of E/M code for billing purposes.

However, there is one exception where the level of E/M code for billing purposes is determined solely by the duration of the service provided and without regard to the intensity or complexity of the patient's psychiatric problem:

“When counseling and/or coordination of care dominates (more than 50%) the physician/patient and/or family encounter (face-to-face in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), the time may be considered the key or controlling factor to quality for a

particular level of E/M services. This includes time spent with parties who have assumed responsibility for the care of the patient or decision making whether or not they are family members (e.g., foster parents, person acting locum parentis, legal guardian). The extent of counseling and/or coordination of care must be documented in the medical record.”

Thus, if a psychiatrist provides counseling and/or coordination and medical management and more than 50% of the time spent was counseling and/or coordination of care, then in that case, the total time spent with patient is the sole controlling factor for selecting the proper E/M code.

A few examples:

- If a psychiatrist spends 45 minutes in the office providing counseling, mental status assessment and medication management and the counseling portion of the visit was at least 22½ minutes, then a psychiatrist may properly code the visit as a 99215.
- In the above example, if the total time was 25 minutes with more than 50% counseling, then the visit may be coded as a 99214.
- If a psychiatrist sees a patient in the hospital, provides counseling to the patient, mental status evaluation, medication evaluation, and coordination of care with a nurse and a family member, attends a treatment team meeting and the total floor and patient face-to-face time was 25 minutes of which more than 50% was counseling and/or coordination of care, then a psychiatrist may properly code the visit as a 99232.
- In the above example, if the total floor time (face-to-face patient time plus time spent on floor with staff, other physicians, treatment team, social worker, patient’s family) was 35 minutes with more than 50% counseling, then the visit may be coded as 99233.

WHAT IS COUNSELING FOR PURPOSES OF E/M CODES?

CPT[®] defines counseling as follows:

Counseling is a discussion with a patient and/or family concerning one or more of the following areas:

- *Diagnostic results, impressions, and/or recommended diagnostic studies*
- *Prognosis*
- *Risks and benefits of management (treatment) options*
- *Instructions for management (treatment) and/or follow-up*
- *Importance of compliance with chosen management (treatment) options*

- *Risk factor reduction*
- *Patient and family education*

Although CPT[®] considers “counseling” as separate and distinct from psychotherapy, psychiatrists typically include counseling (as defined in CPT[®]) as part of their regular treatment – especially with patients in the hospital, but also in their offices and in the outpatient clinic. Many of the components of supportive psychotherapy may be considered as overlapping with counseling. In *Introduction to Supportive Psychotherapy* part of the *Core Competencies in Psychotherapy Series* published by the American Psychiatric Press, Inc., the authors define supportive psychotherapy from the perspective of both the therapist’s objectives and the patient’s goals:

“ . . . the therapist’s objectives – to maintain or improve the patient’s self-esteem, to minimize or prevent recurrence of symptoms, and to maximize the patient’s adaptive capacities . . . the patient’s goals – to maintain or reestablish the best-possible level of functioning given the limitations of his or her personality, native ability, and life circumstances . . . ”²

Again, these components and elements of supportive psychotherapy closely track the elements of “counseling” offered in the CPT[®]³.

CPT[®] Elements of Counseling

Corresponding Elements of Supportive Psychotherapy

Diagnostic results, impressions, and/or recommended diagnostic studies	→	Advice and Teaching
Prognosis	→	Reassurance & Encouragement
Risks and benefits of management (treatment) options	→	Advice and teaching, Rationalizing and Reframing
Instructions for management (treatment) and/or follow-up	→	Anticipatory Guidance, Reducing and Preventing Anxiety Naming the Problem Advice and Teaching
Importance of compliance with chosen management (treatment) options	→	Expanding the Patient’s Awareness
Risk factor reduction	→	Naming the Problem Expanding the Patient’s Awareness Advice and Teaching

² Winston, A. Rosenthal, R & Pinsker, H., *Introduction to Supportive Psychotherapy*, American Psychiatric Press, Inc. 2004, p. 1

³ The author extends his appreciation to Richard N. Rosenthal, M.D., one of the co-authors of *Introduction to Supportive Psychotherapy* for his assistance in reviewing and revising this chart.

Patient and family education



Praise,
Encouragement,
Advice and Teaching,
Naming the Problem

Of course, the above chart merely demonstrates some aspects of the correlation between supportive psychotherapy and counseling. Documentation of the counseling component of the evaluation and management services can appropriately focus on these components and elements of supportive psychotherapy that track as counseling.

WHAT IS COORDINATION OF CARE FOR PURPOSES OF E/M CODES?

There is no explicit definition or elaboration of coordination of care in CPT[®]. However, coordination of care would typically include interactions with family members, other physicians treating the patient, hospital staff including social worker, nurses, treatment team. The focus of coordination of care is typically management of patient's non-psychiatric medical problems, discharge planning, interaction with family members. Obviously, coordination of care occurs primarily in an inpatient setting. For office services, coordination of care typically includes collaboration with social service agencies, case managers, family members, assistance with SSI, SSDI benefit issues, insurance carriers. However, for office services, coordination of care must be provided during the patient face-to-face time in order to count towards the E/M time requirement. On the other hand, for inpatient services, coordination of care is part of floor time and care can be provided without the patient being present and still counts toward the E/M time requirement.

PROPER DOCUMENTATION WHEN CODING AN E/M SERVICE BASED UPON COUNSELING AND/OR COORDINATION OF CARE

The key to using E/M codes by a psychiatrist is proper documentation. When a psychiatrist selects an E/M code based upon counseling and/or coordination of care, the session note must include the following:

- a statement of the total time spent during the visit, e.g., "Total time: 25 minutes" (face-to-face with patient for office, outpatient and floor time & patient time for hospital)
- a statement that "More than 50% of the visit included counseling and/or coordination of care."
- documentation of the specific nature of the counseling and/or coordination of care
- documentation of medical/medication management both in office and in hospital.

Thus, documentation of an inpatient visit based upon counseling and/or coordination of care would typically include the following elements: interval history, interval mental status, medication management, counseling, coordination of care and a clear statement that “counseling and Coordination of care >50% of total floor/patient time of 25 minutes” for a 99232 inpatient visit. Documentation of an office or outpatient department visit would typically contain documentation of the same elements, but with the following statement: counseling and coordination of care >50% of total of 40 minutes spent with patient for a 99215 office visit. The Medicare Primer posted on the NYSPA website includes sample vignettes and session notes illustrating circumstances when coding of an E/M service based upon counseling and/or coordination of care would be appropriate.

The NYSPA website includes documentation templates for both inpatient and outpatient E/M services when billing for counseling and coordination of care as the predominant service and instructions for using the templates (E/M Visit Template – Inpatient Psych Note, E/M Template – Outpatient Psych Note, and E/M Template Guidelines).

USING E/M CODES INSTEAD OF CODE 90801

A review of the 2007 fee schedule reveals drastic reductions in code 90801 (initial diagnostic interview) in all settings. Psychiatrists may wish to consider using E/M codes in lieu of 90801. In an inpatient unit, the E/M codes for the highest level of initial hospital care (99223) have significantly higher reimbursement than 90801 (34% higher). However, use of 99223 requires documentation of a comprehensive history, comprehensive examination and medical decision making of high complexity. Total patient-bedside and floor time will average 70 minutes.

Similarly, consideration could be given to using 99205 in an outpatient department or an office instead of 90801. 99205 has the same documentation requirements as 99223 (i.e., comprehensive history, comprehensive examination and medical decision making of high complexity), but averages 60 minutes patient/family face-to-face time.

USING CONSULTATION CODES INSTEAD OF CODE 90801

Consultation codes may not be freely substituted for a 90801. CMS has recently re-confirmed that consultation codes can only be used in response to a specific request from another treating provider and requires a written report to the requesting provider. In the case of group practices or shared medical records (e.g., inpatient chart) a written entry in the patient's chart is sufficient. A consultation code may not be used for a patient-initiated consultation or when the patient is merely referred by another provider for evaluation and possible treatment, but the referring provider does not request a consultation report. A formal consultation may be followed by treatment without affecting the status of the consultation. Traditional E/M documentation is required for all

consultation codes (e.g., comprehensive history, comprehensive examination and medical decision making of high complexity for the highest level consultation code).

CONCLUSION

The appropriate use of E&M codes instead of the psychiatric codes (908xx) may be an important option for psychiatrists to consider when treating patients covered under the Medicare program. Medicare reimbursement changes effective in 2007 offer psychiatrists the opportunity to enhance reimbursement by switching from psychiatric codes to E&M codes when clinically justified and with appropriate documentation.

Dated: January 16, 2008

Prepared by Seth P. Stein

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HOW TO USE THE TEMPLATES FOR PROGRESS NOTES FOR E/M CODES FOR COUNSELING AND/OR COORDINATION OF CARE

Each template includes the essential documentation required to be included in an inpatient and outpatient progress note when providing an E/M service when the primary service (more than 50% of the service time as defined below) involves counseling and/or coordination of care.

Please note that E/M codes and these templates should never be used when psychotherapy is provided. When psychotherapy is provided, the 908xx psychotherapy codes must be used.

When billing for an E/M service based upon counseling and/or coordination of care, it is imperative that the counseling and/or coordination of care be documented as follows:

- The actual duration of the service time must be included in the progress note. The templates include a specific section to enter the total time.
- For outpatient visits, only face to face time with the patient providing counseling and/or coordination of care constitutes the service time.
- For inpatient visits, the service time includes both face to face patient time and floor time providing counseling and/or coordination of care.
- In addition, a statement must be included in the progress note that: “Greater than 50% of patient face to time spent providing counseling and/or coordination of care” (for outpatient services) or “Greater than 50% of patient time and floor time spent providing counseling and/or coordination of care” (for inpatient services).
- The templates include a statement to be checked off confirming compliance with this requirement.
- The templates also include a place to insert the CPT code selected for the service provided.

The elements of the templates include:

Interval History: Include documentation of new history since last visit.

Interval Psychiatric Assessment/Mental Status Examination: Update mental status of patient and psychiatric assessment

Current Diagnosis: Note the current diagnoses.

Diagnosis Update: Note any changes in diagnosis after visit.

Current Medication(s)/Medication Update: Update medication and note any changes. A box is included to permit a check off to indicate that no side affects or adverse reactions were noted by the psychiatrist or reported by the patient. If there are side affects or adverse reactions noted or reported, include documentation.

Counseling Provided: Circle whether counseling was provided to patient, family and/or caregivers. Check off one or more focuses of counseling and include specific documentation of counseling topics that were checked off.

Coordination of Care Provided: Check off one or more individuals with whom coordination of care was provided and then include documentation of specific coordination of care activities checked off.

Duration: Insert total session time in minutes. Remember that for outpatient services, only face to face time with the patient may be counted for the total session time, but for inpatient services, the session time include both face to face time with the patient and floor time providing counseling and/or coordination of care.

CPT Code: Insert CPT code selected for service provided.

Greater than 50%: Check off when counseling and/or coordination of care exceeded 50% of total session time: patient face to face time for outpatient services and floor time plus patient face to face time for inpatient services) involves counseling and/or coordination of care.

Justification for Continued Stay: This section is only included in the inpatient note and is intended to comply with the requirements of the NYS Medicaid Program to document medical necessity for continued inpatient psychiatric hospitalization. Check off the appropriate justification/s for the continued stay and include specific documentation in the progress note (use the **Additional Documentation** section) for the justification/s selected. (NYSPA extends appreciation to Barry Perlman, M.D., St. Joseph's Hospital, Yonkers, New York, for this element of the inpatient progress note template.)

Prepared by: Seth P. Stein, Esq., NYSPA Executive Director and General Counsel
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**OUTPATIENT/OFFICE PSYCHIATRIC PROGRESS NOTE
COUNSELING AND/OR COORDINATION OF CARE**

Patient's Name: _____ **Date of Visit:** _____

Interval History: _____

Interval Psychiatric Assessment/ Mental Status Examination:

Current Diagnosis: _____

Diagnosis Update: _____

Current Medication(s)/Medication Change(s) – No side effects or adverse reactions noted or reported ☐

Lab Tests: Ordered ☐ Reviewed ☐ : _____

Counseling Provided with Patient / Family / Caregiver (circle as appropriate and check off each counseling topic discussed and describe below:

- | | | |
|--|---|------------------------------------|
| ☐ Diagnostic results/impressions and/or recommended studies | ☐ Risks and benefits of treatment options | |
| ☐ Instruction for management/treatment and/or follow-up options | ☐ Importance of compliance with chosen treatment | |
| ☐ Risk Factor Reduction | ☐ Patient/Family/Caregiver Education | ☐ Prognosis |
-
- _____
-
- _____
-
- _____
-
- _____

Coordination of care provided (with patient present) with (check off as appropriate and describe below):

Coordination with: ☐ Nursing ☐ Residential Staff ☐ Social Work ☐ Physician/s ☐ Family ☐ Caregiver

Additional Documentation (if needed): _____

Duration of face to face visit w/patient : _____ **min.** **Start Time** _____ **Stop Time** _____ **CPT** _____

Greater than 50% of face to face time spent providing counseling and/or coordination of care: ☐

**INPATIENT PSYCHIATRIC PROGRESS NOTE
COUNSELING AND/OR COORDINATION OF CARE**

Patient's Name: _____ **Date of Visit:** _____

Interval History: _____

Interval Psychiatric Assessment/ Mental Status Examination: _____

Current Diagnosis: _____

Diagnosis Update: _____

Current Medication(s)/Medication Change(s) – No side effects or adverse reactions noted or reported ☐

Lab Tests: Ordered ☐ Reviewed ☐ : _____

Counseling Provided with Patient / Family / Caregiver (circle as appropriate and check off each counseling topic discussed and describe below:

☐ Diagnostic results/impressions and/or recommended studies

☐ Risks and benefits of treatment options

☐ Instruction for management/treatment and/or follow-up

☐ Importance of compliance with chosen treatment options

☐ Risk Factor Reduction

☐ Patient/Family/Caregiver Education

☐ Prognosis

Coordination of care provided with (check off as appropriate and describe below):

Coordination with: ☐ Nursing Staff ☐ Treatment Team ☐ Social Work ☐ Physician/s ☐ Family ☐ Caregiver

Additional Documentation (if needed): _____

Duration of face to face visit with patient and floor time (in minutes): _____ **CPT Code** _____

Greater than 50% of patient time and floor time spent providing counseling and/or coordination of care: ☐

Justification for Continued Stay (record must include documentation to support justification for continued stay):

☐ A. Continued danger to self and/or others.

☐ B. Continued behavior intolerable to patient or society.

☐ C. High probability of A or B recurring if patient were to be discharged, and imminent re-hospitalization likely.

☐ D. Recovery depends on use of modality, but patient unwilling or unable to cooperate.

☐ E. Major change of clinical conditions required extended treatment.

☐ F. Has a general medical condition (other than mental disorder) requiring hospital care and due to psychological aspects, patient cannot be managed as well on non-psychiatric unit.

☐ ALC



Interactive Complexity

Revised 11/3/12

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, 90847, 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

CPT CODE 1/1/13 CHANGES

FAQ

Q: Our agency often does both a MH Assessment and a Medication Assessment on the same day for our clients. May we bill for both a 323-90791 *Psychiatric Diagnostic Evaluation* and a 565-90792 *Psychiatric Diagnostic Evaluation with a Medical Component* on the same day by different providers?

A: Yes

Q: Our agency sometimes does a MH Assessment with the client and the family of the client separately on the same day by the same provider. May we bill either 323-90791 or 565-90792 twice in the same day by the same provider?

A: Yes, but only if different “informants” (such as client and family member) are seen in each Psychiatric Diagnostic Evaluation. They must be seen separately and documented as such.

Q: Clinician’s Gateway will no longer accept “0” minutes in the face-to-face fields for some codes. Are we now unable to bill for phone services?

A: Yes, you may bill. For now, when providing MH Services on the telephone—enter the number of contact minutes into the face-to-face fields. Also, be sure to indicate “telephone” in the “location” field so that only Medi-Cal is billed.

A: Do we use code 323-90791 (Psychiatric Diagnostic Evaluation) when we complete the Community Functioning Evaluation?

A: No, use code 324-96151 (Behavioral Evaluation). One advantage to this code is that all disciplines (with appropriate training and experience) may gather the Community Functioning Evaluation (or approved equivalent form) data.

Q: Now, that Medicare requires that the choice of many billing codes (those with time frames, min-max) be done on the basis of face-to-face time, can we bill for work done exclusively on the phone (e.g. crisis, therapy, etc.)?

A: Yes, the choice of the code would then be based on the *client contact time* and you would select the location code “telephone”. Such claims will bypass Medicare and bill directly to Medi-Cal.

Q: Medical Providers (MD, DO, NP, PA, CNS) claim medication services on codes that require face-to-face time, how do they bill for medication support on the phone?

A: Medical Providers (MD, DO, NP, PA, CNS) use a specific County Code of 367 for non-face-to-face medication training and support.

A: For RN/LVN see below.

Q: RN and LVN’s cannot bill Medicare, how do they bill for medication support?

A: RN/LVN's use a County Code 369 for medication support. It may be face-to-face (f-f) or non- f-f.

Q: Some CPT codes now require a minimum amount of client f-f time, are we unable to bill for those services if our f-f time is below the minimum required?

A: You may not use a CPT code in which the f-f time does not meet the minimum required by the CPT manual (i.e. a minimum of 16" for Individual Psychotherapy). However, if there is another appropriate code (that the service meets) you may claim and chart to that service.

Q: The Crisis Intervention code has been eliminated and replaced with Crisis Therapy (377-90839, 378+90840). We have MHRS and Adjunct staff who used to provide Crisis Intervention services but who are not allowed to do Psychotherapy, may they bill the new "therapy" code?

A: Yes, the definition of Crisis Intervention Services has not changed—only the Code Label. With the appropriate training and experience your staff may provide Crisis Intervention Services—now identified as Crisis Therapy.

Q: In Children's Services we used to use Code 319 for "Collateral Family Therapy". We now see code 413-90846 ("Family Psychotherapy without Patient Present") and code 449-90847 ("Family Psychotherapy with Patient Present") on the Master Code List. Which should we use?

A: Codes 413-90846 and 449-90847 have now been added to the Children's Programs' RU's. These are the codes to now use as they are more specific and map to an approved CPT code for billing purposes.

Q: The Interactive Complexity add-on code 491+90785 is used for 456-90853 Group Psychotherapy. Can it also be used for 455-90849 Multi-Family Group Psychotherapy and/or 391 Group Rehabilitation services?

A: No, the only group related code that the add-on code 491+90785 Interactive Complexity may be used with is code 406-90853 Group Psychotherapy.

Q: The Interactive Complexity add-on code 491+90785 is used for Individual Psychotherapy. Can it also be used for 413-90846 and/or 449-90847 Family Psychotherapy codes?

A: No, Interactive Complexity add-on code may not be used for Family Psychotherapy; however it may be used with Psychiatric Diagnostic Evaluation (323-90791, 565-90792), Group Psychotherapy (456-90853), Individual Psychotherapy (441-90832, 442-90834, 443-90837), and the Individual Psychotherapy add-on codes (465+90833, 467+90836, 468+90838).

Q: May Interactive Complexity 491+90785 be used with all E/M codes?

A: No, 491+90785 Interactive Complexity add-on code may only be used in conjunction with a Primary E/M code which also has a Psychotherapy add-on code (465+90833, 467+90836, 468+90838) associated with it.

Q: May we bill the Psychiatric Diagnostic Evaluation codes 323-90791, or 565-90792 without the client present?

A: Yes, you may review medical records, interview others involved in the client's care and still utilize these codes. If you interview the client on the phone—note that as the location code and you may bill these codes.

Q: How do I enter Interactivity Complexity 491+90785 for billing purposes?

A: In Clinician's Gateway select "present" in the Interactive Complexity Field.

A: For InSyst, select the 491+90785 code and enter one (1) minute for the duration of service as a placeholder.

Q: Clinician's Gateway does not allow me to select multiple 30" Crisis Therapy 378+90840 add-on codes. May we then only bill for the first 1 1/2 hours of crisis?

A: You may bill for the length of service provided, and Clinician's Gateway will bill the appropriate number of 30" Crisis Therapy Add-on's to the Insurer. However, when entering data into the database you total all of the f-f time beyond the first 60 minutes and enter those minutes in the "second f-f minutes" field for the add-on code.

Q: May we use the Psychiatric Diagnostic Evaluation codes 323-90791, or 565-90792, for re-assessment purposes?

A: Yes, these codes may be used for both Initial and re-assessments.

Q: If we provide an E/M service in the field, at school or at a home may we use the E/M codes 99211-99215 which indicate "Office or other outpatient visit"?

A: Yes, also select the appropriate "Location Code" when utilizing these E/M codes (e.g. telephone, field, school, home, etc.).

Q: Clinician's Gateway used to support Co-Staffing of a service. It no longer does for some procedures, may we bill for both of the staff's time?

A: Yes, if each provider writes a separate note and indicates what unique contribution each had, or why a second person was needed (e.g. safety). If "duplicate entry" is displayed, select the reason.

Q: The CPT manual indicates Interactive Complexity 491+90785, includes: "Use of play equipment, interpreter or translator to overcome barriers to diagnostic or therapeutic interaction". May we claim Interactive Complexity when we have an Interpreter present to overcome the language barriers to therapeutic interventions?

A: No, currently CMS has indicated that the Interactive Complexity code "...should not be used to bill solely for translation or interpretation services as that may be a violation of federal statute".

Q: The CPT manual indicates Interactive Complexity 491+90785, includes: "Use of play equipment, interpreter or translator to overcome barriers to diagnostic or therapeutic interaction". May we claim Interactive Complexity when we utilize play therapy equipment for the majority of the session (sand tray, etc.)?

A: Yes, the use of play equipment throughout the session allows you to claim for Interactive Complexity.

Q: May we choose the time bracketed (min-max) CPT Codes based on total time so that we may be reimbursed for transportation and documentation time as well as f-f time?

A: No, CPT Codes with time-frames (min-max) must be chosen only on the basis of f-f time (or contact time if done on the phone). However, you may claim for your time for transportation and documentation time as below. (Also, see examples, in the Power Point CPT Code Jan 2013 Changes Training.)

A: For Insyst:

- Choose the appropriate code based on the f-f time and then enter the Total Number of minutes (inclusive of documentation and travel time) even if the time exceeds that listed for the code. Do not choose a code which allows for more time. InSyst will claim to Medicare and Medi-Cal appropriately behind the scenes.
- If you have needed to choose Crisis Therapy or Psychotherapy add-on codes—add the documentation and travel time to the minutes for the last add-on code (but do not add an additional add-on code for those minutes).

A: For Clinician's Gateway

- Choose the appropriate code based on the f-f time and enter that time in the "Primary F-f Time field". In the "Primary Clinician Time" field, add the f-f time with the documentation and travel time and enter the Total Time.
- If add-on codes for Crisis Therapy or Psychotherapy are needed--do not add the documentation time and travel time to the "Primary Clinician Time" field (just enter Primary F-F time). After entering the remaining f-f time in the "2nd FF Time field"-- add the documentation and travel time to the add-on code's f-f time in the "Secondary Total Time Field". (Be sure to also indicate the remaining f-f time in the 2nd FF Time field).
- See examples, in the Power Point CPT Code Jan 2013 Changes Training.

Q: May we utilize the 690 Mobile Crisis Response Code?

A: No, this code is specific to the "Crisis Response Program's" RU only. As appropriate use the Crisis Therapy Codes: 377-90839 & 378+90840.

Q: May we utilize the “New Patient” E/M codes 545-9, 992(01-05)?

A: CBO’s may use these codes if they have not provided Psychiatric Services to the client in the past three years. Alternatively, they may use Psychiatric Diagnostic Evaluation 565-90792 (there is no 3 year limit). County Clinics must use the code Psychiatric Diagnostic Evaluation 565-90792. Any person qualified to use E/M can also use 99212-15 E/M codes.

Q: In a paper record (not Clinician’s Gateway note) how do we enter the minutes for crisis when there are multiple add-on codes, do we break them down per code?

A: You do need to indicate every add-on code, but then total the minutes (with f-f time broken out). For example: 128 minutes f-f time, 30 minutes documentation and 60 minutes travel time. Indicate as such:

In Chart:

377-90839,,378+90840, 378+90840

F-F 128”, Doc 30”, Travel 60”, Total 218”

In InSyst:

377-90839 60"

378+90840 30"

378+90840 128"

Q: May we utilize E/M codes that are not in our program’s RU such as SNF E/M codes?

A: No, programs may only provide those services authorized in their contract. Contact Provider Relations if you believe you are contracted for a procedure code that is not being accepted in InSyst.

Q: In Clinician’s Gateway I received an error statement “problem with form”, what does this indicate?

A: Hover your cursor over the red dot for more information. Call the IS help desk if you need additional assistance at 510-567(3)-8160.

Q: Where can I learn more about the 2013 CPT Psychotherapy/Psychiatric Services changes—especially utilizing the E/M Codes?

A: See below:

The National Council Resource Page:

- http://www.thenationalcouncil.org/cs/cpt_codes

The American Psychiatric Association Resource Page

- <http://www.psych.org/practice/managing-a-practice/cpt-changes-2013/current-procedural-terminology-cpt-code-changes-for-2013>

The AACAP

- http://www.aacap.org/cs/business_of_practice/reimbursement_for_practitioners

The American Psychological Association

- <http://www.apapracticecentral.org/reimbursement/billing/psychotherapy-codes.pdf>
- [http://www.apapracticecentral.org/reimbursement/billing/index.aspx?__utma=12968039.338271549.1342112804.1359501649.1361380803.10&__utmb=12968039.1.10.1361380803&__utmc=12968039&__utmz=12968039.1361380803.10.6.utmcsr=google|utmccn=\(organic\)|utmcmd=organic|utmctr=american psychological association cpt code changes&__utmv=-&__utmk=224931866](http://www.apapracticecentral.org/reimbursement/billing/index.aspx?__utma=12968039.338271549.1342112804.1359501649.1361380803.10&__utmb=12968039.1.10.1361380803&__utmc=12968039&__utmz=12968039.1361380803.10.6.utmcsr=google|utmccn=(organic)|utmcmd=organic|utmctr=american psychological association cpt code changes&__utmv=-&__utmk=224931866)

The AMA

- <http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt.page?>
- The AMA app: EM Quickref (android or apple)
- **AMA Webinar - Psychotherapy/Psychiatric Services: [CPT® 2013 Changes - Psychotherapy/Psychiatric Services](#)**. This one-hour program discusses the changes made in the Psychotherapy/Psychiatric Services coding section.

Alameda County Behavioral Health Care Services
CBO Procedure Code Table - Effective with January 2013 Dates of Service
REVISED 2-8-13

InSyst Proc Code	CPT Code Medicare/ Ins	HCPC CODE Medi-Cal		E/M	Face To Face	SFC	MD DO	Lic PhD	CNS NP PA	LCSW	MFT	Intern	RHB Coun	Unlic	Nurse
121		H2013	PHF Contract Day			20 - 29									
141		H0018	Crisis Residential Day			40 - 49									
165		H0019	Adult Residential Day			65 - 79									
221		S9484	Crisis Stabilization			20 - 24	X	X	X	X	X	X	X	X	X
281		H2012	Day Care Intens Half Day			81 - 84									
282		H2012	Day Care Intens AB3632 Half			81 - 84									
285		H2012	Day Care Intens Full Day			85 - 89									
286		H2012	Day Care Intens Full-AB3632			85 - 89									
291		H2012	Day Care Rehab Half Day			91									
292		H2012	Day Care Rehab Half-AB3632			91									
295		H2012	Day Care Rehab Full Day			95									
296		H2012	Day Care Rehab Full-AB3632			95									
571		T1017	Brokerage Services			01-08	X	X	X	X	X	X	X	X	X
581		H0032	Plan Development			30	X	X	X	X	X	X	X	X	X
323	90791	H2015	90791 Psychiatric Diag Eval (Init Assmnt)			30	X	X	X	X	X	X	X	X	X
565	90792	H2010	90792 Psych Diag Eval w/medical			60	X		X						
324	96151	H2015	96151 Behavioral Eval (CFE)			30	X	X	X	X	X	X	X	X	X
441	90832	H2015	90832 Psychotherapy 30 min		16-37	40	X	X	X	X	X	X	X	X	X
465	90833	H2010	90833 + PsyThpy with E/M 30 min	X	16-37	60	X		X						
442	90834	H2015	90834 Psychotherapy 45 min		38-52	40	X	X	X	X	X	X	X	X	X
467	90836	H2010	90836 + PsyThpy with E/M 45 min	X	38-52	60	X		X						
443	90837	H2015	90837 Psychotherapy 60 min		53 >	40	X	X	X	X	X	X	X	X	X
468	90838	H2010	90838 + PsyThpy with E/M 60 min	X	53 >	60	X		X						
545	99201*	H2010	99201 E/M NEW OFC SIMPLE 10 MIN	X	1-15	60	X		X						
546	99202*	H2010	99202 E/M NEW OFC EXP 20 MIN	X	16-25	60	X		X						
547	99203*	H2010	99203 E/M NEW OFC DETAIL 30 MIN	X	26-37	60	X		X						
548	99204*	H2010	99204 E/M NEW OFC COMPRE 45 MIN	X	38-52	60	X		X						
549	99205*	H2010	99205 E/M NEW OFC COMPLEX 60MIN	X	53 >	60	X		X						

Alameda County Behavioral Health Care Services
CBO Procedure Code Table - Effective with January 2013 Dates of Service
REVISED 2-8-13

InSyst Proc Code	CPT Code Medicare/ Ins	HCPC CODE Medi-Cal		E/M	Face To Face	SFC	MD DO	Lic PhD	CNS NP PA	LCSW	MFT	Intern	RHB Coun	Unlic	Nurse
641	99211	H2010	99211 E/M EST OP SIMPLE 5MIN	X	1-7	60	X		X						
643	99212	H2010	99212 E/M EST OP PROBFocus 10MIN	X	8-12	60	X		X						
644	99213	H2010	99213 E/M EST OP EXPANDED 15MIN	X	13-20	60	X		X						
645	99214	H2010	99214 E/M EST OP MOD COMPL 25M	X	21-32	60	X		X						
646	99215	H2010	99215 E/M EST OP HIGHCOMPL 40M	X	33 >	60	X		X						
381	H2017**	H2017	Individual Rehabilitation			40	X	X	X	X	X	X	X	X	X
391	H2017**	H2017	Group Rehabilitation			50	X	X	X	X	X	X	X	X	X
377	90839**	H2011	90839 Crisis Thpy 60 min		30-75	70	X	X	X	X	X	X			
378	90840**	H2011	90840 + Crisis Thpy ADD 30 min		16-45	70	X	X	X	X	X	X			
311		H2015	Collateral			10	X	X	X	X	X	X	X	X	X
318		H2015	Collateral Family Therapy			10	X	X	X	X	X	X	X	X	X
413	90846	H2015	90846 FAMILY PSYCH WO PATIENT			10	X	X	X	X	X	X			
449	90847	H2015	90847 FAMILY PSYCH W PATIENT			40	X	X	X	X	X	X			
455	90849	H2015	90849 MULTI FAMILY GRP PSYCH			50	X	X	X	X	X	X			
456	90853	H2015	90853 GROUP PSYCHOTHERAPY			50	X	X	X	X	X	X			
367	H0034**	H0034	Medication Training & Support (non face/face)			60	X		X						
369	H2010**	H2010	Meds Mgmt by RN LVN Only			60									X
491	90785	H2015	90785 + INTERACTIVE COMPLEXITY			30	X	X	X	X	X	X			
415	96101	H2015	96101 PSYCH TESTING			30	X	X	X	X	X	X			
535	96111	H2015	96111 EXT DEV TEST INTERP RPT			30	X	X	X						
417	96118	H2015	96118 NEUROPSYCH TESTING			30	X	X	X						
498		H2019	Therapeutic Behavioral Svcs			58	X	X	X	X	X	X	X	X	X

BOLD = NEW JANUARY 2013

*restricted to 1 every 3yrs

** not billable to Medicare

+ Add-On Code may not be used alone

Revised 2-8-13

InSyst Procedure Codes

Crosswalk: Old Codes to New Codes																
Old Codes Prior to 1/1/2013			Codes Effective 1/1/2013				Credentials Approved for Each Code									
OLD InSyst Proc Code	OLD CPT Code Medicare	OLD CPT Code Description	NEW InSyst Procedure Codes	NEW CPT Code Medicare/ INS	NEW CPT Code Description	Face to Face Time	MD DO	Lic PhD / PsyD	CNS NP PA	LCSW	LMFT	Intern (Waiv. Reg.)	RHB Couns (MHRS)	Unlic (Adjunct)	RN LVN	
321		Evaluation	324	96151	Behavioral Eval (CFE or approved equivalent)		X	X	X	X	X	X	X	X	X	
331/433/464	90801/90802	Assessment	323	90791	Psychiatric Diag Eval (Assessment)		X	X	X	X	X	X	X	X	X	
			(+) 491	90785	+ INTERACTIVE COMPLEXITY	--										
			565	90792	Psych Diag Eval w Medical (Assessment)		X		X							
			(+) 491	90785	+ INTERACTIVE COMPLEXITY	--										
351/457	90853/90857	Group Therapy	456	90853	GROUP PSYCHOTHERAPY		X	X	X	X	X	X				
			(+) 491	90785	+ INTERACTIVE COMPLEXITY	--										
371		Crisis Intervention	377	90839	Crisis Therapy 60 min (aka Crisis Svcs)	30-75	X	X	X	X	X	X	X	X	X	
			(+) 378	90840	+ Crisis Therapy ADD 30 min (aka Crisis Svcs)	16-45										
341/444/447	90804/90810	Indiv Psy 20-30 min	441	90832	Psychotherapy 30 min	16-37	X	X	X	X	X	X				
			(+) 491	90785	+ INTERACTIVE COMPLEXITY	--										
341/445/448	90806/90812	INDV PSYCH 45-50 MIN	442	90834	Psychotherapy 45 min	38-52	X	X	X	X	X	X				
			(+) 491	90785	+ INTERACTIVE COMPLEXITY	--										
341/446/450	90808/90814	INDV PSYCH 75-80 MIN	443	90837	Psychotherapy 60 min	53 >	X	X	X	X	X	X				
			(+) 491	90785	+ INTERACTIVE COMPLEXITY	--										
463	90805	IND PSY W E&M 20-25 MIN	E/M (+) 465	90833	+ PsyThpy with E/M 30 min	16-37	X		X							
			(+) 491	90785	+ INTERACTIVE COMPLEXITY	--										
464	90807	IND PSY W E&M 45-50 MIN	E/M (+) 467	90836	+ PsyThpy with E/M 45 min	38-52	X		X							
			(+) 491	90785	+ INTERACTIVE COMPLEXITY	--										
466	90809	IND PSY W E&M 75-80 MIN	E/M (+) 468	90838	+ PsyThpy with E/M 60 min	53 >	X		X							
			(+) 491	90785	+ INTERACTIVE COMPLEXITY	--										
318		Collateral Family Therapy	413	90846	FAMILY PSYCH WO PATIENT		X	X	X	X	X	X				
			449	90847	FAMILY PSYCH W PATIENT		X	X	X	X	X	X				
New Codes Not in Crosswalk																
			369	--	Meds Mgmt by RN LVN & PT (f-f & non f-f)										X	
			367	--	Non Face to Face Medication Trng & Support		X		X							

<i>Unchanged Codes</i>															
<i>Unchanged Codes Prior to 1/1/2013</i>			<i>Unchanged Codes Effective 1/1/2013</i>				<i>Credentials Approved for Each Code</i>								
OLD InSyst Proc Code	OLD CPT Code Medicare	OLD CPT Code Description	NEW InSyst Procedure Codes	NEW CPT Code Medicare/ INS	NEW CPT Code Description	Face to Face Time	MD DO	Lic PhD / PsyD	CNS NP PA	LCSW	LMFT	Intern (Waiv. Reg.)	RHB Couns (MHRS)	Unlic (Adjunct)	RN LVN
121		PHF Contract Day	121		PHF Contract Day										
141		Crisis Residential Day	141		Crisis Residential Day										
165		Adult Residential Day	165		Adult Residential Day										

InSyst Procedure Codes

221		Crisis Stabilization	221		Crisis Stabilization										
281		Day Care Intens Half Day	281		Day Care Intens Half Day										
282		Day Care Intens AB3632 Half	282		Day Care Intens AB3632 Half										
285		Day Care Intens Full Day	285		Day Care Intens Full Day										
286		Day Care Intens Full-AB3632	286		Day Care Intens Full-AB3632										
291		Day Care Rehab Half Day	291		Day Care Rehab Half Day										
292		Day Care Rehab Half-AB3632	292		Day Care Rehab Half-AB3632										
295		Day Care Rehab Full Day	295		Day Care Rehab Full Day										
296		Day Care Rehab Full-AB3632	296		Day Care Rehab Full-AB3632										
311		Collateral	311		Collateral		X	X	X	X	X	X	X	X	X
381	H2017	Individual Rehabilitation	381		Individual Rehabilitation		X	X	X	X	X	X	X	X	X
391	H2017	Group Rehabilitation	391		Group Rehabilitation		X	X	X	X	X	X	X	X	X
455	90849	90849 MULTI FAMILY GRP PSYCH	455	90849	90849 MULTI FAMILY GRP PSYCH		X	X	X	X	X	X			
456	90853	90853 GROUP PSYCHOTHERAPY	456	90853	90853 GROUP PSYCHOTHERAPY		X	X	X	X	X	X			
			(+) 491	90785	+ INTERACTIVE COMPLEXITY	--									
581		Plan Development	581		Plan Development		X	X	X	X	X	X	X	X	X
571		Brokerage Services	571		Brokerage Services		X	X	X	X	X	X	X	X	X
413	90846	90846 FAMILY PSYCH WO PATIENT	413	90846	90846 FAMILY PSYCH WO PATIENT		X	X	X	X	X	X			
449	90847	90847 FAMILY PSYCH W PATIENT	449	90847	90847 FAMILY PSYCH W PATIENT		X	X	X	X	X	X			
415	96101	96101 PSYCH TESTING	415	96101	96101 PSYCH TESTING		X	X	X	X	X	X			
417	96118	96118 NEUROPSYCH TESTING	417	96118	96118 NEUROPSYCH TESTING		X	X	X						
535	96111	96111 EXT DEV TEST INTERP RPT	535	96111	96111 EXT DEV TEST INTERP RPT		X	X	X						
498		Therapeutic Behavioral Svcs	498		Therapeutic Behavioral Svcs		X	X	X	X	X	X	X	X	X

Unchanged Codes -Continued																
Unchanged Codes Prior to 1/1/2013			Unchanged Codes Effective 1/1/2013				Credentials Approved for Each Code									
OLD InSyst Proc Code	OLD CPT Code Medicare	OLD CPT Code Description	NEW InSyst Procedure Codes	NEW CPT Code Medicare/ INS	NEW CPT Code Description	Face to Face Time	MD DO	Lic PhD / PsyD	CNS NP PA	LCSW	LMFT	Intern (Waiv. Reg.)	RHB Couns (MHRS)	Unlic (Adjunct)	RN LVN	
367	H0034	Med Trng & Support (non f-f)	367	H0034	Med Trng & Support (non f-f)		X		X							
545	99201	99201 E/M NEW OFC SIMPLE 10 MIN	545	99201	99201 E/M NEW OFC SIMPLE 10 min	1-15	X		X							
546	99202	99202 E/M NEW OFC EXP 20 MIN	546	99202	99202 E/M NEW OFC EXP 20 min	16-25	X		X							
547	99203	99203 E/M NEW OFC DETAIL 30 MIN	547	99203	99203 E/M NEW OFC DETAIL 30 min	26-37	X		X							
548	99204	99204 E/M NEW OFC COMPRE 45 MIN	548	99204	99204 E/M NEW OFC COMPRE 45 min	38-52	X		X							
549	99205	99205 E/M NEW OFC COM 60 min	549	99205	99205 E/M NEW OFC COMPLEX 60 min	53 >	X		X							
641	99211	99211 E/M EST OP SIMPLE 5MIN	641	99211	99211 E/M EST OP SIMPLE 5 min	1-7	X		X							
643	99212	99212 E/M EST OP PROBFOCUS 10MIN	643	99212	99212 E/M EST OP PROBFOCUS 10 min	8-12	X		X							
644	99213	99213 E/M EST OP EXPANDED 15MIN	644	99213	99213 E/M EST OP EXPANDED 15 min	13-20	X		X							
645	99214	99214 E/M EST OP MOD COMPL 25M	645	99214	99214 E/M EST OP MOD COMPL 25 min	21-32	X		X							
646	99215	99215 E/M EST OP HIGHCOMPL 40M	646	99215	99215 E/M EST OP HIGHCOMPL 40 min	33 >	X		X							

InSyst Procedure Codes

Eliminated Codes																
Eliminated Codes Prior to 1/1/2013			Effective 1/1/2013				Credentials Approved for Each Code									
OLD InSyst Proc Code	OLD CPT Code Medicare	OLD CPT Code Description	NEW InSyst Procedure Codes	NEW CPT Code Medicare/ INS	NEW CPT Code Description	Face to Face Time	MD DO	Lic PhD / PsyD	CNS NP PA	LCSW	LMFT	Intern (Waiv. Reg.)	RHB Couns (MHRS)	Unlic (Adjunct)	RN LVN	
469	90862	90862 MEDICATION MANAGEMENT	USE E/M				X		X							
564	M0064	M0064 BRIEF MEDS MGT <15 MIN	USE E/M				X		X							
361		Medication Support	MD F-F USE E/M				X		X							
			MD NON F-F 367				X		X							
			RN/LVN 369											X		
312		Collateral - AB3632	NON AB3632 CODE													
319		Col Family Therapy AB3632	NON AB3632 CODE													
322		Evaluation - Ab3632	NON AB3632 CODE													
332		Assessment - AB3632	NON AB3632 CODE													
342		Individual Therapy AB3632	NON AB3632 CODE													
352		Group Therapy AB3632	NON AB3632 CODE													
362		Medication Support AB3632	MD F-F USE E/M				X		X							
			MD NON F-F 367				X		X							
			RN/LVN 369											X		
372		Crisis Intervention-AB3632	NON AB3632 CODE													
382		Individual Rehab - AB3632	NON AB3632 CODE													
392		Group Rehab - AB3632	NON AB3632 CODE													
572		Brokerage Svs-AB3632	NON AB3632 CODE													
582		Plan Development - AB3632	NON AB3632 CODE													

CLINICIAN'S GATEWAY **(CPT Codes 2013 : Add-on Codes and Time)**

Procedure codes now exist that are designed to be used in sets, as opposed to a single code per service. Please refer to charting documentation for coding guidelines. Total and Face-to Face times are now recorded for each code.

1. When writing a progress note in Clinician's Gateway, first choose the Primary code and enter the total time spent on that activity in the Primary Clinician Time field.

This screenshot shows the top section of the Clinician's Gateway form. A yellow callout box points to the 'Procedures' dropdown menu, which currently shows '377 90839 Crisis Thpy 60 min'. The callout text reads: 'Choose Primary Procedure code. Enter TOTAL time for Primary code activity.' Other fields visible include Client (75087772 TEST), First Name (CINDYTWO), Service Date (3/8/2007), and Primary Clinician Time (0:00).

2. Enter the Face-to-Face time in the Primary FF Time field below the "Instructions" line.

This screenshot shows the 'Instructions' section of the form. A yellow callout box points to the 'Primary FF Time' field, which is currently empty. The callout text reads: 'Enter Face-to-Face time for the Primary Procedure Code'. The field is labeled 'Hours:Minutes'.

3. Enter the Secondary add-on code and the times spent on that activity in the "E/M Plus Psychotherapy or Additional Crisis" fields. (psychotherapy time or additional crisis time) Enter times into both the 2nd Face-to-Face and Total time fields.

This screenshot shows the 'E/M Plus Psychotherapy or Additional Crisis' dropdown menu. A yellow callout box points to the dropdown, which currently shows '378 90840 Crisis Therapy Additional minutes'. The callout text reads: 'Choose the Secondary code. Enter its corresponding Face-to-Face and Total Times.' Other fields visible include Client (75087772 TEST), First Name (CINDYTWO), Service Date (3/8/2007), and Primary Clinician Time (0:00).

This screenshot shows the dropdown menu for the 'E/M Plus Psychotherapy or Additional Crisis' field. A yellow callout box points to the dropdown, which lists several options: 'None', '465 90833 Psychotherapy 30 minutes with patient/family member when performed with E/M service', '467 90836 Psychotherapy 45 minutes with patient/family member when performed with E/M service', '468 90838 Psychotherapy 60 minutes with patient/family member when performed with E/M service', and '378 90840 Crisis Therapy Additional minutes'. Another yellow callout box points to the '2nd FF Time' and '2nd Tot Time' fields, with the text: 'Enter Face-to-Face and Total Times Spent'.

- Some Procedures allow coding to indicate Interactive Complexity (no time recorded).

E/M Plus Psychotherapy or Additional Crisis: 468 90838 Psychotherapy 60 minutes with patient/family member when performed with E/M service

Interactive Complexity: **90785 Present**

- Both secondary and Primary Clinician Time will be transferred to InSyst for billing.

Number: 75087772, Last Name: TEST, First Name: CINDYTWO

Procedures: 377 90839 Crisis Thpy 60 min

Service Location: Select Location, Emergency? ☐ Pregnant? ☐

Primary Clinician: 10904 - Peterson, Camille E, Provider: 9999CG - CLINICIAN GATEWAY TEST MHS AD

E/M Plus Psychotherapy or Additional Crisis: 378 90840 Crisis Therapy Additional minutes

Interactive Complexity: **Not Present**

Primary Total time will be transferred to the Staff Log and to InSyst

Secondary Total time will be transferred into InSyst but **NOT** onto the Daily Approval or the Staff Log **at this time**. Write secondary time on a separate paper staff log stapled to the Daily Staff Log. Add the times together before writing final indirect admin time notes.

Service Date: 4/7/2007, Utilization review date: 11/26/2011, Client Plan due date: N/A, Med. Compliant: N/A, Side Effects: N/A

Primary Clinician Time: 1:00, 2nd PF Time: 0:20, 2nd Tot Time: 2:45

- Only Primary Clinician Time is reported on the Daily Approval and Daily Staff Log at this time. In the future, secondary time will be included.

▼ Daily Approval Service Date: 2/7/2013 Search

Srv. #	Date	Type	Client #	Client Name	Reporting Unit	Procedure	Status	Approve	Time	# In Group	Approve Time
1277585	2/7/2013	Indiv.	75135386	TESTCASE DAVE	9999CG CLINICIAN GATEWAY TEST MHS AD	442 90834 Psychotherapy 45 min	PENDING	Pending	00:50	1	00:50
1276867	2/7/2013	Indiv.	75087772	TEST CINDYTWO	9999CG CLINICIAN GATEWAY TEST MHS AD	377 90839 Crisis Thpy 60 min	PENDING	Pending	01:00	1	01:00

Primary Code Time only included 2 service records on 2/7/2013 for a total time of 01:50. Approve Time

ALAMEDA COUNTY Behavioral Health Care Services

Home | Help | Log Out

Individual Staff Log

Service Date: 10/26/2012

Svc #	Type	RU	Client #	Client Name	Procedure	Time	Grp Ct	Loc	Rec.	Flags
1182862	Indirect	01028 BACS MHS ADULT SERVICE TEAM			519 Inform At-Risk About MH Svs	03:00	1	School	05	
1182149	Indiv.	9999CG CLINICIAN GATEWAY TEST MHS AD	75087772	TEST CINDYTWO	331 Assessment	00:30	1			76
1182148	Indiv.	9999CG CLINICIAN GATEWAY TEST MHS AD	75087772	TEST CINDYTWO	331 Assessment	00:30	1			

3 service records on 10/26/2012 for a total time of 04:00

Currently, Primary Code time is listed but Secondary Code time is not. In the future, Secondary Code time will be added

I hereby certify, under penalty of perjury, that the information contained in this document is accurate and free from fraudulent claiming.

7. **To account for your time currently:**

- Record the time spent doing the secondary activity on a separate old-style manual paper staff log.
- Add the times from the 2 logs together to check your daily total time.
- Add indirect/MAA services as appropriate in Clinician's Gateway.
- Staple the manual paper staff log to the Clinician's Gateway generated staff log.

In the future, Clinician's Gateway will transfer both Primary and Secondary code times to the Daily Approval and Daily Staff Log, calculating the totals again for you. Thank you for your patience as we work through all of the programming changes required due to the new CPT coding structure.

Image of ACBHCS Staff Log form:

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE - MENTAL HEALTH INDIVIDUAL STAFF LOG											
REPORTING UNIT # 		CONFIDENTIAL INFORMATION California W&I Code Section 5328				STAFF NAME: 					
DATE OF SERVICE 						STAFF # 					
RU	Client Number	Client Name (Last, First)	Proc. Code	TIME		Grp Ct		CO-STAFF		Recipient	Next Appt
				HRS:MIN				Co-Staff Number	HRS:MIN		
											
											
											
											
											
											
											
											
											
											
											
											
											
											
											
											
											
											
											
											
											
											
											
											
											
											
											
											

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES GUIDELINES FOR SCOPE OF PRACTICE

February 2013

SERVICE ACTIVITY	LICENSED LPHA: <i>Clinical Psychologist (PHD/PSYD), LCSW, LMFT,</i>	Medication Prescribers: MD, DO, NP, CNS, PA	Registered Nurses	UNLICENSED LPHA: (Intern**) Waivered Psychologist, MFT-I, ASW,	GRADUATE STUDENT / TRAINEE: (Intern**) <i>Students in MH programs: MSW, MA, MS, PHD/PSYD</i>	MHRS (RHB Counselor**) <i>AA + 6 yrs., BA + 4 yrs., or MA/MS/PHD/ PSYD—in MH or related field but not waived or registered. Co-sig's recommended.</i>	ADJUNCT STAFF (Unlic worker**) <i>Program documents qualifications, requires supervision and staff works within scope. Co-sig's recommended.</i>
Assessment	Yes	Yes	No	Yes ^	Yes # *	No = +	No = +
Evaluation (CFE related only)	Yes	Yes	Yes	Yes	Yes # *	Yes = ~	Yes = ~
Plan Development	Yes	Yes	Yes	Yes	Yes *	Yes = *	Yes = *
Individual Rehab	Yes	Yes	Yes	Yes	Yes *	Yes = ~	Yes = ~
Therapy (Ind / Family)	Yes	Yes	No	Yes	Yes *	No	No
Group Therapy	Yes	Yes	No	Yes	Yes *	No	No
Group Rehab	Yes	Yes	Yes	Yes	Yes *	Yes = ~	Yes = ~
Collateral	Yes	Yes	Yes	Yes	Yes *	Yes = ~	Yes = ~
Medication Services E/M	No	Yes	No	No	No	No	No
Psychological Testing	Yes =	Yes =	No	Yes =	Yes=*	No	No
Crisis Therapy (Crisis Svcs)	Yes	Yes	Yes=	Yes =	Yes=*	Yes = ~	Yes = ~
Case Management Brokerage/Linkage	Yes	Yes	Yes	Yes	Yes*	Yes = ~	Yes = ~
Medication Services RN Only	No	No	Yes	No	No	No	No

* Requires co-signature by licensed LPHA.

Cannot provide Dx—report source (including if referral source).

^ Diagnosis may be made but must be co-signed by licensed LPHA.

+ May bill for Assessment—but can only gather and provide assess info.

~ Licensed co-signatures not required—but recommended.

= If within scope of practice and with appropriate training & experience.

****Designation indicates the category on the Staff Master.**

SECTION 2: E/M TRAININGS BASED ON COMPLEXITY

Click links below:

1. THE NATIONAL COUNCIL: E/M 102
2. AACAP INTRODUCTION TO E/M CODING , PT. 1 & 2

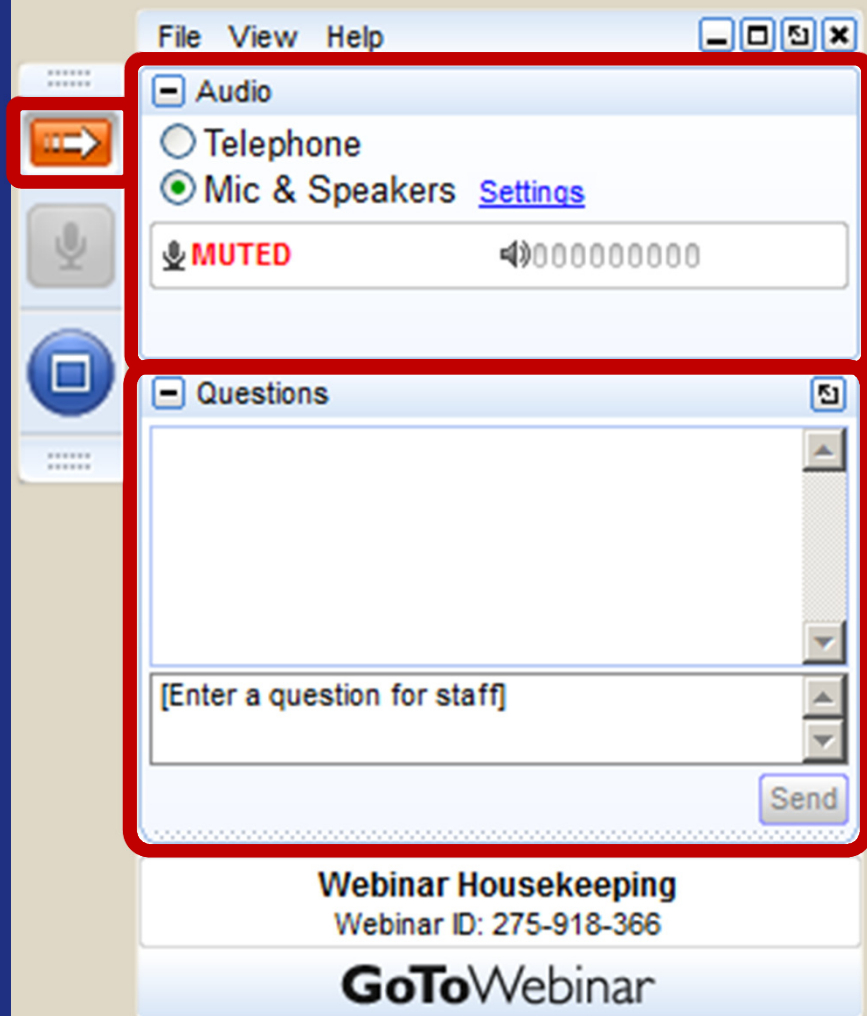


CPT Code Changes: E/M 102, Level Selection and Documentation Support *Corrected*

Revisions made to slides #30 and #64

January 9, 2013

Slides available for download at:
www.TheNationalCouncil.org/CS/CPT_Codes



Open and close your control panel

Join audio:

- Choose "Mic & Speakers" to use VoIP
- Choose "Telephone" and dial using the information provided

Submit questions and comments via the Questions panel

Note: Today's presentation is being recorded and will be provided within 48 hours.



Today's Agenda

- > Overarching CPT Code Changes for 2013
- > E/M Codes: Which Practitioners Can Use Them
- > New vs. Established Patients
- > E/M Level Selection
- > Pharmacologic Management
- > Interactive Complexity
- > Prolonged Psychotherapy Services
- > Additional Resources
- > Q&A



Today's Speakers

- > **Adam Falcone, Esq.**
Partner, Feldesman Tucker Leifer Fidell LLP

- > **David R. Swann, MA, LCAS, CCS, LPC, NCC;**
Senior Healthcare Integration Consultant,
MTM Services



Adam Falcone, Esq.
Partner,
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CPT Codes are:

> **Procedure codes**

Diagnostic Codes
Rates
Policy Decisions

> **Established by the AMA, with CMS**

Individual
Payers

> **Reviewed annually**, although biggest changes to psychiatry section since 1998

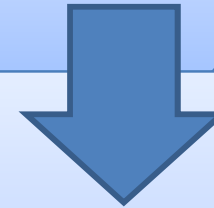
And tight
timelines



Implementation of 2013 Changes

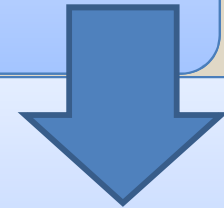
Code Changes

- Stakeholder input process
- Additions, deletions, modifications
- CMS approval and preliminary notification



Payer Valuation of Codes

- Independent decisions
- Often expressed in relation to Medicare rates
- For public agencies, may require regulatory changes



Provider and Other Stakeholder Preparation

- Alignment of HIT systems and charge sheets
- Amendments to contracts and provider agreements
- Documentation trainings for direct service providers and compliance staff



2013 and Behavioral Health Shift to Evaluation/Management

- > Removal of “combination codes” for psychotherapy and evaluation/management (90805, 90807)
- > Elimination of Medication Management codes in Psychotherapy section for providers who can use E/M codes for pharmacologic management

Additional changes:

- > New psychotherapy codes: time, place, number
- > Addition of codes for crisis services
- > Add-on codes for interactive complexity



Implementation on January 1, 2013

- > Effective date required under HIPAA
- > Implementation has not been delayed
- > Individual carriers transitioning into new codes (interactive complexity, crisis codes, rates for add-on psychotherapy codes) at different time frames



Major Changes – Initial Psychiatric Diagnostic Procedures

Two new codes distinguish between:

- > an initial evaluation with medical services provided by a physician (90792) and
- > an initial evaluation provided by a non-physician (90791).



Initial Psychiatric Diagnostic Procedure: 90791

> Initial Evaluation 90791 includes the following:

- Biopsychosocial assessment including history, mental status and recommendations
- May include communication with family, others, and review and ordering of diagnostic studies



Initial Psychiatric Diagnostic Evaluation with Medical Services: 90792

- > Initial Evaluation 90792 with medical services and provided by a physician includes those services in (90791) AND:
- > Medical assessment Physical exam beyond mental status as appropriate
- > May include communication with family, others, *prescription medications*, and review and ordering of *laboratory* or other diagnostic studies



Reporting Psychiatric Diagnostic Procedures

- > Psychiatric Diagnostic Codes can be reported once per day.
- > Cannot be reported with an E/M code on same day by same provider.
- > Cannot be reported with psychotherapy service code on same day.



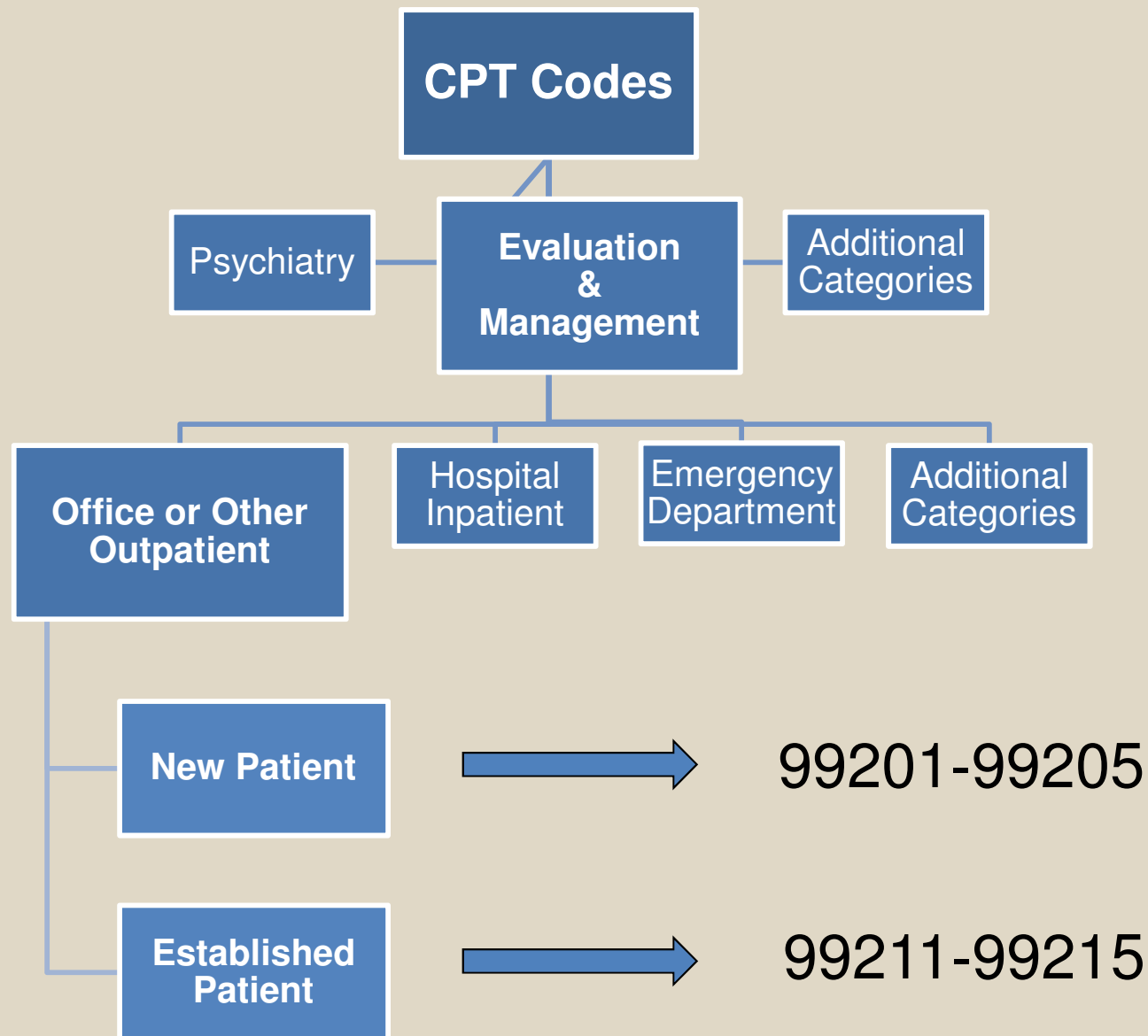
Reporting Psychiatric Diagnostic Procedures, cont.

- > May be reported more than once for a patient when *separate diagnostic evaluations* are conducted with the patient and other collaterals such as family members, guardians, and significant others.
- > Providers must use the patient's name for services reported under these codes.



E/M, 90791 and 90792: Which to Use?

- > Rates for 90791 are higher than 90792, even though 90792 includes medical services
- > Carrier limits on 90791 and 90792
- > Risk of using 90791 as a physician just because rate is higher than 90792





Evaluation/Management Codes

- > Psychiatrists, Physician Extenders, Nurse Practitioners and others who are licensed to perform medical activities must use E/M codes for services such as medication management
- > These codes are the same ones all physicians use for similar services, and use the numbers 99XXX
- > Documentation requirements are much more specific for these codes and require addressing various degrees of medical complexity
- > APA has a training program online for members in the use of these codes
- > Other mental health professionals do not use these codes



Evaluation/Management Codes, cont.

- > E/M codes, since they are a category of CPT codes, are comprised of five digits
- > E/M codes specifically begin with 99
- > E/M subsequent numbers depend on the type of E/M
 - A level 1 (last digit a 1) is the least complex
 - A level 2 (last digit a 2) is greater complexity
- > The highest code level will end in a 3 (an inpatient hospital admission), or a 5 (outpatient or consultations)



Recovery Audit Finding: Not a New Patient – Incorrect Coding

- > Recovery Auditor Contractors (RACs) determined that providers are incorrectly billing new patient services for reimbursement under Medicare Part B.
- > New patient Evaluation and Management (E/M) services for the same beneficiary within a 3-year period should not be billed to Medicare.
- > A problem exists when multiple new patient E/M services are reimbursed under Medicare Part B inside of this time frame.
 - *CMS, Medicare Quarterly Provider Compliance Newsletter, (February 2011).*



CPT E/M New Patient Definition

- > CPT® 2012 states: “A new patient is one who has not received any professional services from the physician or another physician of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.”
- > Solely for the purposes of distinguishing between new and established patients, professional services are those face to face services rendered by a physician and reported by a specific CPT code(s).



CPT E/M Established Patient Definition

- > An established patient is one who has received professional services from the physician or another physician of the same specialty and subspecialty who belongs to the same group practice, within the past 3 years.
- > In the instance where a physician is on call for or covering for another physician, the patient's encounter will be classified as it would have been by the physician who is not available.



New or Established Patient?

- > Joe, age 12, sees Dr. Kirk, a child psychologist, at Neighborhood Health Services.
 - Four years earlier, Joe had also seen Dr. Kirk at Neighborhood Health Services.
 - Is Joe a new patient?

New vs. established patient distinction does not apply.

The psychologist is not considered to be providing a medical service, so the service cannot be coded as an E/M service.



New or Established Patient?

- > Last year, Jane saw Dr. Brown, a general psychiatrist, who practices at ABC Medical Group.
 - Dr. Brown has since moved his practice to XYZ Medical Group.
 - Today Jane sees Dr. Brown at XYZ Medical Group. She has never been to XYZ Medical Group.
 - Is Jane a new patient?

No. She received a professional service from the same physician within three years, even though the practice group is different.



New or Established Patient?

- > Last year, Jane saw Dr. Brown, a general psychiatrist, who practices at ABC Medical Group.
 - Since then, Dr. Brown has since moved his practice to XYZ Medical Group.
 - Today Jane sees a psychiatrist at XYZ Medical Group who is not Dr. Brown. She has never been to XYZ Medical Group.
 - Is Jane a new patient?

Yes. She has not received a professional service from this physician or the practice group within the last three years.



New or Established Patient?

- > While Dr. Brown is on vacation, he arranges for Dr. Green, a psychiatrist who works at a medical practice on the other side of town, to cover for him.
- > Jane sees Dr. Green when Dr. Brown is on vacation.
- > Is Jane a new patient?

No. Dr. Green is covering for Dr. Brown, so she is classified as if she were seen by Dr. Brown.



New or Established Patient?

- > John, a new patient, sees Dr. Brown at XYZ Medical Group.
 - Afterwards, Dr. Brown refers John to Dr. Smith, who specializes in addiction psychiatry, and also practices with XYZ Medical Group.
 - Two weeks later, John sees Dr. Smith.
 - Is John a new patient?

Yes. Dr. Smith is a sub-specialist.



New or Established Patient?

- > Over the last month, Chris has been receiving psychotherapy services from a L.C.S.W. at a community behavioral health organization.
- > Today he sees Dr. White, a psychiatrist, for the first time for an office visit.
- > Is Chris a new patient?

Yes. This is the first time he is seeing a physician and received a medical service.



Non-Physician Practitioners

- > A new patient is defined as an individual who has not received any professional services from the physician/non-physician practitioner (NPP) or another physician of the same specialty who belongs to the same group practice within the previous three years.
- > An established patient is an individual who has received professional services from the physician/NPP or another physician of the same specialty who belongs to the same group practice within the previous three years.
- > *CMS, Evaluation and Management Services Guide (December 2010).*
- > **Added 1/11/13:** For purposes of E/M services, Medicare defines non-physician practitioners (NPPs) as:
 - Nurse practitioners;
 - Clinical nurse specialists;
 - Certified nurse midwives; and
 - Physician assistants



Medicare – New Patient Definition

- > Medicare's definition of a new patient, taken from the Chapter 12 of the Medicare Claims Processing Manual, instructs:
- > “Interpret the phrase ‘new patient’ to mean a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous three years” [emphasis added.]



New or Established Patient?

- > Tom has been receiving psychotherapy from Nurse Jones, a N.P.
 - The following week he sees a psychiatrist for an office visit.
 - Is Tom a new patient?

Yes. Although Tom was seen by a N.P., he did not received an E/M or other “medical service.” Because he has not received a medical service from the organization in the last three years, he is considered a new patient.



New or Established Patient?

- > Dr. Smith, a General Psychiatrist, practices for ABC Behavioral Health Services in one of their 6 behavioral health offices within the state of Ohio.
- > Dr. Smith sees John, a depressed patient on October 1, 2011. John relocates to Mayberry, Ohio, where there is another ABC Behavioral Health Services, and is seen by Dr. Jones, who is also employed by ABC Behavioral Health Services.
- > Each office of ABC Behavioral Health Services maintains their own medical records and one office doesn't have access to another's medical records.
- > Is John a New patient?

It depends on how group practice is defined. For example, WPS (a Medicare Part B carrier) defines group practice by Federal Tax Identification Number (TIN). If ABC bills under a single TIN, then John is not a new patient.



Important Caveats on Proper Coding

- > Medicare does not always speak with one voice.
 - Local Medicare policies can dictate coding rules.

- > Medicare is not the only payor.
 - Payor policies make a difference.



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Services Should Always Be Medically Necessary



Two Paths to E/M Selection

Path One

- Based on the **Elements** (History, Exam, and Medical Decision Making)

Path Two

- Basing the code on **Time** (when Counseling and/or Coordination of Care > 50% time)
- If you are using an add on psychotherapy code, you cannot use time as the basis of selecting the code for the E/M portion of the work.



SELECTING E/M CODES

Path One 

Based on the Elements
History, Exam, and MDM



E/M Level Selection

History

Chief Complaint

History of Present Illness (HPI)

Past, Family and/or Social History (PFSH)

Review of Systems (ROS)

Exam

Number of system/body areas examined

“Bullets” or elements completed within specific systems

Medical Decision Making

Number of Diagnoses or Management Options

Amount and/or Complexity of Data to be Reviewed

Risk of Significant Complications, Morbidity, and/or Mortality

* Each line impacts kind of History, Exam, and MDM



“Bullets?”

Reference:
***CMS 1997 Documentation
Guidelines for Evaluation &
Management Services***

**Includes guidelines for
single-organ examinations,
like Psychiatry**

***Link available on
National Council's
[CPT Resource Page](#)***

1997 DOCUMENTATION GUIDELINES FOR EVALUATION AND MANAGEMENT SERVICES

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“Bullets?”

Excerpt from Psychiatry section of 1997 *Documentation Guidelines for Evaluation & Management Services*

Link available on
National Council's
[CPT Resource
Page](#)

System/Body Area	Elements of Examination
Psychiatric	• Description of speech including: rate; volume; articulation; coherence; and spontaneity with notation of abnormalities (eg, perseveration, paucity of language) • Description of thought processes including: rate of thoughts; content of thoughts (eg, logical vs. illogical, tangential); abstract reasoning; and computation • Description of associations (eg, loose, tangential, circumstantial, intact) • Description of abnormal or psychotic thoughts including: hallucinations; delusions; preoccupation with violence; homicidal or suicidal ideation; and obsessions • Description of the patient's judgment (eg, concerning everyday activities and social situations) and insight (eg, concerning psychiatric condition) Complete mental status examination including • Orientation to time, place and person • Recent and remote memory • Attention span and concentration • Language (eg, naming objects, repeating phrases) • Fund of knowledge (eg, awareness of current events, past history, vocabulary) • Mood and affect (eg, depression, anxiety, agitation, hypomania, lability)

Content and Documentation Requirements

Level of Exam

Perform and Document:

Problem Focused

One to five elements identified by a bullet.

Expanded Problem Focused

At least six elements identified by a bullet.

Detailed

At least nine elements identified by a bullet.

Comprehensive

Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.



E/M New Patient Visit

Level	E/M Code	History	Exam	Medical Decision Making	Time
1	99201	Problem Focused	Problem Focused	Straightforward	10
2	99202	Expanded Problem Focused	Expanded Problem Focused	Straightforward	20
3	99203	Detailed	Detailed	Low	30
4	99204	Comprehensive	Comprehensive	Moderate	45
5	99205	Comprehensive	Comprehensive	High	60

Requires 3 out of 3 components for History, Exam, MDM



E/M Established Patient Visit

Level	E/M Code	History	Exam	Medical Decision Making	Time
1	99211	None	None	None	5
2	99212	Problem Focused	Problem Focused	Straightforward	10
3	99213	Expanded Problem Focused	Expanded Problem Focused	Low	15
4	99214	Detailed	Detailed	Moderate	25
5	99215	Comprehensive	Comprehensive	High	40

Requires 2 out of 3 components for History, Exam, MDM



Example: 99212 vs. 99213

Level	E/M Code	History	Exam	Medical Decision Making	Time
2	99212	Problem Focused	Problem Focused	Straightforward	10
3	99213	Expanded Problem Focused	Expanded Problem Focused	Low	15
Distinction between 99212 vs. -213		Number of Systems Reviewed (N/A vs. 1 system)	Number of bullets reviewed (1-5 bullets vs. at least 6 bullets)	Problem Points, Data Pts, or Risk levels (0-1 vs. 2; 0-1 vs. 2; minimal vs. low)	n/a for this ex.

Requires **2 out of 3 components** for History, Exam, MDM; in this example, **not** selecting based on time



Outpatient E/M for Established Patients

	99211	99212	99213	99214	99215
HISTORY					
Chief Complaint	NA	Required	Required	Required	Required
History of Present Illness	NA	1-3 Elements	1-3 Elements	4+ Elements	4+ Elements
ROS*	NA	NA	Pertinent	2-9 Systems	10-14 Systems
PFSH**	NA	NA	NA	1 of 3 Elements	2 of 3 Elements
PHYSICAL EXAMINATION					
1997 CMS Doc. Guidelines	NA	1-5 Bulleted Elements	6-8 Bulleted Elements	9 or more Elements	Comprehensive
MEDICAL DECISION MAKING					
	NA	Straight Forward	Low	Moderate	High
TIME					
Face-to- Face	5 min	10 min	15 min	25 min	40 min



Example: 99212 or 99213?

A 42-year-old male established patient with a history of bipolar II disorder, last seen 2 months prior, is seen for an office visit. Interval history taking focuses on the presence/absence of symptoms, the patient's level of social/vocational function, and the patient's adherence to the medication regimen. A mental status examination focuses on the patient's affective state. The patient's lithium blood level is reviewed. The side effects of the medication are reviewed, and prescriptions for the same medications are provided.



Example, cont.

> History:

- Chief complaint: yes → *Always Required*
- HPI: 1-2 chronic conditions reviewed → *Brief*
- PFSH: No additional review → *N/A*
- ROS: Reviewed one system (psychiatric) → *Problem Pertinent = Expanded Problem Focused*

> **Exam:** Mood and Affect = 1 bullet = **Problem Focused**

> **Medical Decision Making:** Estab. Prob/Stable = 1 pt.

> Li Level is reviewed = 1 pt., Moderate risk with Rx mgt,
= **Straightforward Complexity of MDM**



Answer: 99213

A 42-year-old male established patient with a history of bipolar II disorder, last seen 2 months prior, is seen for an office visit. Interval history taking focuses on the presence/absence of symptoms, the patient's level of social/vocational function, and the patient's adherence to the medication regimen. A mental status examination focuses on the patient's affective state. The patient's lithium blood level is reviewed. The side effects of the medication are reviewed, and prescriptions for the same medications are provided.

Explanation for code choice: In order to make a decision about medications, the psychiatrist must do an **expanded problem-focused history and examination**. An expanded problem-focused history includes one to three elements of a review of systems. The actual medical decision to continue the medication regimen is of **low complexity**. Requires 2 of the 3 to match.



Outpatient E/M for Established Patients

Established	99211	99212	99213	99214	99215
HISTORY					
Chief Complaint	NA	Required	Required	Required	Required
History of Present Illness	NA	1-3 Elements	1-3 Elements	4+ Elements	4+ Elements
ROS*	NA	NA	Pertinent	2-9 Systems	10-14 Systems
PFSH**	NA	NA	NA	1 of 3 Elements	2 of 3 Elements
PHYSICAL EXAMINATION					
1997 CMS Doc. Guidelines	NA	1-5 Bulleted Elements	6-8 Bulleted Elements	9 or more Elements	Comprehensive
MEDICAL DECISION MAKING					
	NA	Straight Forward	Low	Moderate	High
TIME					
Face-to- Face	5 min	10 min	15 min	25 min	40 min



Outpatient E/M for New Patients

New Patient	99201	99202	99203	99204	99205
HISTORY					
Chief Complaint	Required	Required	Required	Required	Required
History of Present Illness	1-3 Elements	1-3 Elements	4 + Elements	4+ Elements	4+ Elements
ROS*	NA	Pertinent	2-9 Systems	10-14 Systems	10-14 Systems
PFSH**	NA	NA	1 of 3 Elements	3 of 3 Elements	3 of 3 Elements
PHYSICAL EXAMINATION					
1997 CMS Doc. Guidelines	1-5 Bulleted Elements	6-8 Bulleted Elements	9 or More Bulleted Elements	Comprehensive	Comprehensive
MEDICAL DECISION MAKING					
	Straight Forward	Straight Forward	Low	Moderate	High
TIME					
Face-to- Face	10 min	20 min	30 min	45 min	60 min



Additional Resource for Level Selection

Coding by Key
Components created by
the *American Academy
of Child & Adolescent
Psychiatry*

*Link available on
National Council's
[CPT Resource Page](#)*

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Evaluation and Management Services Guide Coding by Key Components

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

History	Chief Complaint (CC)	History of present illness (HPI)	Past, family, social history (PFSH)	Review of systems (ROS)	
	Reason for the visit	Location; Severity; Timing; Quality; Duration; Context; Modifying Factors; Associated signs and symptoms	Past medical; Family medical; Social	Constitutional; Eyes; Ears, Nose, Mouth, and Throat; Cardiovascular; Respiratory; Genitourinary; Musculoskeletal; Gastrointestinal; Skin/Breast; Neurological; Psychiatric; Endocrine; Hematologic/Lymphatic; Allergic/Immunologic	
	CC	HPI	PFSH	ROS	History Type
	Yes	Brief (1-3 elements or 1-2 chronic conditions)	N/A	N/A	Problem focused (PF)
		Extended (4 elements or 3 chronic conditions)	Pertinent (1 element)	Extended (2-9 systems)	Expanded problem focused (EPF)
Complete (2 elements (est) or 3 elements (new/initial))			Complete (10-14 systems)	Detailed (DET)	
Comprehensive (COMP)					
Examination	System/body area		Examination		
	Constitutional	3/7 vital signs: sitting or standing BP, supine BP, pulse rate and regularity, respiration, temperature, height, weight - General appearance			
	Musculoskeletal	- Muscle strength and tone - Gait and station			
	Psychiatric	- Speech - Thought process - Associations - Abnormal/psychotic thoughts - Judgment and insight - Orientation - Recent and remote memory - Attention and concentration - Language - Fund of knowledge - Mood and affect			
	Examination Elements		Examination type		
	1-5 bullets		Problem focused (PF)		
	At least 6 bullets		Expanded problem focused (EPF)		
	At least 9 bullets		Detailed (DET)		
	All bullets in Constitutional and Psychiatric (shaded) boxes and 1 bullet in Musculoskeletal (unshaded) box		Comprehensive (COMP)		
	Med Dec Making	Medical Decision Making Element			Determined by
Number of diagnoses or management options			Problem points chart		
Amount and/or complexity of data to be reviewed			Data points chart		
Risk of significant complications, morbidity, and/or mortality			Table of risk		
Problem Points					
Category of Problems/Major New symptoms			Points per problem		
Self-limiting or minor (stable, improved, or worsening) (max=2)			1		
Established problem (to examining physician); stable or improved			1		
Established problem (to examining physician); worsening			2		
New problem (to examining physician); no additional workup or diagnostic procedures ordered (max=1)			3		
New problem (to examining physician); additional workup planned*			4		
*Additional workup does not include referring patient to another physician for future care					



Example #2

99203: Office Visit, New Patient

A 27-year-old woman with a history of depression who is visiting the area is seen in an initial office visit. She is currently under treatment in her hometown. History taking focuses on a review of her past psychiatric history, present illness, and interval history since her last visit to her treating psychiatrist. Her medication history is reviewed, as is her side-effect history. A mental status examination focuses on her current affective state, ability to attend and concentrate, and insight. A prescription for an antidepressant is provided, along with education on its use and side effects.

Explanation for code choice: Although a new patient to the examining psychiatrist, this patient has an existing treatment source. The psychiatrist obtains a detailed history and performs a detailed mental status examination (Requires at least 9 bulleted elements). (A detailed history requires a detailed [two to nine elements] review of symptoms.) The provision of a prescription requires medical decision making of low complexity. Requires 3 of 3



Example #3

99205: Office Visit, New Patient

A 38-year-old man brought by his parents for evaluation of paranoid delusions and alcohol abuse is seen in an initial office visit. History taking focuses on the family history of mental illness. The past medical and psychiatric history, history of present illness, and social history of the patient are taken. The results of a mental status examination reveal a poorly groomed individual, poor eye contact, no spontaneity to speech, flat affect, no hallucinations, paranoid delusions about the police, no suicidal/homicidal ideation, and intact cognitive status. The patient has no history of current medical problems. The patient denies alcohol use. The parents are interviewed and provide a history of the patient that includes at least 5 years of binge drinking. Routine blood studies are ordered. The patient's vital signs are taken. A prescription for a neuroleptic is given, and education about medication is provided to the patient and the parents. Referrals to a dual-diagnosis treatment program and Alcoholics Anonymous are made.



Example #3

99205: Office Visit, New Patient (continued)

Explanation for code choice: This initial evaluation requires complex (high) medical decision making because of the psychotic symptoms in the context of alcohol

abuse. The psychiatrist must complete a comprehensive history and examination. The comprehensive history includes a complete review of systems. HPI extended; PFSH 3 elements; ROS complete = Comprehensive Hx.

Exam = all bullets in shaded box and 1 bullet in unshaded (musculoskeletal)

MDM= High risk; Problem pt. (4); Data pt. 1+1; = High Complexity



Pharmacological Management

- > Pharmacologic Management Code 90862 has been eliminated
- > Psychiatrists must now use the appropriate E/M code for pharmacologic management when both psychotherapy and E/M is provided
- > If reporting psychotherapy and E/M, pharmacologic management is considered part of E/M service
- > Do not count time of pharmacologic management in psychotherapy codes
- > If providing only pharmacologic management, report only E/M service codes
- > These changes will result in an increase use of E/M codes by psychiatrists



Alternative Pharmacological Management Code – HCPCS Code

- > Healthcare Common Procedure Coding System Used by Medicare – HCPCS
- > **M0064** – Brief Office Visit for Monitoring or Changing Drug Prescriptions for the Treatment of Mental, Psychoneurotic, and Personality Disorders



Example #4: “Pharmacologic Management”

- > 9 yo male seen for follow up visit for ADHD. Visit attended by patient and mother, history obtained from both. Grades are good, but patient distracted in class. Lunch appetite poor but eats well at other meals. No problems with depression, anxiety, sleep.
- > He appears dressed appropriately, interacts well, has normal rate and tone of speech, there is no HI/SI or psychosis, associations intact, he is oriented x3, he is euthymic and affect is appropriate.



Example #4 Pharmacologic Management

- > Problem 1: ADHD
- > Comment: Relatively stable, mild sx's.
- > Plan: Renew Ritalin, increase dose
 - Recheck in 2 months



Example #4 Pharmacologic Management – Code 99213

- > **HX:** Expanded Problem Focused: Brief (1-3):associated signs and sxs, quality, context
 ROS: **Problem pertinent: 1 system (psychiatric)**
- > **EXAM:** Expanded problem focused: **at least 6**
- > **MDM(LOW):** Problem: **1 pt.** Established, Minimal
 Data: Obtain info from someone else besides the patient= 2, limited
 Risk: Chronic illness with mild exacerbation=moderate, manage with prescription



Interactive Complexity: +90785

- > Refers to specific communication factors **during** a visit that complicates delivery of the primary psychiatric procedure
- > Typical patients:
 - Have others legally responsible for their care, such as minors or adults with guardians
 - Request others to be involved in their care during the visit
 - Require the involvement of other third parties, such as child welfare agencies, parole or probation officers, or schools



Interactive Complexity: Factors

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.



Interactive Complexity: Factors, cont.

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.

NOTE: 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.



Additional Resource for Interactive Complexity

Guide created by the
**American Academy of
Child & Adolescent
Psychiatry**

Link available on
National Council's
[CPT Resource Page](#)



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 <i>during</i> a visit that complicate delivery of the primary psychiatric procedure. Report with CPT add-on code 90785 .	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.
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 <i>intensity</i> of the psychotherapy service, and does not change the <i>time</i> for the psychotherapy service.	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.
May Not Report With	• Psychotherapy for crisis (90839, 90840) • E/M <i>alone</i>, i.e., E/M service <i>not</i> reported in conjunction with a psychotherapy add-on service • Family psychotherapy (90846, 990847, 90849)		
Complicating Communication Factor Must Be Present During the Visit	The following examples are <i>NOT</i> 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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Coding Outpatient Psychotherapy Sessions Provided Without E/M Services

Actual length of session	Code as	Code description
0-15 minutes	Not reported	-
16-37 minutes	90832	30 minutes
38-52 minutes	90834	45 minutes
53-89 minutes	90837	60 minutes
90-134 minutes	90837 99354	60 minutes Prolonged Services
135-154 minutes	90837 99354 99355	60 minutes Prolonged Services Prolonged Services, each additional 30 minutes



Risk Management: How Are You Selecting Codes?

- > “We’re going to instruct our people to only use 99202 for new patient visits.”
- > “Our back office staff will select the codes after reviewing the documentation.”



Remember:

- > If you know one Medicaid program, you know one Medicaid program
 - Individual payers have individual policies and individually-determined rates
- > Medical necessity must drive your services



Resources

- > AMA Code Book www.amabookstore.com or 1-800-621-8335
- > [National Council webpage](#) dedicated to the CPT changes with resources such as:
 - 2012-2013 Crosswalk
 - Frequently Asked Questions
 - Free training resources
- > *Compliance Watch*, new CPT series
 - www.TheNationalCouncil.org/CS/Compliance_Watch_Newsletter



Resources

- > American Psychiatric Association:
<http://www.psych.org>
- > American Academy of Child & Adolescent Psychiatrists:
www.aacap.org
- > 1997 Documentation Guidelines for Evaluation and Management Services
<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf>
- > Center for Medicare and Medicaid Services (CMS)
<http://www.cms.gov/Medicare/Medicare.html?redirect=/home/medicare.asp>



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50th Anniversary of the
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Mental Health Act*

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ATTENDEES



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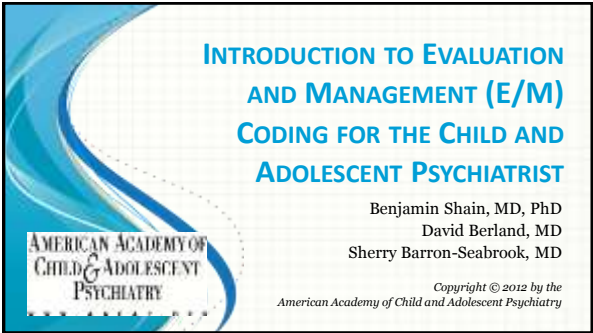
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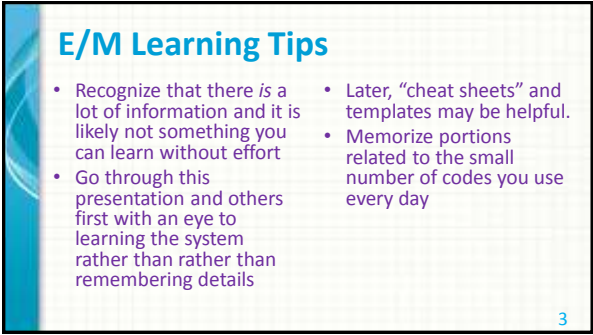
National Council

CPT Resource Page: www.TheNationalCouncil.org/CS/CPT_Codes

Nina Marshall: ninam@thenationalcouncil.org, (202) 684-7457 x 280







What are E/M Codes?

- Code starts with “99”
- Used to report a medical service rendered during a patient visit
- Evaluation (collecting and assessing information) and Management (planning treatment or further assessment; prescribing medication)
- Used by all physicians and other medical providers
- May be reported in addition to a “procedure” unless specifically restricted

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Why use E/M?

- They pay more for the same service
- For most psychiatrists there will be no choice starting in 2013
- But,
 - Aren’t these codes complicated, hard to document, easy to miscode, and vulnerable to audit?
 - Yes, yes, yes, yes
- We believe this series of webinars will give you the information you need to code in confidence

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PAYMENT

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Medicare Payments

Code	Payment	Code	Payment
90862	\$58.54	90801	\$152.49
99211	\$19.74	90802	\$166.10
99212	\$42.55	99204	\$160.66
99213	\$70.46	99205	\$199.46
99214	\$104.16	99222	\$133.09
99215	\$139.89	99223	\$195.38

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In Other Words...

Code	Payment
90862	\$58.54
99211	\$19.74
99212	\$42.55
99213	\$70.46
99214	\$104.16
99215	\$139.89

- Medicare payment for 99213 is 20% more than it is for 90862 and, for 99214, is 78% more
- Payments from other payers may be similarly more

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DOCUMENTATION

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E/M Documentation Guidelines

- 1995
 - First expansion of CPT manual
- 1997
 - Spells out the elements of a general multi-system exam and 11 single organ system exams
 - Included in these is a single system psychiatric examination
 - Download: <http://www.cms.gov/medicare/>
- Voluntary auditing guidelines

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Reason for Documentation

- Facilitates:
 - The ability to evaluate and plan the patient's immediate treatment and to monitor his/her health care over time
 - Communication and continuity of care among health care professionals
 - Appropriate utilization review and quality of care evaluations
 - Collection of data that may be useful for research and education
 - Accurate and timely claims review and payment

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General Principles of Documentation

- Complete and legible
 - Assessment, clinical impression or diagnosis
- Include:
 - Reason for the encounter and relevant history, physical examination findings and prior diagnostic test results
 - Plan for care
 - Date and legible identity of the observer

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General Principles of Documentation

- Rationale for ordering ancillary services should be easily inferred
- Past and present diagnoses should be accessible
- Appropriate health risk factors should be identified
- Document the patient's response to, changes in treatment, and revision of diagnosis
- The CPT and ICD-9-CM codes reported should be supported

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General Audit Issues

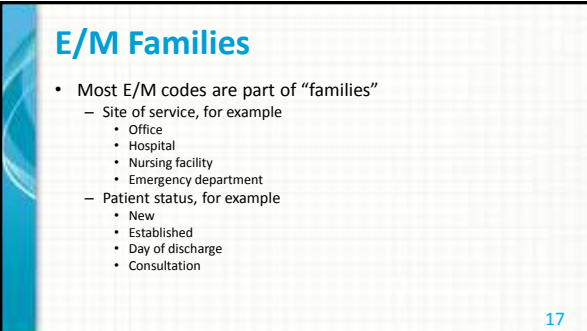
- Upcoding
- Downcoding
- Meet E/M criteria
- Medical necessity
- Red flags
 - High use of highest level code
 - Exclusive use of one level code

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CODING STRUCTURE

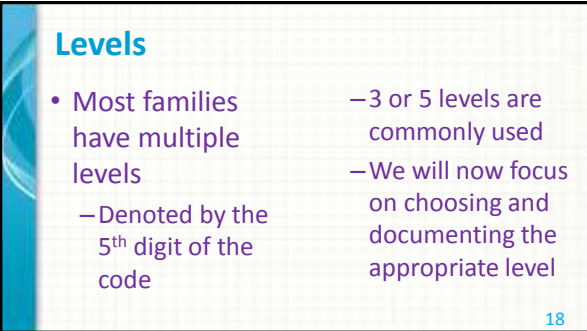
16



E/M Families

- Most E/M codes are part of “families”
 - Site of service, for example
 - Office
 - Hospital
 - Nursing facility
 - Emergency department
 - Patient status, for example
 - New
 - Established
 - Day of discharge
 - Consultation

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Levels

- Most families have multiple levels
 - Denoted by the 5th digit of the code

- 3 or 5 levels are commonly used
- We will now focus on choosing and documenting the appropriate level

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E/M Components

- History
- Examination
- Medical decision making
- Counseling
- Coordination of care
- Time
- Nature of presenting problem

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KEY COMPONENT
OVERVIEW

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History

- Chief complaint
- History of present illness (HPI)
 - Elements
 - Chronic or inactive problems
- Past, family, social history (PFSH)
 - Past history
 - Family history
 - Social history
- Review of systems (ROS)
 - 14 organ systems

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Physical Examination

- Psychiatric single system examination
 - Constitutional
 - Psychiatric (mental status)
 - Musculoskeletal

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Medical Decision Making

- Number of diagnoses or management options
- Amount and/or complexity of data to be reviewed
- Risk of complications and/or morbidity or mortality, related to
 - presenting problem,
 - diagnostic procedure, or
 - management option

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HISTORY DETAIL

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History

- Chief Complaint
- History of Present Illness
- Past, Family, and Social History
- Review of Systems

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Chief Complaint

- Only 1 level, but all levels of history require
- CC states the reason for the encounter
 - May be from the provider perspective, e.g.,
 - Main symptom(s)
 - Follow up visit for ...
 - May be from the patient perspective, e.g.,
 - “I cry too much.”
 - “My mother told me to come.”

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HPI

Description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present.

- Elements:
- Location
 - Quality
 - Severity
 - Duration
 - Timing
 - Context
 - Modifying factors
 - Associated signs and symptoms

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HPI Example

The patient reports intermittent¹ emotional² problems of moderate³ sadness⁴ starting with a romantic breakup⁵ six months ago⁶, now more so when alone⁷ and associated with poor sleep and appetite⁸.

- 1. Timing
- 2. Location
- 3. Severity
- 4. Quality
- 5. Context
- 6. Duration
- 7. Modifying factors
- 8. Associated signs and symptoms

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HPI Levels

- Brief
 - 1-3 elements OR
 - Status of 1-2 chronic or inactive conditions
- Extended
 - 4 or more elements OR
 - Status of at least 3 chronic or inactive conditions

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Past, Family and/or Social History
(PFSH)

- Past history
 - Illnesses
 - Operations
 - Injuries
 - Treatments
- Family history
 - Medical events in patient’s family
- Social history
 - Past and current activities

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Past, Family and/or Social History
(PFSH)

- Pertinent
 - Item from 1 area
- Complete
 - Item each from 2 areas (established patient)
 - Item each from all 3 areas (new patient)

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Review of Systems

- Constitutional
- Eyes
- Ears, Nose, Mouth, and Throat
- Cardiovascular
- Respiratory
- Genitourinary
- Musculoskeletal
- Gastrointestinal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic and Lymphatic
- Allergic/Immunologic

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Review of Systems

- Problem pertinent: System directly related to the problem(s) identified in the HPI
- Extended: 2-9 systems
- Complete: 10 or more systems
 - Document individually systems with positive or pertinent negative responses
 - “All other systems reviewed and are negative” is permissible
 - In the absence of such a notation, at least 10 systems must be individually documented

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History Type

HPI	PFSH	ROS	Type
Brief	N/A	N/A	<i>Problem focused</i>
Brief	N/A	Problem pertinent	<i>Expanded problem focused</i>
Extended	Pertinent*	Extended	<i>Detailed</i>
Extended	Complete	Complete	<i>Comprehensive</i>

*No PFSH required with subsequent hospital visits

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History Type

HPI	PFSH	ROS	Type
1-3 elements or 1-2 chronic	N/A	N/A	<i>Problem focused</i>
1-3 elements or 1-2 chronic	N/A	1 system	<i>Expanded problem focused</i>
4 elements or 3 chronic	1 element*	2-9 systems	<i>Detailed</i>
4 elements or 3 chronic	3 elements**	10-14 systems	<i>Comprehensive</i>

*No PFSH required with subsequent hospital visits
**2 elements for established patients

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PHYSICAL EXAMINATION
DETAIL

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Physical Examination

- Cardiovascular
- Ears, nose, mouth and throat
- Eyes
- Genitourinary (female)
- Genitourinary (male)
- Hematologic, Lymphatic, Immunologic
- Musculoskeletal
- Neurological
- Psychiatric
- Respiratory
- Skin

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Psychiatric Exam
Constitutional (shaded box)

- Three vital signs:
 - Sitting or standing blood pressure
 - Supine blood pressure
 - Pulse rate and regularity
 - Respiration
 - Temperature
 - Height
 - Weight
- General appearance of patient, e.g.:
 - Development
 - Nutrition
 - Body habitus, deformities
 - Attention to grooming

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Psychiatric Exam
Musculoskeletal (unshaded box)

- Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements
- Examination of gait and station

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Mental Status (shaded box)

- Speech
- Thought process
- Associations
- Abnormal or psychotic thoughts
- Judgment and insight
- Orientation
- Recent and remote memory
- Attention span and concentration
- Language
- Fund of knowledge
- Mood and affect

[illegible]41[illegible]

Level of Exam	Perform and Document
Problem Focused	1-5 elements identified by a bullet
Expanded Problem Focused	At least 6 elements identified by a bullet
Detailed	At least 9 elements identified by a bullet
Comprehensive	Perform all elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border

[illegible]



**MEDICAL DECISION
MAKING DETAIL**

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Medical Decision Making

- Number of diagnoses or management options
- Amount and/or complexity of data to be reviewed
- Risk of complications and/or morbidity or mortality

2/3 elements must be met or exceeded

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Number of Diagnoses or Management Options

- Based on
 - Number or types of problems addressed during the encounter
 - Complexity of establishing a diagnosis
 - The management decisions that were made
- Other indicators
 - Problem undiagnosed
 - Number or types of tests ordered
 - Need for consultation
 - Problem worsening

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Number of Diagnoses or
Management Options

- Minimal
- Limited
- Multiple
- Extensive

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Problem Points

Category of Problems/Major New symptoms	Points per problem
Self-limiting or minor (stable, improved, or worsening) (max=2)	1
Established problem (to examining physician); stable or improved	1
Established problem (to examining physician); worsening	2
New problem (to examining physician); no additional workup or diagnostic procedures ordered (max=1)	3
New problem (to examining physician); additional workup planned*	4

*Additional workup does not include referring patient to another physician for future care

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Number of Diagnoses or
Management Options

Level	Total Problem Points
Minimal	0-1
Limited	2
Multiple	3
Extensive	4

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Amount and/or Complexity of Data
to be Reviewed

- Types of diagnostic tests ordered
- Review of old medical records
 - Document the relevant findings
- History from other sources
 - Document the relevant findings
- Discussion of test results with physician who interpreted the test

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Amount and/or Complexity of Data
to be Reviewed

- Minimal or None
- Limited
- Moderate
- Extensive

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Data Points

Categories of Data to be Reviewed (max=1 for each)	Points
Review and/or order of clinical lab tests	1
Review and/or order of tests in the radiology section of CPT	1
Review and/or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than patient	1
Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider	2
Independent visualization of image, tracing, or specimen itself (not simply review report)	2

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Amount and/or Complexity of Data to be Reviewed

Level	Total Data Points
Minimal or None	0-1
Limited	2
Moderate	3
Extensive	4

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Risk of Significant Complications, Morbidity, and/or Mortality

- Based on risks associated with the presenting problem, diagnostic procedure, and the possible management options
- The highest level of risk in any one of these categories determines the overall risk

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TABLE 10-10

Level of Risk	Presenting Problem	Diagnostic Procedure	Management Options
Minimal	Stable, chronic condition with no change in symptoms or signs.	Physical examination only.	Stable, chronic condition with no change in symptoms or signs.
Limited	Stable, chronic condition with minor change in symptoms or signs.	Physical examination and laboratory tests.	Stable, chronic condition with minor change in symptoms or signs.
Moderate	Stable, chronic condition with moderate change in symptoms or signs.	Physical examination, laboratory tests, and imaging studies.	Stable, chronic condition with moderate change in symptoms or signs.
Extensive	Stable, chronic condition with extensive change in symptoms or signs.	Physical examination, laboratory tests, imaging studies, and specialized tests.	Stable, chronic condition with extensive change in symptoms or signs.

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Table of Risk

Level of risk	Presenting problem(s)	Diagnostic procedure(s) ordered	Management options selected
Minimal	One self-limited or minor problem	Venipuncture; EKG; urinalysis	Rest
Low	Two or more self-limited or minor problems; One stable chronic illness; Acute uncomplicated illness	Arterial puncture	OTC drugs
Moderate	One or more chronic illnesses with mild exacerbation, progression, or side effects; Two or more stable chronic illnesses; Undiagnosed new problem with uncertain prognosis; Acute illness with systemic symptoms		Prescription drug management
High	One or more chronic illnesses with severe exacerbation, progression, or side effects; Acute or chronic illnesses that pose a threat to life or bodily function		Drug therapy requiring intensive monitoring for toxicity

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Medical Decision Making

2/3 elements must be met or exceeded:

Number of diagnoses or management options	Amount and/or complexity of data	Risk	Complexity of decision making
Minimal	Minimal or None	Minimal	Straightforward
Limited	Limited	Low	Low
Multiple	Moderate	Moderate	Moderate
Extensive	Extensive	High	High

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Medical Decision Making

2/3 elements must be met or exceeded:

Problem Points	Data Points	Risk	Complexity of Medical Decision Making
0-1	0-1	Minimal	Straightforward
2	2	Low	Low
3	3	Moderate	Moderate
4	4	High	High

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“Typical” Time

- Guide when code level is determined by key components
- Actual time may be more or less
- This system rewards efficiency
- No need to track or document

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Counseling and/or Coordination of Care Exception

- Counseling and/or coordination of care is more than 50% of the time of the encounter
- Time becomes the controlling factor
 - Face-to-face time for office visits
 - Unit time for facility visits
- Document
 - Length of time of the encounter and of the time spent in counseling and coordination of care
 - The counseling and/or coordination of care activities

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Counseling

- Discussion of
 - Diagnostic results
 - Impressions
 - Recommended diagnostic studies
 - Prognosis
 - Risks and benefits of management options
- Instructions for management and/or follow-up
- Importance of compliance with chosen management options
- Risk factor reduction
- Patient and family education

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Code by Type of Visit

- Driven by complexity of medical decision making
 - Acute medical problems
 - Managing chronic conditions
- Exceptions
 - “Check up”
 - After gap in treatment
 - Stable patient requires careful monitoring
 - Counseling and/or coordination of care are greater than 50% of the time of the visit

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New and Established Patient

- New patient
 - Not seen within the past 3 years
- Established patient
 - Seen within the past 3 years
- “Seen”
 - **Exact** same specialty and subspecialty
 - Same group practice.
 - Covering same as covered

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That’s It for Now!

- Please view other AACAP presentations for application of specific E/M codes to patient examples and other CPT coding topics
- Questions sent to Jennifer Medicus at jmedicus@aacap.org will be passed on to the AACAP CPT Coding Subcommittee.

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SECTION 3: ADDITIONAL RESOURCES

SEE BOOKMARKS PANEL FOR DETAILS



American Psychiatric Association CPT Coding Resources for APA Members

Current Procedural Terminology (CPT) Code Changes for 2013

For 2013 there have been major changes to the codes in the Psychiatry section of the AMA's Current Procedural Terminology, the codes that must be used for billing and documentation for all insurers. These changes apply to any services provided beginning January 1, 2013.

- A distinction has been made between an initial evaluation with medical services done by a physician (90792) and an initial evaluation done by a non-physician (90791).
- The psychotherapy codes have been simplified and expanded to include time with both the patient and/or family member: There are now just three timed codes to be used for psychotherapy in all settings (90832- 30 minutes; 90834-45 minutes; 90837- 60 minutes) instead of a distinction made by setting and whether E/M services were provided. When psychotherapy is done in the same encounter as an E/M service, there are timed add-on codes for psychotherapy (indicated in CPT by the + symbol) that are to be used by psychiatrists to indicate both services were provided (+90833 -30 minutes, +90836 - 45 minutes, +90838 – 60 minutes). The time for each psychotherapy code is now described as being as time spent with the patient *and/or family member*, a change from the previous psychotherapy code times, which denoted only time spent face-to-face with the patient.

Note: Since the new psychotherapy codes are not for a range of time, like the old ones, but for a specific time, the CPT "time rule" applies. If the time is more than half the time of the code (i.e., for 90832 this would be 16 minutes) then that code can be used. For up to 37 minutes you would use the 30 minute code; for 38 to 52 minutes, you would use the 45-minute code, 90834; and for 53 minutes and beyond, you would use 90837, the 60-minute code.

- In lieu of the separate codes for interactive psychotherapy, there is now an add-on code for interactive complexity, which may be used when the patient encounter is made more complex by the need to involve people other than the patient (+90785). This add-on can be used with initial evaluation codes (90791 and 90792), with the psychotherapy codes, with the non-family group psychotherapy code (90853), and with the E/M codes when they're used in conjunction with psychotherapy services. Although it is expected this code will be used most frequently in the treatment of children, it can be used any time the interaction with the patient and/or family member is more complex than normal or when other parties must be involved. The CPT manual includes specific guidelines as to what constitutes interactive complexity that should be understood before this add-on code is used. Documentation must clearly indicate exactly what that complexity was.
- Another change is that a new code has been added for psychotherapy for a patient in crisis (90839). When a crisis encounter goes beyond 60 minutes there is an add-on code for each additional 30 minutes (+90840). This code was developed at the behest of the National Association of Social Workers, and it is expected that psychiatrists will generally use a high level



American Psychiatric Association CPT Coding Resources for APA Members

E/M code when providing care for a patient in crisis. The CPT manual has guidelines as to what constitutes a crisis and permits the use of this code.

- Code 90862 has been eliminated, and psychiatrists will now use the appropriate evaluation and management (E/M) code when they do pharmacologic management for a patient. When psychotherapy is done during the same session as the pharmacologic management, one of the new psychotherapy add-on codes should be used along with the E/M code. (A new code, add-on code +90863, has been created for medication management when done with psychotherapy by the psychologists in New Mexico and Louisiana who are permitted to prescribe, but this code is **not** to be used by psychiatrists or other medical mental health providers).

What is an add-on code? An add-on code is a code that can only be used in conjunction with another, primary code and is indicated by the plus symbol (+) in the CPT manual. While basic CPT codes are valued to account for pre- and post-time, add-on codes are only valued based on intra-service time since the pre- and post-time is accounted for in the primary code. In the new Psychiatry codes there are three different types of add-on codes: 1.) Timed add-on codes to be used to indicate psychotherapy when it is done with medical evaluation and management; 2.) A code to be used when psychotherapy is done that involves interactive complexity (and 3.) A code to be used with the crisis therapy code for each 30 minutes beyond the first hour. See above for details about these add-on codes.

All of these changes are represented in the chart and crosswalk provided on the following pages.

For more information contact the APA's Office of Healthcare Systems and Financing at hsf@psych.org or call the Practice Management HelpLine at 888-343-4671.



American Psychiatric Association CPT Coding Resources for APA Members

Psychiatry Coding Changes for 2013

Initial Psychiatric Evaluation (formerly 90801 or new patient E/M code)
90791, Psychiatric diagnostic evaluation (no medical services)
90792, Psychiatric diagnostic evaluation (with medical services) (New patient E/M codes may be used in lieu of 90792)
Psychotherapy (formerly 90804-90808, 90816-90821) For use in all settings; time is with patient and/or family)
90832, psychotherapy, 30 minutes
90834, psychotherapy, 45 minutes
90837, psychotherapy, 60 minutes
Evaluation Management (E/M) and Psychotherapy (formerly 90805-90809, 90817-90822)
Appropriate E/M code (not selected on basis of time), and +90833, 30-minute psychotherapy add-on code
Appropriate E/M code (not selected on basis of time), and +90836, 45-minute psychotherapy add-on code
Appropriate E/M code (not selected on basis of time), and +90838, 60-minute psychotherapy add-on code
Medication Management (formerly 90862 or E/M code)
Appropriate E/M code (99xxx series)
Interactive Psychotherapy (formerly 90802, 90810-90815, 90823-90829, 90857) For use with the psychiatric evaluation codes, the psychotherapy and psychotherapy add-on codes, and the group (non-family) psychotherapy code
+90785, interactive psychotherapy
Crisis Psychotherapy (new)
90839, psychotherapy for crisis, first 60 minutes (Appropriate E/M code may be used in lieu of 90839)
+90840, psychotherapy for crisis, each additional 30 minutes



American Psychiatric Association CPT Coding Resources for APA Members

CROSSWALK 2012 Codes to 2013 Codes

These changes take effect January 1, 2013. We encourage everyone to purchase the 2013 edition of the CPT manual from the AMA. You can do this by calling the AMA at 800-621-8335 or go to <https://catalog.ama-assn.org/Catalog/home.jsp>. The following table provides a crosswalk between the CPT coding options in 2012 to the CPT coding options that take effect on January 1, 2013. In addition to new numbers and revised or new descriptors, a new concept – add-on codes – has been introduced. This list includes only those codes that have been revised in some way and is not a full list of CPT codes describing psychiatric work.

2012 Code	2013 Code(s)
Initial Psychiatric Evaluation	
90801 , psychiatric diagnostic evaluation	90791 , psychiatric diagnostic evaluation (no medical services) 90792 , psychiatric diagnostic evaluation with medical services (E/M new patient codes may be used in lieu of 90792)
90802 , interactive psychiatric diagnostic evaluation	90791 or 90792 , with +90785 (interactive complexity add-on code)
Outpatient Psychotherapy	
(Time is face-to-face with patient)	(Time is with patient and/or family)
90804 , outpatient psychotherapy 20-30 min.	90832 , psychotherapy, 30 min.
90805 , outpatient psychotherapy w/ E/M services 20-30 min.	Appropriate outpatient E/M code (not selected on basis of time), and +90833 , 30-minute psychotherapy add-on code
90806 , outpatient psychotherapy 45-50 min.	90834 , psychotherapy, 45 min.
90807 , outpatient psychotherapy w/ E/M services 45-50 min.	Appropriate outpatient E/M code (not selected on basis of time), and +90836 , 45-minute psychotherapy add-on code
90808 , outpatient psychotherapy 75-80 min.	90837 , psychotherapy, 60 min.
90809 , outpatient psychotherapy w/ E/M services 75-80 min.	Appropriate outpatient E/M code (not selected on basis of time), and +90838 , 60-minute psychotherapy add-on code
Outpatient Interactive Psychotherapy	
(Time is face-to-face with patient)	(Time is with patient and/or family)
90810 , interactive psychotherapy, 20-30 min.	90832 psychotherapy, 30 min., and +90785 , interactive complexity add-on code
90811 , interactive psychotherapy w/ E/M, 20-30 min.	Appropriate outpatient E/M code (not selected on basis of time), and +90833 , 30-minute psychotherapy add-on code, and +90785 , interactive complexity add-on code
90812 , interactive psychotherapy, 45-50 min.	90834 , psychotherapy, 45 min. and +90785 , interactive complexity add-on code
90813 , interactive psychotherapy w/ E/M, 45-50 min.	Appropriate outpatient E/M code (not selected on basis of time), and +90836 , 45-minute psychotherapy add-on code, and +90785 , interactive complexity add-on code
90814 , interactive psychotherapy, 75-80 min.	90837 , psychotherapy, 60 min., and +90785 , interactive complexity add-on code
90815 , interactive psychotherapy w/ E/M, 75-80 min.	Appropriate outpatient E/M code (not selected on basis of time), and +90838 , 60-minute psychotherapy add-on code, and +90785 , interactive complexity add-on code



American Psychiatric Association CPT Coding Resources for APA Members

2012 Code	2013 Code(s)
Inpatient Psychotherapy	
(Time is face-to-face with patient)	(Time is with patient and/or family)
90816 , inpatient psychotherapy, 20-30 min.	90832 , psychotherapy, 30 min.
90817 , inpatient psychotherapy, 20-30 min. w/ E/M	Appropriate inpatient E/M code (not selected on basis of time), and +90833 , 30-minute psychotherapy add-on code
90818 , inpatient psychotherapy, 45-50 min.	90834 , psychotherapy, 45 min.
90819 , 45-50 min. w/ E/M	Appropriate inpatient E/M code (not selected on basis of time), and +90836 , 45-minute psychotherapy add-on code
90821 , inpatient psychotherapy, 75-80 min.	90837 , psychotherapy, 60 min.
90822 , 75-80 min. w/ E/M	Appropriate inpatient E/M code (not selected on basis of time), and +90838 , 60-minute psychotherapy add-on code
Interactive Inpatient Psychotherapy	
(Time is face-to-face with patient)	(Time is with patient and/or family)
90823 , interactive inpatient psychotherapy, 20-30 min.	90832 , psychotherapy, 30 min. +90785 , interactive complexity add-on code
90824 , interactive inpatient psychotherapy, 20-30 min. w/ E/M	Appropriate inpatient E/M code (not selected on basis of time), and +90833 , 30-minute psychotherapy add-on code, and +90785 , interactive complexity add-on code
90826 , interactive inpatient psychotherapy, 45-50 min.	90834 , psychotherapy, 45 min. +90785 , interactive complexity add-on code
90827 , interactive inpatient psychotherapy, 45-50 min. w/ E/M	Appropriate inpatient E/M code (not selected on basis of time), and +90836 , 45-minute psychotherapy add-on code, and +90785 , interactive complexity add-on code
90828 , interactive inpatient psychotherapy, 75-80 min.	90837 , psychotherapy, 60 min. +90785 , interactive complexity add-on code
90829 , interactive inpatient psychotherapy, 75-80 min. w/ E/M	Appropriate inpatient E/M code (not selected on basis of time), and +90838 , 60-minute psychotherapy add-on code, and +90785 , interactive complexity add-on code
Other Psychotherapy Codes	
90857 , Interactive group psychotherapy	90853 , group psychotherapy (other than of multi-family), and +90785 , interactive complexity add-on code
No existing code	90839 , psychotherapy for crisis, first 60 min.
No existing code	+90840 , crisis code add on for each additional 30 min.
Other Psychiatric Services or Procedures	
90862 , pharmacologic management	Appropriate E/M code (Prescribing psychologists will use +90863)

Questions – Go to <http://www.psychiatry.org/practice> , or call 800-343-4671 or send an email to hsf@psych.org. To purchase a copy of the 2013 CPT manual call the AMA at 800-621-8335 or go to <https://catalog.ama-assn.org/Catalog/home.jsp> .

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AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

E/M

Psychotherapy

E/M Alone

E/M Plus Psychotherapy

Psychotherapy Alone

E/M Code Examples

	Outpatient	Inpatient PHP
99204		
99205		
99213		
99214		
99215		
99222		
99223		
99231		
99232		
99233		

Step 1: Select E/M Code

Step 2: Select Psychotherapy Time

Report

E/M Code

Psychoanalysis

Report

90845

Psychotherapy

Family Therapy

Group Therapy

Psychotherapy for Crisis

Type

Report

Pt not present 90846

Pt present 90847

Group 90849

Psychotherapy Time

Report

30 (16-37*) min 90832

45 (38-52*) min 90834

60 (53+*) min 90837

Psychotherapy Time

Report

30-74 min 90839

+30 min 90840

Report

90853

Interactive Complexity Present

Psychotherapy Time

Report

30 (16-37*) min E/M Code, 90833 and 90785

45 (38-52*) min E/M Code, 90836 and 90785

60 (53+*) min E/M Code, 90838 and 90785

Psychotherapy Time

Report

30 (16-37*) min 90832 and 90785

45 (38-52*) min 90834 and 90785

60 (53+*) min 90837 and 90785

Report

90853 and 90785

* Per CPT Time Rule

* Per CPT Time Rule

Medical screening including the history, examination, and medical decision-making are required to determine the need and/or location for appropriate care and treatment of the patient (eg, office and other outpatient setting, emergency department, nursing facility). The levels of evaluation and management (E/M) services encompass the wide variations in skill, effort, time, responsibility, and medical knowledge required for the prevention or diagnosis and treatment of illness or injury and the promotion of optimal health.

How to Use This Quick Reference Guide

The descriptors for the levels of many of the E/M services recognize seven components, six of which are used in defining the levels of E/M services. The first three of these components (history, examination, and medical decision-making) are considered the **key** components and are required in selecting a level of E/M services. The next three components (counseling, coordination of care, and the nature of the presenting problem) are considered **contributory** factors in the majority of encounters. Although the first two of these contributory factors are important E/M services, it is not required that these services be provided during every patient encounter. The final component—time—is discussed in detail in the E/M Guidelines of *CPT® 2013*.

The tables contained within this guide summarize the requirements for reporting E/M services. The Pediatric and Neonatal Critical, Intensive, and Subsequent Care Codes have also been added to the listing of code families, with tabular illustrations of the requirements for reporting these services. Note: The E/M guidelines and the full code descriptors provided in the *CPT® 2013* codebook are essential elements in determining final code selection.

Contents of This Guide

1. Office or Other Outpatient Services (New Patient)
2. Office or Other Outpatient Services (Established Patient)
3. Initial Observation Care
 1. Subsequent Observation Care
 5. Initial Hospital Care
 6. Subsequent Hospital Care
7. Observation or Inpatient Care Services (Including Admission and Discharge Services)
8. Office or Other Outpatient Consultations
9. Inpatient Consultations
10. Emergency Department Services
11. Initial Nursing Facility Care
12. Subsequent Nursing Facility Care
13. Domiciliary, Rest Home (eg, Boarding Home), or Custodial Care Services (New Patient)
14. Domiciliary, Rest Home (eg, Boarding Home), or Custodial Care Services (Established Patient)
15. Home Services (New Patient)
16. Home Services (Established Patient)
17. Initial Inpatient Neonatal and Pediatric Critical Care
18. Subsequent Inpatient Neonatal and Pediatric Critical Care
19. Initial Neonatal Intensive Care
20. Continuing Neonatal and Infant Inpatient Low Birth-Weight Intensive Care
21. Critical Care Time Reporting

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Office or Other Outpatient Services					
Patient: New					
Required Components: 3/3					
Code	99201	99202	99203	99204	99205
Required Key Components					
History and Exam (#1 and #2)					
Problem-Focused	X				
Expanded Problem-Focused		X			
Detailed			X		
Comprehensive				X	X
Medical Decision Making (Complexity) (#3)					
Straightforward	X	X			
Low			X		
Moderate				X	
High					X
Contributory Factors					
Presenting Problem (Severity) (#1)					
Self-limited or Minor	X				
Low to Moderate		X			
Moderate			X		
Moderate to High				X	X
Counseling (#2) See E/M Guidelines					
Coordination of Care (#3) See E/M Guidelines					
Typical Face-to-Face Time (#4)					
Minutes	10	20	30	45	60

Table 1

Office or Other Outpatient Services					
Patient: Established					
Required Components: 2/3					
Code	99211	99212	99213	99214	99215
Required Key Components					
History and Exam (#1 and #2)					
Problem-Focused	N/A	X			
Expanded Problem-Focused			X		
Detailed				X	
Comprehensive					X
Medical Decision Making (Complexity) (#3)					
Straightforward	N/A	X			
Low			X		
Moderate				X	
High					X
Contributory Factors					
Presenting Problem (Severity) (#1)					
Minimal	X				
Self-Limited or Minor		X			
Low to Moderate			X		
Moderate to High				X	X
Counseling (#2) See E/M Guidelines					
Coordination of Care (#3) See E/M Guidelines					
Typical Face-to-Face Time (#4)					
Minutes	5	10	15	25	40

Table 2

Patient Name: _____	Date: _____																														
Identifying Data: _____	Source of Info: _____																														
HISTORY																															
CHIEF COMPLAINT/REASON FOR ENCOUNTER:																															
HPI ((1-3 elements - Brief; 4+ elements – Extended) Elements: Location, Quality, Severity, Duration, Timing, Content, Modifying Factors, Associated Signs & Symptoms																															
PAST PSYCHIATRIC HISTORY: (1 history area – Pertinent; 2-3 history areas – Complete)																															
PAST MEDICAL HISTORY: Diagnoses: _____ Medications: _____ Surgeries: _____ Allergies: _____																															
PAST FAMILY, SOCIAL, HISTORY (PFSH):																															
<table border="0" style="width: 100%;"> <tr> <th style="text-align: left; width: 50%;">REVIEW OF SYSTEMS & ACTIVE MEDICAL PROBLEMS</th> <th style="text-align: left; width: 50%;">NOTES IF POSITIVE</th> </tr> <tr> <td colspan="2"><i>(1 system - Problem Pertinent; 2-9 systems – Extended; 10 or more systems or some systems noted as "all others negative"- Complete)</i></td> </tr> <tr> <td>1. Constitutional</td> <td>pos___ neg___</td> </tr> <tr> <td>2. Eyes</td> <td>pos___ neg___</td> </tr> <tr> <td>3. Ears/Nose/Mouth/Throat</td> <td>pos___ neg___</td> </tr> <tr> <td>4. Cardiovascular</td> <td>pos___ neg___</td> </tr> <tr> <td>5. Respiratory</td> <td>pos___ neg___</td> </tr> <tr> <td>6. Gastrointestinal</td> <td>pos___ neg___</td> </tr> <tr> <td>7. Genitourinary</td> <td>pos___ neg___</td> </tr> <tr> <td>8. Muscular</td> <td>pos___ neg___</td> </tr> <tr> <td>9. Integumentary</td> <td>pos___ neg___</td> </tr> <tr> <td>10. Neurological</td> <td>pos___ neg___</td> </tr> <tr> <td>11. Endocrine</td> <td>pos___ neg___</td> </tr> <tr> <td>12. Hematologic/Lymphatic</td> <td>pos___ neg___</td> </tr> <tr> <td>13. Allergies/Immune</td> <td>pos___ neg___</td> </tr> </table>		REVIEW OF SYSTEMS & ACTIVE MEDICAL PROBLEMS	NOTES IF POSITIVE	<i>(1 system - Problem Pertinent; 2-9 systems – Extended; 10 or more systems or some systems noted as "all others negative"- Complete)</i>		1. Constitutional	pos___ neg___	2. Eyes	pos___ neg___	3. Ears/Nose/Mouth/Throat	pos___ neg___	4. Cardiovascular	pos___ neg___	5. Respiratory	pos___ neg___	6. Gastrointestinal	pos___ neg___	7. Genitourinary	pos___ neg___	8. Muscular	pos___ neg___	9. Integumentary	pos___ neg___	10. Neurological	pos___ neg___	11. Endocrine	pos___ neg___	12. Hematologic/Lymphatic	pos___ neg___	13. Allergies/Immune	pos___ neg___
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11. Endocrine	pos___ neg___																														
12. Hematologic/Lymphatic	pos___ neg___																														
13. Allergies/Immune	pos___ neg___																														
PSYCHIATRIC SPECIALTY EXAMINATION																															
<i>(1-5 bullets- Problem Focused; at least 6 bullets Expanded Problem Focused; at least 9 bullets - Detailed; all bullets- Comprehensive Exam)</i>																															
• Vital Signs (any 3 or more of the 7 listed): Blood Pressure: (Sitting/Standing) _____ (Supine) _____ Temp _____ Pulse (Rate/Regularity) _____ Respiration _____ Height _____ Weight _____	Patient personally examined: __ Yes __ No																														
• General Appearance and Manner: (e.g., development, nutrition, body habitus, deformities, attention to grooming)																															
• Musculoskeletal: __Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) (note any atrophy or abnormal movements) (and/or) __Examination of gait and station																															
• Speech: Check if normal: __rate__volume__articulation__coherence__spontaneity (note abnormalities; e.g., perseveration, paucity of language)																															

Thought processes: Check if normal: __associations__processes__abstraction __computation	
Description of associations (e.g., loose, tangential, circumstantial, intact):	
Description of abnormal or psychotic thoughts (e.g., hallucinations, delusions, preoccupation with violence, homicidal or suicidal ideation, obsessions):	
Suicidal ideation: __ Present__ Absent Homicidal ideation: __Present __ Absent Violent ideation: __Present __ Absent	
Description of patient’s judgment and insight:	
Orientation:	
Memory (Recent/Remote):	
Attention/Concentration:	
Language:	
Fund of knowledge: __intact __inadequate	
Mood and affect:	
Other Findings (e.g. cognitive screens, etc.):	
MEDICAL DECISION MAKING	
Need for admission/evaluation:	Data
	Medical Records/Labs/Diagnostic Tests Reviewed:
Diagnoses	Treatment Plan
Axis I-V:	Intervention/Psychotherapy
	Medication
Rule outs:	Labs/Radiology/Tests/Consultation
Formulation:	Other
	__Greater than 50% of time spent in counseling/coordination of care (document)

Physician Name (Print)

Physician Signature

Date and Time

PROGRESS NOTE: E/M + PSYCHOTHERAPY

Date _____ Name _____

CC _____

HPI _____

_____ [#__elements=_____ (location, severity, timing, quality, duration, context, modifying factors, assoc s/s)]

PFSH _____

_____ [#__elements = _____]

ROS _____

_____ [#__systems=_____]

Current Psych Meds _____

_____ Non-Psych Meds Reviewed and List Updated []

[HPI _____, PFSH _____, ROS _____ = HISTORY TYPE _____]

EXAM

Constitutional: Appearance _____ VS _____

M-S: Muscle strength + tone _____ Gait + Station _____

Psych: _____

_____ [#__bullets = _____]

MEDICAL DECISION MAKING

Problem #1 _____

Status _____

Plan _____

Problem #2 _____

Status _____

Plan _____

[#__ Problem points. #__ Data points. Risk= _____ = MDM _____]

Additional Info: _____

[HX = _____, EXAM = _____, MDM = _____] = CPT Code _____

PSYCHOTHERAPY: Supportive[] CBT[] Behavior-modifying[] Psychoeducation[] Time _____ CPT Code _____

Cheryl Waskiewicz, APRN

Major Changes to CPT Codes for Psychiatry and Psychotherapy in 2013

September 2012

Effective January 1, 2013, there will be significant changes to Current Procedural Terminology (CPT) codes for psychiatry and psychotherapy services. The CPT code set is defined by the American Medical Association (AMA) and describes procedures and services by physicians and other health care professionals. CPT codes are used as the basis for billing third-party payers, and changes to these codes can affect insurers' coverage and pricing decisions. Changes to CPT code sets are made by AMA on an annual basis, but decisions made this year will have a much higher-than-usual impact on psychiatry and psychotherapy services.

Significant Changes to the 2013 Psychiatry CPT Code Set

Several commonly used psychiatric CPT codes have been deleted or modified. Changes include:

- Removal of evaluation and management (E&M) plus psychotherapy codes from the psychiatry section (90805, 90807)
- Deletion of pharmacologic management (providers to use appropriate E&M code)
- Psychotherapy and E&M services are distinguished from each other (time spent on E&M services is not counted towards psychotherapeutic services, and separate codes can be used in combination with one another)
- Inclusion of add on codes for psychiatry, which are services performed in addition to a primary service or procedure (and never as a stand-alone service)
- Addition of code 90785 for interactive complexity
- New code for psychotherapy for a patient in crisis

The scope of these changes is not yet fully known – AMA's revisions are just the first step in a longer implementation process (see chart below). While insurers, including Medicare and Medicaid, cannot use codes that were outright deleted by AMA, they can still make pricing and coverage decisions within the remaining (and new or modified) codes. Whatever changes are ultimately adopted by payers, they are likely to have a large impact on health care agencies' workflow, billing processes, and practice management systems.

CPT Code Change and Adoption Process

Step 1: AMA adopted changes to CPT codes (additions, deletions, modifications) in September 2012.

Step 2: Insurers make decisions about which codes to continue to pay for and establish pricing. They cannot continue to use CPT codes that have been deleted by AMA.

NOTE: Many Medicaid agencies have coverage and reimbursement policies that tie back to Medicare coverage decisions made by CMS.

Step 2a: CMS publishes rule about 2013 pricing for Medicare, usually in November.

Step 2b: State Medicaid agencies decide which codes to keep and adjust pricing.

Step 3: Insurers and providers make changes to billing systems, contracts, and work flow, as needed, for services provided after 1/1/2013

Crosswalk: 2012 to 2013 CPT Code Sets

Included below is a crosswalk of some of the major changes to the psychiatry section of the CPT code set. The National Council strongly encourages organizations to purchase their own copy of the 2013 CPT code book at: www.amabookstore.com or (800) 621-8335.

2012 Code	Action Taken	2013 Code		Report with Psychotherapy Add-On Code		Report with Code for Interactive Complexity (90785)
Diagnostic Procedures						
90801: psychiatric diagnostic evaluation	Deleted	90791: psychiatric diagnostic evaluation (no medical services)	+	n/a	+	When appropriate
		90792: psychiatric diagnostic evaluation with medical services (or E&M new patient codes)	+	n/a	+	When appropriate
90802: interactive psychiatric diagnostic evaluation	Deleted	90791 or 90792	+	n/a	+	90785
Psychotherapy						
90804: outpatient psychotherapy, 20-30 min.	Deleted	90832: psychotherapy, 30 minutes	+	n/a	+	When appropriate
90805: outpatient psychotherapy with E&M services, 20-30 min.	Deleted	Appropriate E&M code	+	90833: 30 min add-on	+	When appropriate
90806: outpatient psychotherapy, 45-50 min.	Deleted	90834: psychotherapy, 45 minutes	+	n/a	+	When appropriate
90807: outpatient psychotherapy with E&M services, 45-50 min.	Deleted	Appropriate E&M code	+	90836: 45 min add-on	+	When appropriate
90808: outpatient psychotherapy, 75-80 min.	Deleted	90837: psychotherapy, 60 minutes	+	n/a	+	When appropriate
90809: outpatient psychotherapy with E&M services, 75-80 min.	Deleted	Appropriate E&M code	+	90838: 60 min add-on	+	When appropriate
Interactive Psychotherapy						
90810: interactive psychotherapy, 20-30 min.	Deleted	90832: psychotherapy, 30 min.	+	n/a	+	90785
90811: interactive psychotherapy with E&M, 20-30 min.	Deleted	Appropriate E&M code	+	90833: 30 min add-on	+	90785
90812: interactive psychotherapy, 45-50 min.	Deleted	90834: psychotherapy, 45 min.	+	n/a	+	90785
90813: interactive psychotherapy with E&M, 45-50 min.	Deleted	Appropriate E&M code	+	90836: 45-min add-on	+	90785
90814: interactive psychotherapy, 75-80 min.	Deleted	90837: psychotherapy, 60 min.	+	n/a	+	90785
90815: interactive psychotherapy with E&M, 75-80 min.	Deleted	Appropriate E&M code	+	90838: 60 min add-on	+	90785
Other						
(None)	New code	90839: psychotherapy for crisis, first 60 minutes	+	90840: psychotherapy for crisis, each additional 30 min.		No
90857: interactive group psychotherapy	Deleted	90853: group psychotherapy (other than multiple-family group)	+	n/a	+	90785
90862: pharmacologic management	Deleted	Appropriate E&M code	+	Yes , according to psychotherapy time		No

Questions? Contact Nina Marshall at ninam@thenationalcouncil.org.

CPT Code Changes for 2013 Frequently Asked Questions

Last Updated 12/2/2012

1. Why are CPT codes changing?

CPT code changes occur every year. The Current Procedural Terminology, or CPT, code set is maintained by the American Medical Association and used to describe procedures and services by physicians and other health care professionals. CPT codes are used as the basis for billing third-party payers, and changes to these codes can affect insurers' coverage and pricing decisions. The CPT code set is updated every year to reflect changes in technology and procedures, but this year's changes will result in a higher-than-usual impact on behavioral health. The last time major changes were made to the Psychiatry section was in 1998.

2. What are some of the major changes between 2012 and 2013 for behavioral health?

Several commonly used CPT codes from the Psychiatry section have been deleted or modified. Changes include:

- Removal of evaluation and management (E/M) plus psychotherapy codes from the psychiatry section (90805, 90807)
- Deletion of pharmacologic management (providers to use appropriate E/M code, except for providers who cannot use E/M codes)
- Psychotherapy and E/M services are distinguished from each other (time spent on E/M services is not counted towards psychotherapeutic services, and separate codes can be used in combination with one another)
- Inclusion of add on codes for psychiatry, which are services performed in addition to a primary service or procedure (and never as a stand-alone service)
- Addition of code 90785 for interactive complexity
- New code for psychotherapy for a patient in crisis

3. When will these changes take effect? Will there be any delay?

Under HIPAA, the new CPT code set will take effect on January 1, 2013. You should be in touch with your payers about their transition timeline.

4. Are these changes related to the ICD-10 changes?

No. ICD-10 codes are used to describe diagnoses. CPT codes are used to describe procedures. Changes to each code set are independent of each other.

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5. Where can we find rates for each of these codes?

Rates for individual services will be payer-specific. CPT codes describe individual services, and insurance and other payers independently set rates for those services.

Contracts with private payers usually have an appendix with a fee schedule. Some contracts are designed so the payer can change rates without amending a contract. If your contract is not designed in this way, it may require a contract amendment.

Payers may not have assigned rates yet, so it may be some time before learning what the rates will be for 2013.

On November 1, 2012, CMS published through regulation the relative value units (RVUs) for services for 2013 (except for crisis psychotherapy codes). This is the first step for establishing rates under Medicare. The psychiatry section of the published rule begins on page 531 of this document: http://www.ofr.gov/OFRUpload/OFRData/2012-26900_PI.pdf.

Organizations should be in touch with all payers about their implementation timelines, including their state Medicaid agency, Medicare Administrative Contractors (MACs), and other third-party payers.

6. What are “add-on codes”?

Add-on codes identify procedures that are carried out in addition to a primary procedure. They only apply to services or procedures performed by the same health care professional. Add-on codes should only be reported along with a primary procedure, and must never be reported alone as a stand-alone code.

Examples of add-on codes are:

- Add-on codes for psychotherapy: 90833 (30 min.), 90836 (45 min.), 90838 (60 min.)
- Add-on code for interactive complexity: 90785

An example for use of an add-on code:

Evaluation and Management service plus 30 minute psychotherapy session by a psychiatrist:

Code as: 99211 (or other appropriate level of E/M code) and 90833 (30 min psychotherapy add-on)

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7. How do we submit add-on codes on claims? Do we include the + before the 5 digits?

The add-on code is a second line on the claim, and must be submitted along with the primary service that it is supplementing. Do not include a “+” sign; only use the 5-digit code.

8. What are Evaluation and Management (E/M) codes?

Evaluation and Management (or E/M) is a category of medical services. This is not a new category of codes for CPT, though many medical providers in behavioral health used codes from the psychiatry section of the CPT book instead of the E/M section. Since the E/M-related codes in the Psychiatry section have been deleted, behavioral health medical services will have to be coded using E/M codes. The Centers for Medicare and Medicaid Services developed a fact sheet on E/M codes: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Evaluation_Management_Fact_Sheet_ICN905363.pdf.

Using E/M codes has an impact on documentation and service requirements, and providers should be careful to learn about these before billing for them.

The National Council will be holding a webinar on E/M code selection and documentation on December 3, 2012. Registration is available [here](#). Slides and a recording of the presentation will be posted [here](#) (after December 3).

9. By using Evaluation and Management (E/M) codes, will psychiatrists have to take blood pressure and other physical health care measurements?

It depends on the level of code being billed. One commonly used set of guidelines on how to code and document different E/M levels is the Centers for Medicare and Medicaid Services’ “[1997 Documentation Guidelines for Evaluation and Management Services](#).”

Regardless the psychiatrist does not have to take the measurements her/himself.

10. What is “Interactive Complexity”?

Interactive complexity is a new term in CPT for 2013. It refers to specific factors that complicate the delivery of a psychiatric procedure. The code book lists specific circumstances where this might apply, like needing to involve third parties like probation officers, interpreters, other legal guardians, etc.

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Interactive complexity is an add-on code and should not be reported as a standalone service; the code is 90785.

Interactive complexity can be used with:

- Initial evaluation codes (90791 and 90792)
- Psychotherapy codes
- Non-family group psychotherapy codes
- E/M codes when used in conjunction with psychotherapy services

See slides 73-79 of [CPT Code Changes for 2013](#) for additional information on interactive complexity.

11. What codes should be used for Pharmacologic Management?

The code 90862 for pharmacologic management has been deleted for 2013. Instead, providers are to use:

- E/M Codes (Physicians, Nurse Practitioners, and other health care professionals who may use E/M Codes)
- +90863 (Psychologists and other health care professionals with prescribing authority may not use E/M codes; however can report as an add-on to psychotherapy services) (the only group are prescribing psychologists, and only two states that allow that)

12. What codes should be used for extended psychotherapy sessions (e.g. 80 or 120 minutes)?

The longest psychotherapy session code for 2013 is 60 minutes (90837). That can be used for any session longer than 53 minutes. Generally speaking, you should be in contact with carriers about any modifications to billing procedures for longer sessions. Depending on the individual payer's policy, modifier 22 for "increased procedural services" might be used.

13. Will they now accept the two new and separate intake codes from both the clinician and psychiatrist for the same client?

The evaluation codes 90791 and 90792 (with medical) can be reported by separate providers. Any deviation would be a result of individual payer policy.

14. Must crisis services be provided face-to-face or can they be provided by telephone?

It is unlikely that payers will cover services provided over the phone.

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15. Will they reimburse for an intake code if client was already seen and billed for intake within the past 3 years?

Yes, the 90791 and 90792 can be used subject to the payer's approval for an established patient. Limits to the use and reimbursement of these two codes must be determined with payer. For E/M, this would describe an established patient and the appropriate code would need to be reported.

16. Can psychiatrists bill "add-on" codes with their E/M codes if they are not the primary clinician providing the client's psychotherapy?

Psychiatrists can report add on codes such as psychotherapy with a primary E/M code. The work and documentation would need to support the reporting of the add-on code.

17. Where can I find additional resources?

The National Council is maintaining a website with resources for implementing these changes at: www.thenationalcouncil.org/cs/cpt_codes.

We strongly recommend that each organization purchase a copy of the AMA's CPT code book for 2013. The code book contains complete definitions of each code, along with instructions on how they can be used in combination with each other. Books can be purchased from the AMA at: www.amabookstore.com or (800) 621-8335.

18. How do we get a copy of the November 9th presentation, "CPT Code Changes for 2013: Impact on Behavioral Health"?

The presentation slides and audio are available on the National Council website. www.thenationalcouncil.org/cs/cpt_codes.

19. Who can we contact for more in depth consultation on use of E/M codes or the transition to 2013 CPT codes?

The National Council recommends contacting David Swann with MTM Services:

David R. Swann, MA, LCAS, CCS, LPC, NCC
Senior Healthcare Integration Consultant, MTM Services
Email: david.swann@mtmservices.org
Phone: (336) 710-3585

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20. Can non-psychiatrists (psychologists, LPCs, LCSWs) bill for 90791 even though its description is “psychiatric diagnostic evaluation,” or will they no longer be able to bill for evaluations?

Use of code 90791 is not limited to physicians. The CPT code book says that 90791 includes “an integrated biopsychosocial assessment, including history, mental status, and recommendations.” There is a separate piece that describes the medical services to make it 90792.

21. Do the new time requirements for psychotherapy (e.g., 90832, psychotherapy, 30 minutes) include time for documentation by the provider? Under 90832, is 30 minutes the minimum amount of time that must be met in order to consider this a billable session?

The time reported is actual face-to-face time with the patient and/or family member (the patient needs to be part of all or some of the service), so it does not include documentation time if documentation is completed without the input of the patient and/or family member.

If time dedicated to documentation is a concern, concurrent/collaborative documentation has been shown to support compliance and efficiency, and therapists and clients alike find it to be helpful.

When selecting a time-based code for psychotherapy, the CPT instructions are that a “unit of time is attained when the mid-point is passed.” Additionally, when codes are in sequential times, choose the code with the closest time. Therefore:

- 16-37 minutes for 90832 and 90833
- 38-52 minutes for 90834 and 90836
- 53+ minutes for 90837 and 90838

22. It was inferred that all of the psychotherapy codes must have the patient present in order to bill insurance. We used to be able to use 90846 for family therapy without the patient present. Was this code not replaced?

90846 (family psychotherapy without the patient present) and 90847 (family psychotherapy with patient present) have not changed. If you bill the individual psychotherapy codes 90832-90838 then the patient needs to be present for all or part of the service.

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23. We have psych nurse practitioners and master level therapists in our practice. Our clients appreciate the convenience of seeing the psych NP for med review and then seeing their therapist following that appointment for psychotherapy. As we read through the information, it appears with the new codes we will not be able to allow our clients to do this. Is this accurate

You cannot report a psychiatric diagnostic procedure (90791 or 90792) on the same day as psychotherapy. You can, however, report an E/M code with psychotherapy on the same day (either by the same professional with an add-on code, or separate clinician with principal psychotherapy code).

That said, there are some policy-level decisions by payers (e.g., a few state Medicaid programs), that prohibits billing of multiple visits by separate providers on a single day. You would need to confirm with your payer that you can continue to do this (but if they were OK with it in 2012, it's not likely they'd be more restrictive in 2013).

24. We do facility as well as professional billing. On our UB04 claims, we use HCPCS codes along with the appropriate revenue code. Currently, the HCPCS codes mirror the CPT codes. Will the 2013 HCPCS codes for behavioral health services change to match the changes in the CPT coding system?

If Level I HCPCS codes (aka CPT Codes) are used in your reporting, they will have to be updated to reflect 2013 changes effective January 1.

25. Are the "other psychotherapy" codes (90845-90857) changing?

Changes to the "Other Psychotherapy" codes include:

- Addition of 90839, crisis psychotherapy
- Addition of 90840, add-on code for each additional 30 minutes of psychotherapy for crisis
- Allowance of combining 90853 (group psychotherapy) with 90785 (add-on code for interactive complexity)
- Deletion of 90857 (interactive group psychotherapy)

There were no changes to: psychoanalysis (90845), family psychotherapy (without the patient present) (90846), family psychotherapy (conjoint psychotherapy) (90847), multiple-family group psychotherapy (90849), nor group psychotherapy (90853).

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Last Updated 12/2/2012. For additional questions, contact NinaM@thenationalcouncil.org.

26. Dr. A sees a patient in February 2013 for diagnosis of depression then the same patient returns to our group within 3 years and sees Dr. B with a diagnosis of anxiety. Can both Drs. A and B code bill for an initial psychiatric evaluation or an E/M?

They can bill either psychiatric evaluation or E/M.

When billing E/M:

- If Dr. A and Dr. B. have the same specialty in your group, and the patient was seen within 3 years, then when Dr B. sees the patient it should be billed as an “established patient.”

When billing 90791 or 90792:

- Cannot bill psychotherapy or E/M on the same day

27. Can a 90791 assessment by a clinician (e.g., social worker) AND a 90792 assessment with medical completed by a psychiatrist be provided and billed on the same day?

Yes, they can both be reported on the same day, provided that: it aligns with payer policy (including for same-day billing), and that it is not reported on the same day as an E/M service performed by the same individual for the same patient.

28. Can a center bill a medical E/M service and psychotherapy service on same day by different providers? Or does the center count as one provider?

Yes, they can be reported on the same day unless the payer prohibits this.

29. What is the best way to code for school based services, or rather, consultation with school personnel.

No different than office-based for psychotherapy, group and family codes. Consultation codes may not be reportable to the payer, so that would need to be confirmed with the payer.

30. In differentiating between a new and established patient for E/M categories and whether a “service” has been provided in the past three years, is a “service” any service provided by any provider (case management, rehab, physician) or is a “service” only a service provided by a physician?

A patient is considered established if he or she has received a professional service by the physician or another physician in group of the same specialty (and sub-specialty) within the past three years.

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Last Updated 12/2/2012. For additional questions, contact NinaM@thenationalcouncil.org.

31. 90863 is listed in the Psychiatry section as “pharmacologic management.” Why can’t physicians use this for medication reviews?

90863 is only to be used as an add-on code by psychologists with prescribing authority, and only when provided in conjunction with psychotherapy (by the same psychologist).

Physicians and others who may report E/M codes should never use 90863.

32. Are these new codes for services rendered after 1/1/13? Or should they be used for any service billed in 2013?

The codes should be used for any services rendered on or after 1/1/2013. Services provided in 2012 should be billed with 2012 codes. This means that the IT systems need to accommodate both to bill accurately.

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Last Updated 12/2/2012. For additional questions, contact NinaM@thenationalcouncil.org.

Crosswalk: 2012 to 2013 CPT Code Sets

Included below is a crosswalk of some of the major changes to the psychiatry section of the CPT code set. The National Council strongly encourages organizations to purchase their own copy of the 2013 CPT code book at: www.amabookstore.com or (800) 621-8335.

2012 Code	Action Taken	2013 Code		Report with Psychotherapy Add-On Code		Report with Code for Interactive Complexity (90785)
Diagnostic Procedures						
90801: psychiatric diagnostic evaluation	Deleted	90791: psychiatric diagnostic evaluation (no medical services)	+	n/a	+	When appropriate
		90792: psychiatric diagnostic evaluation with medical services (or E/M new patient codes)	+	n/a	+	When appropriate
90802: interactive psychiatric diagnostic evaluation	Deleted	90791 or 90792	+	n/a	+	90785
Psychotherapy						
90804: outpatient psychotherapy, 20-30 min.	Deleted	90832: psychotherapy, 30 minutes	+	n/a	+	When appropriate
90805: outpatient psychotherapy with E/M services, 20-30 min.	Deleted	Appropriate E/M code	+	90833: 30 min add-on	+	When appropriate
90806: outpatient psychotherapy, 45-50 min.	Deleted	90834: psychotherapy, 45 minutes	+	n/a	+	When appropriate
90807: outpatient psychotherapy with E/M services, 45-50 min.	Deleted	Appropriate E/M code	+	90836: 45 min add-on	+	When appropriate
90808: outpatient psychotherapy, 75-80 min.	Deleted	90837: psychotherapy, 60 minutes	+	n/a	+	When appropriate
90809: outpatient psychotherapy with E/M services, 75-80 min.	Deleted	Appropriate E/M code	+	90838: 60 min add-on	+	When appropriate
Interactive Psychotherapy						
90810: interactive psychotherapy, 20-30 min.	Deleted	90832: psychotherapy, 30 min.	+	n/a	+	90785
90811: interactive psychotherapy with E/M, 20-30 min.	Deleted	Appropriate E/M code	+	90833: 30 min add-on	+	90785
90812: interactive psychotherapy, 45-50 min.	Deleted	90834: psychotherapy, 45 min.	+	n/a	+	90785
90813: interactive psychotherapy with E/M, 45-50 min.	Deleted	Appropriate E/M code	+	90836: 45-min add-on	+	90785
90814: interactive psychotherapy, 75-80 min.	Deleted	90837: psychotherapy, 60 min.	+	n/a	+	90785
90815: interactive psychotherapy with E/M, 75-80 min.	Deleted	Appropriate E/M code	+	90838: 60 min add-on	+	90785
Other						
(None)	New code	90839: psychotherapy for crisis, first 60 minutes	+	90840: psychotherapy for crisis, each additional 30 min.		No
90857: interactive group psychotherapy	Deleted	90853: group psychotherapy (other than multiple-family group)	+	n/a	+	90785
90862: pharmacologic management	Deleted	Appropriate E/M code	+	Yes , according to psychotherapy time		No

Questions? Contact Nina Marshall at ninam@thenationalcouncil.org.

Evaluation and Management Services Guide

Coding by Key Components

History	Chief Complaint (CC)		History of present illness (HPI)		Past, family, social history (PFSH)		Review of systems (ROS)			
	Reason for the visit		Location; Severity; Timing; Quality; Duration; Context; Modifying Factors; Associated signs and symptoms		Past medical; Family medical; Social		Constitutional; Eyes; Ears, Nose, Mouth, and Throat; Cardiovascular; Respiratory; Genitourinary; Musculoskeletal; Gastrointestinal; Skin/Breast; Neurological; Psychiatric; Endocrine; Hematologic/Lymphatic; Allergic/Immunologic			
	CC		HPI		PFSH		ROS		History Type	
	Yes	Brief (1-3 elements or 1-2 chronic conditions)		N/A		N/A		Problem focused (PF)		
		Extended (4 elements or 3 chronic conditions)		Pertinent (1 element)		Extended (2-9 systems)		Expanded problem focused (EPF)		
Complete (2 elements (est) or 3 elements (new/initial))				Complete (10-14 systems)		Detailed (DET)				
								Comprehensive (COMP)		

Examination	System/body area		Examination	
	Constitutional		3/7 vital signs: sitting or standing BP, supine BP, pulse rate and regularity, respiration, temperature, height, weight - General appearance	
	Musculoskeletal		- Muscle strength and tone - Gait and station	
	Psychiatric		- Speech - Thought process - Associations - Abnormal/psychotic thoughts - Judgment and insight - Orientation - Recent and remote memory - Attention and concentration - Language - Fund of knowledge - Mood and affect	
	Examination Elements		Examination type	
	1-5 bullets		Problem focused (PF)	
	At least 6 bullets		Expanded problem focused (EPF)	
	At least 9 bullets		Detailed (DET)	
	All bullets in Constitutional and Psychiatric (shaded) boxes and 1 bullet in Musculoskeletal (unshaded) box		Comprehensive (COMP)	

Med Dec Making	Medical Decision Making Element		Determined by	
	Number of diagnoses or management options		Problem points chart	
	Amount and/or complexity of data to be reviewed		Data points chart	
	Risk of significant complications, morbidity, and/or mortality		Table of risk	
	Problem Points			
	Category of Problems/Major New symptoms		Points per problem	
	Self-limiting or minor (stable, improved, or worsening) (max=2)		1	
	Established problem (to examining physician); stable or improved		1	
	Established problem (to examining physician); worsening		2	
	New problem (to examining physician); no additional workup or diagnostic procedures ordered (max=1)		3	
	New problem (to examining physician); additional workup planned*		4	
	*Additional workup does not include referring patient to another phvsician for future care			

Evaluation and Management Services Guide

Coding by Key Components

Medical Decision Making	Data Points				
	Categories of Data to be Reviewed (max=1 for each)			Points	
	Review and/or order of clinical lab tests			1	
	Review and/or order of tests in the radiology section of CPT			1	
	Review and/or order of tests in the medicine section of CPT			1	
	Discussion of test results with performing physician			1	
	Decision to obtain old records and/or obtain history from someone other than patient			1	
	Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider			2	
	Independent visualization of image, tracing, or specimen itself (not simply review report)			2	
	Table of Risk				
	Level of Risk	Presenting Problem(s)		Diagnostic Procedure(s) Ordered	Management Options Selected
	Minimal	One self-limited or minor problem		Venipuncture; EKG; urinalysis	Rest
	Low	Two or more self-limited or minor problems; One stable chronic illness; Acute uncomplicated illness		Arterial puncture	OTC drugs
	Moderate	One or more chronic illnesses with mild exacerbation, progression, or side effects; Two or more stable chronic illnesses; Undiagnosed new problem with uncertain prognosis; Acute illness with systemic symptoms			Prescription drug management
High	One or more chronic illnesses with severe exacerbation, progression, or side effects; Acute or chronic illnesses that pose a threat to life or bodily function			Drug therapy requiring intensive monitoring for toxicity	
Problem Points Data Points Risk Complexity of Medical Decision Making					
2/3 elements must be met or exceeded:	0-1	0-1	Minimal	Straightforward	
	2	2	Low	Low	
	3	3	Moderate	Moderate	
	4	4	High	High	

CPT Codes	New Patient Office (requires 3 of 3)				Established Patient Office (requires 2 of 3)			
	CPT Code	History	Exam	MDM	CPT Code	History	Exam	MDM
	99201	PF	PF	Straightforward	99211	N/A	N/A	N/A
	99202	EPF	EPF	Straightforward	99212	PF	PF	Straightforward
	99203	DET	DET	Low	99213	EPF	EPF	Low
	99204	COMP	COMP	Moderate	99214	DET	DET	Moderate
	99205	COMP	COMP	High	99215	COMP	COMP	High
	Initial Hospital/PHP (requires 3 of 3)				Subsequent Hospital/PHP (requires 2 of 3)			
	CPT Code	History	Exam	MDM	CPT Code	History	Exam	MDM
	99221	DET	DET	Straightforward	99231	PF	PF	Straightforward
	99222	COMP	COMP	Moderate	99232	EPF	EPF	Moderate
	99223	COMP	COMP	High	99233	DET	DET	High



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Evaluation and Management (E/M) Patient Examples Office, Established Patient

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IMPORTANT

The sample progress notes below meet criteria for the specified E/M code, but do **not** necessarily meet criteria for the multiple other purposes (e.g., clinical, legal) of documentation. For illustration, the documentation meets requirements specified by the codes for the exact levels of each of the 3 key components. In practice, criteria for these codes may be met by documenting only 2 of 3 of the key components at or above the level required by the code.

SERVICES SHOULD ALWAYS BE MEDICALLY NECESSARY.

99213		Office visit for a 9-year-old male, established patient, with ADHD. Mild symptoms and minimal medication side effects.	Office visit for a 27-year-old female, established patient, with stable depression and anxiety. Intermittent moderate stress.	
HISTORY	CC	9-year-old male seen for follow up visit for ADHD. Visit attended by patient and mother; history obtained from both.	27-year-old female seen for follow up visit for depression and anxiety. Visit attended by patient.	HISTORY: Expanded Problem Focused
	HPI	Grades are good (associated signs and symptoms) but patient appears distracted (quality) in class (context). Lunch appetite poor but eating well at other meals. HPI scoring: 3 elements = <i>Brief</i>	Difficulty at work but coping has been good. Minimal (severity) situational sadness (quality) and anxiety when stressed (context). HPI scoring: 3 elements = <i>Brief</i>	
	PFSH	N/A	N/A	
	ROS	Psychiatric: denies depression, anxiety, sleep problems ROS scoring: 1 system = <i>Problem-pertinent</i>	Psychiatric: no sadness, anxiety, irritability ROS scoring: 1 system = <i>Problem-pertinent</i>	
EXAM	Const	Appearance: appropriate dress, comes to office easily	Appearance: appropriate dress, appears stated age	EXAM: Exp. Problem Focused
	MS	N/A	N/A	
	Psych	Speech: normal rate and tone; Thought content: no SI/HI or psychotic symptoms; Associations: intact; Orientation: x 3; Mood and affect: euthymic and full and appropriate Examination scoring: 6 elements = <i>Expanded problem-focused</i>	Speech: normal rate and tone; Thought content: no SI/HI or psychotic symptoms; Associations: intact; Orientation: x 3; Mood and affect: euthymic and full and appropriate; Judgment and insight: good Examination scoring: 7 elements = <i>Expanded problem-focused</i>	
MEDICAL DECISION MAKING		Problem 1: ADHD Comment: Relatively stable; mild symptoms Plan: Renew stimulant script and increase dose; Return visit in 2 months	Problem 1: Depression Comment: Stable Plan: Renew SSRI script at the same dose; Return visit in 3 months	MEDICAL DECISION MAKING: Low Complexity
	Prob	Problem scoring: 1 established problem, stable (1); total of 1 = <i>Minimal</i>	Problem scoring: 2 established problems, stable (1 for each = 2); total of 2 = <i>Limited</i>	
	Data	Data scoring: Obtain history from someone other than patient (2); total of 2 = <i>Limited</i>	Data scoring: None = <i>Minimal</i>	
	Risk	Risk scoring: Chronic illness with mild exacerbation, progression, or side effects; and Prescription drug management = <i>Moderate</i>	Risk scoring: Two stable chronic illnesses; and Prescription drug management = <i>Moderate</i>	

Evaluation and Management (E/M) Patient Examples

99214		Office visit for a 13-year-old male, established patient, with depression, anxiety, and anger outbursts.	Office visit for a 70-year-old male, established patient, with stable depression and recent mild forgetfulness.	
HISTORY	CC	13-year-old male seen for follow up visit for mood and behavior problems. Visit attended by patient and father; history obtained from both.	70-year-old male seen for follow up visit for depression. Visit attended by patient and daughter; history obtained from both.	HISTORY: Detailed
	HPI	Patient and father report increasing (timing), moderate (severity) sadness (quality) that seems to be present only at home (context) and tends to be associated with yelling and punching the walls (associated signs and symptoms) at greater frequency, at least once per week when patient frustrated. Anxiety has been improving and intermittent, with no evident trigger (modifying factors). HPI scoring: 6 elements = <i>Extended</i>	Patient and daughter report increasing distress related to finding that he has repeatedly lost small objects (e.g., keys, bills, items of clothing) over the past 2-3 months (duration). Patient notices intermittent (timing), mild (severity) forgetfulness (quality) of people's names and what he is about to say in a conversation. There are no particular stressors (modifying factors) and little sadness (associated signs and symptoms). HPI scoring: 6 elements = <i>Extended</i>	
	PFSH	Attending 8 th grade without problem; fair grades PFSH scoring: 1 element: social = <i>Pertinent</i>	Less attention to hobbies PFSH scoring: 1 element: social = <i>Pertinent</i>	
	ROS	Psychiatric: no problems with sleep or attention; Neurological: no headaches ROS scoring: 2 systems = <i>Extended</i>	Psychiatric: no problems with sleep or anger; Neurological: no headaches, dizziness, or weakness ROS scoring: 2 systems = <i>Extended</i>	
EXAM	Const	Appearance: appropriate dress, appears stated age	Appearance: appropriate dress, appears stated age	EXAM: Detailed
	MS	N/A	Muscle strength and tone: normal	
	Psych	Speech: normal rate and tone; Thought process: logical; Associations: intact; Thought content: no SI/HI or psychotic symptoms; Orientation: x 3; Attention and concentration: good; Mood and affect: euthymic and full and appropriate ; Judgment and insight: good Examination scoring: 9 elements = <i>Detailed</i>	Speech: normal rate and tone; Thought process: logical; Associations: intact; Thought content: no SI/HI or psychotic symptoms; Orientation: x 3; Attention and concentration: unable to focus on serial 7s; Mood and affect: euthymic and full and appropriate; Recent and remote memory: mild struggle with telling history and remembered 1/3 objects Examination scoring: 10 elements = <i>Detailed</i>	
MEDICAL DECISION MAKING		Problem 1: Depression Comment: Worsening; appears associated with lack of structure Plan: Increase dose of SSRI; write script; CBT therapist; Return visit in 2 weeks Problem 2: Anxiety Comment: Improving Plan: Patient to work with therapist on identifying context Problem 3: Anger outbursts Comment: Worsening; related to depression but may represent mood dysregulation Plan: Call therapist to obtain additional history; consider a mood stabilizing medication if no improvement in 1-2 months Prob Problem scoring: 2 established problems, worsening (2 for each problem = 4); 1 established problem, improving (1); total of 5 = <i>Extensive</i> Data Data scoring: Obtain history from other (2); Decision to obtain history from other (1); total of 3 = <i>Multiple</i> Risk Risk scoring: One or more chronic illnesses with mild exacerbation, progression; and Prescription drug management = <i>Moderate</i>	Problem 1: Depression Comment: Stable; few symptoms Plan: Continue same dose of SSRI; write script; Return visit in 1 month Problem 2: Forgetfulness Comment: New; mildly impaired attention and memory Plan: Brain MRI; consider referral to a neurologist if persists Problem scoring: 1 established problem, stable (1); 1 new problem with additional workup (4); total of 5 = <i>Extensive</i> Data scoring: Order of test in the radiology section of CPT (1); Obtain history from other (2); total of 3 = <i>Multiple</i> Risk scoring: Undiagnosed new problem with uncertain prognosis; and Prescription drug management = <i>Moderate</i>	MEDICAL DECISION MAKING: Moderate Complexity

Evaluation and Management (E/M) Patient Examples

99215		Office visit for an established adolescent patient with history of bipolar disorder treated with lithium; seen on urgent basis at family's request because of severe depressive symptoms.	Office visit for a 25-year-old male, established patient with a history of schizophrenia, who has been seen bi-monthly but is complaining of auditory hallucinations.	
HISTORY	CC	17-year-old male seen for urgent visit for depression. Visit attended by patient and parents; history obtained from all 3.	25-year-old male seen for follow up visit for schizophrenia. Visit attended by patient.	HISTORY: Comprehensive
	HPI	Patient doing well until 2 days ago (timing) when, for no apparent reason (context), he refused to leave his bed and appeared extremely (severity) and continuously depressed (quality); he is sleeping more and eating little (associated signs and symptoms).	The patient reports doing well until 1 week ago (duration) when he stayed up all night to finish a term paper (context). He has slept poorly (severity) since (timing) and, 2 days ago, began hearing fairly continuous voices (quality) telling him that people plan to shoot him. Attention and organization were good up until this past week (associated signs and symptoms).	
		HPI scoring: 5 elements = <i>Extended</i>	HPI scoring: 6 elements = <i>Extended</i>	
	PFSH	Stopped attending school; family history of suicide is noted from patient's initial evaluation	Doing well in third year of graduate school. Chart notes no family psychiatric history.	
		PFSH scoring: Family and social (2 elements) = <i>Complete</i>	PFSH scoring: Family and social (2 elements) = <i>Complete</i>	
EXAMINATION	ROS	Psychiatric: no problems with anxiety or anger; Neurological: no headaches; All other systems reviewed and are negative.	Psychiatric: denies symptoms of depression or mania; Neurological: no headaches; All other systems reviewed and are negative.	EXAMINATION: Comprehensive
		ROS scoring: All systems = <i>Complete</i>	ROS scoring: All systems = <i>Complete</i>	
	Const	VS: BP (sitting) 120/70, P 90 and regular, R 20; Appearance: appropriate dress, appears stated age	VS: BP (sitting) 115/70, P 86 and regular, Ht 5'10", Wt 180 lbs; Appearance: appropriate dress, appears stated age	
	MS	Gait and station: normal	Gait and station: normal	
	Psych	Speech: sparse and slow; Thought process: logical; Associations: intact; Thought content: hopelessness, thinks of suicide, no HI or psychotic symptoms; Orientation: x 3; Attention and concentration: impaired; Mood and affect: depressed and constricted; Judgment and insight: poor; Fund of knowledge: good; Recent and remote memory: good; Language: able to repeat phrases	Speech: normal rate and tone; Thought process: logical; Associations: intact; Thought content: auditory hallucinations and paranoid ideation, no SI/HI; Orientation: x 3; Attention and concentration: impaired; Mood and affect: euthymic and full and appropriate; Judgment and insight: good; Fund of knowledge: good; Recent and remote memory: good; Language: able to repeat phrases	
MEDICAL DECISION MAKING		Examination scoring: All elements of constitutional and psychiatric and 1 element of musculoskeletal = <i>Comprehensive</i>	Examination scoring: All elements of constitutional and psychiatric and 1 element of musculoskeletal = <i>Comprehensive</i>	MEDICAL DECISION MAKING: High Complexity
		Problem 1: Bipolar disorder Comment: Major relapse Plan: Continue current dose of Lithium for the moment	Problem 1: Psychosis Comment: Major relapse Plan: Increase dose of antipsychotic; write script; hold off on hospital admission as patient historically very adherent; return for visit in 1 day	
		Problem 2: Suicidality Comment: New Plan: Refer to hospital; confer with hospitalist once patient is admitted	Problem 2: Insomnia Comment: Sleep deprivation may have triggered the psychosis relapse Plan: Change to a more powerful hypnotic; write script	
			Problem 3: ADHD Comment: Appears stable Plan: Continue same dose of non-stimulant medication	
	Prob	Problem scoring: 1 established problem, worsening (2); 1 new problem (3); total of 5 = <i>Extensive</i>	Problem scoring: 1 established problem, stable (1); 2 established problems, worsening (2 for each problem = 4); total of 5 = <i>Extensive</i>	
MEDICAL DECISION MAKING	Data	Data scoring: Obtain history from other (2); total of 2 = <i>Limited</i>	Data scoring: None = <i>Minimal</i>	
	Risk	Risk scoring: Chronic illness with severe exacerbation; and illness that poses a threat to life = <i>High</i>	Risk scoring: Chronic illness with severe exacerbation = <i>High</i>	



Psychiatric Services 2012 to 2013 Crosswalk

2012			2013		
Service	CPT Code	2013 Status	Service	CPT Code	Report with interactive complexity (+90785)
Diagnostic					
Diagnostic interview examination	90801	DELETED	Diagnostic evaluation (no medical)	90791	When appropriate
			Diagnostic evaluation with medical	90792	
Interactive diagnostic interview examination	90802	DELETED	Diagnostic evaluation (no medical)	90791	Yes
			Diagnostic evaluation with medical	90792	
Psychotherapy					
Individual psychotherapy 20-30 min	90804, 90816	DELETED	Psychotherapy 30 (16-37*) min	90832	When appropriate
45-50 min	90806, 90818		45 (38-52*) min	90834	
75-80 min	90808, 90821		60 (53+*) min	90837	
Interactive individual psychotherapy 20-30 min	90810, 90823	DELETED	30 (16-37*) min	90832	Yes
45-50 min	90812, 90826		45 (38-52*) min	90834	
75-80 min	90814, 90828		60 (53+*) min	90837	
Psychotherapy with E/M (there is no one-to-one correspondence)					
Individual psychotherapy with E/M, 20-30 min	90805, 90817	DELETED	E/M plus psychotherapy add-on	E/M code (selected using key components, <i>not</i> time) and one of:	When appropriate
45-50 min	90807, 90819				
75-80 min	90809, 90822				
Interactive individual psychotherapy with E/M 20-30 min	90811, 90824	DELETED		+90833 30 (16-37*) min	Yes
45-50 min	90813, 90827			+90836 45 (38-52*) min	
75-80 min	90815, 90829			+90838 60 (53+*) min	
Other Psychotherapy					
(None)			Psychotherapy for crisis	90839, +90840	No
Family psychotherapy	90846, 90847, 90849	RETAINED	Family psychotherapy	90846, 90847, 90849	No
Group psychotherapy	90853	RETAINED	Group psychotherapy	90853	When appropriate
Interactive group psychotherapy	90857	DELETED			Yes
Other Psychiatric Services					
Pharmacologic management	90862	DELETED	E/M	E/M code	No

*Per CPT Time Rule

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CPT Primer for Psychiatrists

What is CPT?

Current Procedural Terminology (CPT) was first published by the American Medical Association (AMA) in 1966. The CPT coding system was created to provide a uniform language for describing medical and surgical procedures and diagnostic services that would facilitate more effective communication between clinicians, third-party payers, and patients. The 2010 CPT Manual is the most recent revision of the 4th edition of the book.

The AMA's CPT Editorial Panel has the sole authority to revise, update, or modify CPT. The panel has seventeen members, eleven nominated by the AMA, and one each from the Blue Cross and Blue Shield Association, the Health Insurance Association of American, the Centers for Medicare and Medicaid Services (formerly HCFA), the American Hospital Association, and the Health Care Professionals Advisory Committee, and one representative from the AMA/Specialty Society RVS Update Committee. In 1990, Tracy Gordy, M.D., became the first psychiatrist to be appointed to the panel. He retired as chair of the panel in November 2007.

The CPT Editorial Panel is supported by the CPT Advisory Committee, which has representatives from over 90 specialty societies. The committee's main role is to advise the editorial panel on procedural coding and nomenclature that is relevant to each committee member's specialty. The committee also serves as a conduit through which revision to CPT can be proposed by specialty societies, or by individual members of those specialty societies.

The AMA's CPT coding system is now used almost universally throughout the United States. The Transaction Rule of the Health Insurance Portability and Accountability Act (HIPAA), which went into effect on October 16, 2002, requires the use of CPT codes by all who are covered by HIPAA. The CPT codes comprise Level I of the HCPCS (Health Care Financing Administration Common Procedure Coding System) codes used by Medicare and Medicaid. Every healthcare provider who is paid by insurance companies should have a working knowledge of the CPT system.

How Is the CPT Manual Organized?

The CPT manual is organized to be as user friendly as possible. The following is a quick survey of its contents.

Introduction

The short introduction contains valuable information for the clinician on how to use the manual, including:

- A description and explanation of the format of the terminology (This section describes how some routine procedural terms are not repeated for subsequent related procedures to conserve entry space.);
- A description of how to request updates of CPT (It is vital that physicians keep the AMA aware of changes in practice that require coding changes.);
- A discussion of the specific guidelines that precede each of the manual's six sections (E/M and the five clinical sections);
- A discussion of "add-on codes" for additional or supplemental procedures;
- An explanation of code modifiers and how they are to be used;
- A brief discussion of how place of service relates to CPT;

- A discussion of the inclusion of codes for unlisted procedures or services in each section;
- A note that some CPT codes require interpretation and reporting if they are to be used;
- A note that special reports may be required to determine the medical appropriateness of rare or very new services;
- A discussion of how to identify code changes from year to year;
- A reference to the expanded alphabetical index now included in the Manual;
- A note on how to obtain electronic versions of CPT; and finally
- How references to AMA resources on the CPT codes are noted in the Manual.

Illustrated Anatomical and Procedural Review

This section provides a review of the basics of anatomy and medical vocabulary that are necessary for accurate coding. Lists of prefixes, suffixes, and roots are given, followed by 22 anatomical illustrations. There is also an index of all the procedural illustrations that appear throughout the manual, listed by their corresponding codes.

Evaluation and Management Codes

Although the rest of the CPT manual is organized according to the numerical order of the codes, the evaluation and management (E/M) codes, 99xxx, are provided in the first code section because they are used by physicians in *all* specialties to report a considerable number of their services. The E/M codes are preceded by fairly extensive guidelines that define the terms used in the code descriptors and provide instructions for selecting the correct level of E/M service.

Major Clinical Sections

Next come the major clinical sections: Anesthesia, Surgery, Radiology, Pathology and Laboratory, and Medicine. Each of these sections is preceded by guidelines. The psychiatry codes, 908xx, are found in the Medicine section. The codes in the Psychiatry subsection cover most of the services mental health professionals provide to patients in both inpatient and outpatient settings.

Category II and III Codes

The Medicine section is followed by a listing of the supplemental Category II and Category III codes. These codes are generally optional codes used to facilitate data collection and are never used as substitutes for the standard Category I CPT codes.

Category II codes are used for performance measurement. According to the CPT Manual, Category II codes are "intended to facilitate data collection about the quality of care rendered by coding certain services and test results that support nationally established performance measures and that have an evidence base as contributing to quality patient care." These codes will be used more and more as Medicare attempts to shift from volume-based payment to quality-based payment.

Category III codes are temporary codes that are used to allow data tracking for emerging services and procedures.

Appendixes and Index

The last section of the manual includes appendixes and an extensive alphabetical index. There are 13 appendixes:

1. Appendix A: Modifiers—modifiers are two-digit suffixes that are added to CPT codes to indicate that the service or procedure has been provided under unusual circumstances (e.g., –21, which indicates a prolonged E/M service) (See Appendix B of this book for a list of modifiers.)
2. Appendix B: Summary of Additions, Deletions, and Revisions (of codes in the current manual)
3. Appendix C: Clinical Examples—provides clinical examples to clarify the use of E/M codes in various situations
4. Appendix D: Summary of CPT Add-On Codes—codes used to denote procedures commonly carried out in addition to a primary procedure
5. Appendix E: Summary of CPT Codes Exempt From Modifier –51 (multiple procedures)
6. Appendix F: Summary of CPT Codes Exempt From Modifier –63 (which denotes a procedure performed on infants)
7. Appendix G: Summary of CPT Codes That Include Moderate (Conscious) Sedation
8. Appendix H: Alphabetic Index of Performance Measures by Clinical Condition or Topic (a listing of the diseases, clinical conditions, and topics with which the Category II codes are associated.)
9. Appendix I: Genetic Testing Code Modifiers (used “to provide diagnostic granularity of service to enable providers to submit complete and precise genetic testing information without altering test descriptors.”)
10. Appendix J: Electrodiagnostic Medicine Listing of Sensory, Motor, and Mixed Nerves
11. Appendix K: Products pending FDA Approval (vaccine products that have been assigned a Category I codes in anticipation of their approval)
12. Appendix L: Vascular Families
13. Appendix M: Crosswalk to Deleted CPT Codes (indicating which current codes are to be used in place of the deleted ones)

The index is preceded by instructions explaining that there are four primary classes of index entries:

1. Procedure or Service
2. Organ or Other Anatomic Site
3. Condition
4. Synonyms, Eponyms, and Abbreviations

The instructions also explain the index’s use of modifying terms, code ranges, and space-saving conventions.

Psychiatry Codes

The codes most frequently used by psychiatrists can be found in the Psychiatry subsection of the Medicine section of the CPT Manual (codes 90785-90899). For 2013 and beyond there have been major changes to the Psychiatry codes. A distinction has been made between an initial evaluation with medical services done by a physician (90792) and an initial evaluation done by a non-physician (90791). The psychotherapy codes have been simplified: There are now three timed codes to be used in all settings (90832- 30 minutes; 90834-45 minutes; 90837- 60 minutes) and accompanying add-on codes for psychotherapy (indicated in CPT by the + symbol) that are to be used by psychiatrists when the psychotherapy is provided in the same encounter as medical evaluation and management (+90833 -30 minutes, +90836 - 45 minutes, +90838 – 60 minutes). In lieu of the codes for interactive psychotherapy, there is now also an add-on code for interactive complexity (+90785) that may be used with any code in the Psychiatry section for which it is appropriate. Another change is that a new code has been added for psychotherapy for a patient in crisis (90839). When a crisis encounter goes beyond 60 minutes there is an add-on code for each additional 30 minutes (+90840). Code 90862 has been eliminated, and psychiatrists will now use the appropriate evaluation and management (E/M) code when they do pharmacologic management for a patient. (A new code, add-on code +90863, has been created for medication management when done with psychotherapy by the psychologists in New Mexico and Louisiana who are permitted to prescribe, but this code is **not** to be used by psychiatrists or other medical mental health providers). All of these changes are discussed in detail below.

Interactive Complexity Add-On

+ 90785 ♦ Interactive Complexity -- This add-on code may be used with any of the codes in the Psychiatry section when the encounter is made more complex by the need to involve others than the patient. It will most frequently be used in the treatment of children. When this add-on is used, documentation must explain what exactly the interactive complexity was (i.e., the need for play equipment with a younger child; the need to manage parents' anxiety; the involvement of parents with discordant points of view).

What is an add-on code? An add-on code is a code that can only be used in conjunction with another code and is indicated by the plus symbol (+) in the CPT manual. While basic CPT codes are valued to account for pre- and post-time, add-on codes are only valued based on intra-service time since the pre- and post-time is accounted for in the basic code. In the new Psychiatry codes there are three different types of add-on codes: 1.) Timed add-on codes to be used to indicate psychotherapy when it is done with along with medical evaluation and management; 2.) A code to be used when psychotherapy is done that involves interactive complexity (e.g., psychotherapy provided to children or geriatric patients who have difficulty communicating without assistance); and 3.) A code to be used with the crisis therapy code for each 30 minutes beyond the first hour.

Psychiatric Diagnostic Evaluation Codes*

90791 ♦ Psychiatric Diagnostic Evaluation – This code is used for an initial diagnostic interview exam for an adult or adolescent patient that does not include any medical services. In all likelihood this code will not be used by psychiatrists. It includes a chief complaint, history of

* +90785, the system complexity add-on code, may be used with these codes

present illness, review of systems, family and psychosocial history, and complete mental status examination, as well as the order and medical interpretation of laboratory or other diagnostic studies. Most insurers will reimburse for one 90791 per episode of illness. Medicare will pay for only one 90791 per year for institutionalized patients unless medical necessity can be established for others.

90792 ♦ Psychiatric Diagnostic Evaluation with Medical Services– This code is used for an initial diagnostic interview exam for an adult or adolescent patient that includes medical services. It includes a chief complaint, history of present illness, review of systems, family and psychosocial history, and complete mental status examination, as well as the order and medical interpretation of laboratory or other diagnostic studies. Most insurers will reimburse for one 90792 per episode of illness. Medicare will pay for only one 90792 per year for institutionalized patients unless medical necessity can be established for others. Medicare permits the use of this code or the appropriate level of the E/M codes (see below) to denote the initial evaluation or first-day services for hospitalized patients. Medicare also allows for the use of 90792 if there has been an absence of service for a three-year period.

For 2013, it is important to note that both codes 90791 and 90802 are not subject to the outpatient mental health services limitation under Medicare that will be eliminated in 2014. They have always been reimbursed at 80% like all other medical codes.

Psychiatric Therapeutic Procedure Codes*

There are now three basic timed individual psychotherapy codes, which are to be used in all settings and add-on codes to be used when psychotherapy is done along with medical evaluation and management and/or when psychotherapy is provided for a patient when there is interactive complexity. Note that the descriptors for the psychotherapy codes now list the time as the time spent “with patient and/or family member,” rather than “face-to-face with the patient” as for the previous psychotherapy codes.

Another difference is the way time is now defined by CPT. The CPT manual has standards in place that are to be used when selecting codes that have a time attached to them, except when rules are stipulated within the codes themselves. The bullets below will provide you with the basics for coding for psychiatric services.

- Time is only the time spent face-to-face with the patient and/or family member.
- When codes have sequential typical times attached to them, as with the basic psychotherapy codes, the code that is closest to the typical time should be selected.
- A unit of time is attained when the mid-point is passed. (For example, if you see a patient for more than 15 minutes you may code using 90832, the 30-minute code; and if you see a patient for 35 minutes, you would also use 90832. However, if you see the patient for 40 minutes, you would use 90834, the 45-minute code).

90832 ♦ Individual Psychotherapy, 30 minutes with patient and/or family member

+90833 ♦ Individual Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the code for the primary procedure.)

90834 ♦ Individual Psychotherapy, 45 minutes with patient and/or family member

* +90785, the system complexity add-on code, may be used with all of these codes

+90836 ♦ Individual Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the code for the primary procedure.)

90837 ♦ Individual Psychotherapy, 60 minutes with patient and/or family member

+90838 ♦ Individual Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the code for the primary procedure.)

Other Psychotherapy Codes*

90845♦ Psychoanalysis – Psychoanalysis is performed by therapists who are trained and credentialed to practice it. Psychoanalysis is reported on a per-session basis and is reimbursed by most insurance programs. The issue of medical necessity has resulted in challenges to reimbursement for psychoanalysis by managed care companies. Note that 90845 is not a time-based code.

90846♦ Family Psychotherapy (Without the Patient Present) – This code is used when the psychiatrist provides therapy for the family of a patient without the patient being present. Under Medicare rules, 90846 is only covered if the therapy is clearly directed toward the treatment of the patient, rather than to treating family members who may have issues because of the patient's illness. While most insurance companies will reimburse for this code, problems may occur because the service is not face-to-face with the patient.

90847♦ Family Psychotherapy (Conjoint Psychotherapy) (With Patient Present) – This code is used when the therapy includes the patient and family members. It is covered by most insurance plans, and is challenged less often than 90846 because the patient is present. It should also be used for couples therapy.

90849♦ Multiple-Family Group Psychotherapy – This code is used when the psychiatrist provides psychotherapy to a group of adult or adolescent patients and their family members. The usual treatment strategy is to modify family behavior and attitudes. The service is covered by most insurance plans.

90853♦ Group Psychotherapy (Other Than of a Multiple-Family Group) – This code relies on the use of interactions of group members to examine the pathology of each individual within the group. In addition, the dynamics of the entire group are noted and used to modify behaviors and attitudes of the patient members. The size of the group may vary depending on the therapeutic goals of the group and/or the type of therapeutic interactions used by the therapist. The code is used to report per-session services for each group member. Most insurance plans cover this procedure.

Codes for Other Psychiatric Services or Procedures *

90865♦ Narcosynthesis for Psychiatric Diagnostic and Therapeutic Purposes (e.g. sodium amobarbital (Amytal) interview) – This procedure involves the administration, usually through slow intravenous infusion, of a barbiturate or a benzodiazepine in order to suppress inhibitions, allowing the patient to reveal and discuss material that cannot be verbalized without the disinhibiting effect of the medication. This code is reimbursed by most insurers.

* +90785, the system complexity add-on code, may be used with all of these codes

90867♦ Therapeutic Repetitive Transcranial Magnetic Stimulation (TMS) initial treatment, including cortical mapping, motor threshold determination, delivery and management

90868♦ Subsequent TMS Delivery and Management, per session

90869♦ Subsequent TMS Motor Threshold Re-Determination with Delivery and Management

90870♦ Electroconvulsive Therapy (Includes Necessary Monitoring); Single seizure – This code is for electroconvulsive therapy (ECT), which involves the application of electric current to the patient's brain for the purposes of producing a seizure or series of seizures to alleviate mental symptoms. ECT is used primarily for the treatment of depression that does not respond to medication. The code includes the time the physician takes to monitor the patient during the convulsive phase and during the recovery phase. When the psychiatrist also administers the anesthesia for ECT, the anesthesia service should be reported separately, using an anesthesia code. ECT is covered by most insurance plans.

90875♦ Individual Psychophysiological Therapy Incorporating Biofeedback Training by any Modality (face-to-face with the patient), With Psychotherapy (e.g., insight-oriented, behavior modifying, or supportive psychotherapy); approximately 20-30 minutes and,

90876♦ approximately 45-50 minutes

These two procedures incorporate biofeedback and psychotherapy (insight oriented, behavior modifying, or supportive) as combined modalities conducted face-to-face with the patient. They are distinct from biofeedback codes 90901 and 90911, which do not incorporate psychotherapy and do not require face-to-face time. Medicare will not reimburse for either of these codes.

90880♦ Hypnotherapy – Hypnosis is the procedure of inducing a passive state in which the patient demonstrates increased amenability and responsiveness to suggestions and commands, provided they do not conflict seriously with the patient's conscious or unconscious wishes. Hypnotherapy may be used for either diagnostic or treatment purposes. This procedure is covered by most insurance plans.

90882♦ Environmental Intervention for Medical Management Purposes on a Psychiatric Patient's Behalf With Agencies, Employers, or Institutions – The activities covered by this code include physician visits to a work site to improve work conditions for a particular patient, visits to community-based organizations on behalf of a chronically mentally ill patient to discuss a change in living conditions, or accompaniment of a patient with a phobia in order to help desensitize the patient to a stimulus. Other activities include coordination of services with agencies, employers, or institutions. This service is covered by some insurance plans, but because some of the activities are not face-to-face, the clinician should check with carriers about their willingness to reimburse for this code.

90885♦ Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes – Although this would seem to be a very useful code, because reviewing data is not a face-to-face service with the patient, Medicare will not reimburse for this code and

some commercial carriers have followed suit. Medicare considers the review of data to be part of the pre-/postwork associated with any face-to-face service.

90887 ♦ Interpretation or Explanation of Results of Psychiatric, Other Medical Examinations and Procedures, or Other Accumulated Data to Family or Other Responsible Persons, or Advising Them How to Assist Patient – Medicare will not reimburse for this service because it is not done face-to-face with the patient, and clinicians should verify coverage by other insurers to ensure reimbursement. It is appropriate to use an E/M code in the hospital where floor time is expressed in coordination of care with the time documented.

90889 ♦ Preparation of Report of Patient's Psychiatric Status, History, Treatment, or Progress (Other Than for Legal or Consultative Purposes) for Other Physicians, Agencies, or Insurance Carriers – Psychiatrists are often called upon to prepare reports about the patient for many participants in the healthcare system. This code would be best used to denote this service. However, because this is not a service provided face-to-face with a patient, Medicare will not reimburse for this code either, and clinicians should verify coverage by other insurers.

90899 ♦ Unlisted Psychiatric Service or Procedure – This code is used for services not specifically defined under another code. It might also be used for procedures that require some degree of explanation or justification. If the code is used under these circumstances, a brief, jargon-free note explaining the use of the code to the insurance carrier might be helpful in obtaining reimbursement. If it is used for a service that is not provided face-to-face with a patient, the psychiatrist should check with the patient's insurer regarding reimbursement.

95970, 95974, 95975 ♦ Neurostimulators, Analysis–Programming – These codes have been approved for vagus nerve stimulation (VNS) therapy for treatment-resistant depression. Clinicians performing VNS therapy should use the appropriate code from the 95970, 95974, and 95975 series of codes found in the neurology subsection of the CPT manual. Medicare will not reimburse for these codes.

M0064 ♦ Brief Office Visit for the Sole Purpose of Monitoring or Changing Drug Prescriptions Used in the Treatment of Mental Psychoneurotic and Personality Disorders – M0064 is not, in fact, a CPT code. It is a HCPCS Level II code (CPT codes are HCPCS Level I), part of the HCPCS system used by Medicare and Medicaid. M0064 should only be used for the briefest medication check with stable patients.

Evaluation and Management Codes

With the elimination of code 90862 and the addition of the add-on codes for psychotherapy when done with evaluation and management (E/M), psychiatrists will be using far more E/M codes than they have in the past. Previously, many psychiatrists just used the E/M codes for their inpatient and nursing facility encounters, but now they will be used for outpatient care as well.

The evaluation and management codes were introduced in 1992 to cover a broad range of services for patients, in both inpatient and outpatient settings. E/M code descriptors provide explicit criteria for selecting codes, and the clinical vignettes given in Appendix C of the CPT Manual provide examples of situations that fulfill these criteria.

Evaluation and management codes cover a family of *general medical services* provided in various settings, i.e., office, hospital, nursing home, emergency department, etc. While E/M codes are frequently used for hospital inpatient services, inpatient and outpatient consultations, and nursing facility services; they are less frequently used in psychiatry for office and other outpatient services, emergency department services, and domiciliary, rest home services. It is extremely important to read the guidelines to the Evaluation and Management section of the CPT Manual because they explain how to choose the appropriate level of service when using E/M codes.

Level of Service

The level of service for an E/M code encompasses the skill, effort, time, responsibility, and medical knowledge necessary to evaluate, diagnose, and treat medical conditions. There are seven components that are used to define E/M levels of service:

- history,
- examination,
- medical decision making,
- counseling,
- coordination of care,
- nature of presenting problem, and
- time.

The three key components used in selecting the level of service within each category or subcategory of E/M service are:

- the extent of the history
- the extent of the examination
- the complexity of medical decision making involved

The clinician's ability to determine the appropriate level of service being provided to the patient within each category or subcategory of evaluation and management services is dependent on a thorough understanding of the Definition of Terms (found in the Evaluation and Management Services Guidelines that precede the listing of the E/M codes in the CPT Manual) and the Instructions for Selecting a Level of E/M Service (also in the Guidelines). The brief synopsis that follows is not an adequate substitute for a careful review of these sections of the CPT Manual.

There are three to five levels of service for each category or subcategory of E/M services. Each level of service represents the total work (skill, time, effort, medical knowledge, risk) expended by the clinician during an incident of service. For example, hospital inpatient services are divided into *initial hospital care* and *subsequent hospital care*, with three levels of service for initial care (99221-99223) and three levels of service for subsequent care (99231-99233); all of the levels based on depth of history and examination and complexity of the decision making involved, and the descriptors for the codes provide a typical time for the code as well. Consultations are divided into *office or other outpatient consultations*, *initial inpatient consultations*. There are five levels of service for office consultations (99241-99245), and initial inpatient consultations (99251-99255). Consultations are provided at the request of another healthcare provider to whom a written report must be given. The CPT Editorial Panel voted to delete the follow-up inpatient consultations and the confirmatory consultations. The appropriate E/M service code (i.e., Established patient, office or other outpatient service) should be used based on the setting and type of service. Clinicians should become thoroughly familiar with the

descriptors and codes within each family of services as well as with the guidelines that spell out the methodology for selecting the level of service provided.

History

There are four levels of history in the E/M codes: problem focused, expanded problem focused, detailed, and comprehensive. The more detailed the history, the greater the work effort.

Examination

The same four categories define the examination: problem focused, expanded problem focused, detailed, and comprehensive. The more extensive the examination, the greater the work effort. For psychiatry, a complete mental state examination (single system examination) qualifies as a comprehensive examination.

Decision Making

There are four levels of medical decision making presented in the E/M codes: 1. Straightforward; 2. Low complexity; 3. Moderate complexity; and 4. High complexity. The more complex the medical decision making, the greater the work effort.

The complexity of the medical decision making depends on: the number of diagnoses or management options; the amount and/or complexity of data to be reviewed; and the risk of complications and/or morbidity or mortality.

For example, the lowest level of service for Office or Other Outpatient Consultations (99241) requires:

- a problem focused history;
- a problem focused examination; and
- straightforward medical decision making

Average time: 15 minutes

While the highest level of service for Office or Other Outpatient Consultations (99245) requires:

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of high complexity

Average time: 80 minutes

The clinician selects 99241 or 99245 (or any of the levels in between, 99242, 99243, 99244) on the basis of the work performed (i.e., extent of history and examination, complexity of medical decision making). The average times given for each code are guidelines for the clinician and are not a requirement when using the key components (history, examination, and medical decision making) in selecting the level of service.

Time and Level of Service

Time (as a component in selecting the level of service) has two definitions in the E/M guidelines. The clinician must review these definitions (see CPT 2010, E/M Services Guidelines) in order to fully understand the rationale for the two definitions.

For office and other outpatient visits and office consultations, intraservice time is defined as the *face-to-face* time spent providing services to the patient and/or family members. Time spent pre- and post-service (time that is not face-to-face) is not included in the average times listed for office and outpatient consultation services. The work associated with the pre- and post-

encounter time has been calculated into the total work that forms the basis for how each code is reimbursed, and, therefore, the average face-to-face times listed with each E/M code are considered fair proxy for the total work effort.

For inpatient hospital care, hospital consultations, and nursing facility care intraservice time is defined as *unit floor time*. Unit floor time includes all work the clinician performs on behalf of the patient while present on the unit or at the bedside. This work includes direct patient contact, review of chart, writing orders, reviewing test results, writing progress notes, meeting with the treatment team, telephone calls, and meeting with the family. Pre- and post-time work such as reviewing patient records in another part of the hospital has been included in the calculation of total work as described above in the definition of face-to-face time.

There is one final and important twist in using time in the selection of the level of service. When counseling and/or coordination of care (see CPT 2013 page tbd) accounts for more than 50 percent of the patient and/or family encounter unit/floor time, then time becomes the *key factor* in selecting level of service. The clinician makes the selection by matching the time of the encounter (face-to-face or unit/floor) to the average time listed for the appropriate E/M service. In this instance there is no consideration of the extent of the history, the exam, the medical decision making required, or the nature of the presenting problem; time is the sole determinant.

Counseling is defined as a discussion with the patient and/or family concerning one or more of the following: diagnostic results, prognosis, risks and benefits of treatment, instructions for management, compliance issues, risk factor reduction, patient and family education. Coordination of care entails discussions about the patient's care with other providers or agencies. These two services are considered contributory factors and although important to E/M service, are not required to be provided at every encounter.

The following are examples of counseling and coordination of care. A clinician spends 35 minutes on the hospital floor (third hospital day for patient) and over 50 percent of that time was spent in counseling and/or coordination of care. The correct code is 99233 (subsequent hospital care), average time 35 minutes. In this case, history, examination, and medical decision making are no longer the factors that determine the selection of the level of service. Instead, the clinician documents the extent of the counseling/coordination of care in the daily progress note.

A patient returns to a psychiatrist's office for a medication check. The encounter takes a total of 25 minutes, during which time more than 12.5 minutes is spent explaining to the patient about how a newly prescribed medication works, how to establish a routine so that no doses will be missed, and the possible side-effects of the medication and what to do if they occur. The appropriate E/M code would be 99213 (office or outpatient service for an established patient), based on the 25-minute time rather than on a detailed history and examination and moderately complex medical decision making that would be required to use this code if counseling and coordination had not taken up more than 50 percent of the time.

Use of Modifiers

Modifiers are two-digit suffixes (e.g., -22, Unusual Procedure Services) that are added to procedural codes to indicate the service or procedure has been provided under unusual circumstances. The modifiers most likely to be used by psychiatrists are:

-22 Unusual Procedure Services

This modifier is used when the work associated with the service provided is greater than that usually required for the listed code.

-25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service

This modifier is used to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual pre- and postoperative care associated with the procedure performed.

-26 Professional Component

This modifier is used for procedures that are a combination of a physician component and a technical component. When the physician component is reported separately, this modifier is added to the usual procedure.

-52 Reduced Services

This modifier is used to report a service that is reduced in time.

The following is an example of how to use modifiers:

The therapy session requires extension from 50 minutes to 65 minutes because of the emergence of important material just before the session was scheduled to end. The session would be coded 90806-22 and a short explanatory note should be appended to the insurance form, explaining the use of the code.

Documentation

Documentation is an extremely complex issue, an issue we can only touch on here. For example, there may be special documentation requirements for Medicare found in the local Medicare contractor's Local Coverage Determination (LCD) policies; or when psychiatrists use E/M codes for treating Medicare patients, the HCFA (CMS) documentation guidelines should be used (but the clinician must decide whether to use the 1995 or 1997 guidelines—see below); and commercial insurers may have their own requirements.

Although accurate documentation of services and procedures is vital for good medicine, documentation has become an increasingly troublesome practical issue for clinicians. It is especially problematic for psychiatrists because of confidentiality issues and the amount of clinical information produced during psychotherapy sessions. Also, documentation for psychotherapy codes is one issue, while documentation for E/M codes is another.

In 1995 the Health Care Financing Administration published documentation guidelines for evaluation and management services. In 1997 revised E/M documentation guidelines were issued. Currently, physicians can choose to base their documentation on either the 1995 or 1997 Documentation Guidelines for Evaluation and Management Services. Following either set will fulfill documentation requirements to the satisfaction of the Medicare program, and should be acceptable to private insurers as well. Generally, psychiatrists will want to use the 1997 guidelines, which allow for a single-system psychiatric exam.

The Health Insurance Portability and Accountability Act (HIPAA), which was approved in December 2000 and became effective in April 2001, has very specific requirements for the privacy of patient records, and has very clear ramifications for the documentation of psychotherapy. HIPAA distinguishes between psychotherapy notes (notes a therapist may keep about the patient's personal life as distinguished from the patient's medical history and

treatment) and the medical record, and holds these personal notes to a higher level of confidentiality. Since 2003, when all physicians were expected to be in compliance with HIPAA, the standard of practice is that psychotherapy notes be kept so that they can be easily separated from the rest of a patient record.

Reimbursement Issues

It is very important for the clinician to understand that just because a code exists for a service in the CPT Manual, this does not guarantee that an insurance carrier or third-party payer will reimburse for that code. For example, Medicare will not pay for code 90882, Environmental Intervention, nor will it pay for certain codes done on the same day as others. You need to be aware of these exceptions. Clinicians may also find their contracts with managed care organizations specify certain codes that are not reimbursable, or that patients' insurance policies specify certain services that are not covered. It is essential to find out about any of these issues before treatment begins.

RBRVS and Medicare Reimbursement Policies

Because Medicare's Resource-Based Relative Value Scale (RBRVS) system for the payment of clinicians has become the basis of fee schedules, even for commercial carriers, a discussion of coding issues associated with Medicare reimbursement is useful even for those psychiatrists who do not treat Medicare beneficiaries.

Since 1992, the Medicare program has reimbursed physician services based on the Resource-Based Relative Value Scale (RBRVS). RBRVS is a system that allows the mathematical calculation of Relative Value Units (RVUs) for every CPT code. The cost of providing each service described in CPT is divided into three components: physician work, practice expense, and professional liability insurance. RVUs are assigned to each component, then added together and multiplied by a conversion factor that is determined annually by CMS and voted on by Congress. The resulting figure is the Medicare fee for each service. Medicare fees vary slightly throughout the country due to adjustments for geographical differences in resource costs. For instance, the fees in New York are higher than those in Mississippi.

Medicare generally excludes from payment all non-face-to-face services such as telephone calls, environmental interventions, record reviews, and case management, although there may be some variation in local payment policies.

The way to avoid delay of payment or audits because of disputes over use of codes that you're not absolutely certain about is to prospectively negotiate with insurers about the use of any codes that are not unquestionably standard.

Conclusions

Careful, correct coding is vital to the practicing psychiatrist. Take it seriously. Not only will correct coding help achieve prompt and appropriate payment for treatment, it will also provide protection from charges of fraud and abuse. Accurate documentation of the services you have provided, and coded for, is the most certain means of protection against allegations of abusive or fraudulent billing. Accurate documentation is also extremely helpful in defending against malpractice allegations. You need to stay current on coding issues.

- Buy and read the AMA's annually published CPT Manual
- Stay in touch with your District Branch and the APA's Office of Healthcare Systems and Financing about coding and billing issues.

- Psychiatrists who provide services under Medicare must educate themselves on policies specific to Medicare. You must be sure to read any correspondence sent to you by your Medicare contractor.

You should code and bill for all services rendered regardless of local or national payer policies – the developing database may help change payment policies that negatively affect reimbursement of mental health services.

It is important that you not try to game the reimbursement system by manipulating codes inappropriately. Medicare/Medicaid fraud, and insurance fraud in general, is a serious priority of the Justice Department.

Note: Although psychiatrists are likely to use only the codes within the Psychiatry and E/M sections of the CPT Manual to cover the services they provide, the Manual clearly states in its introduction: **“Any procedure or service in any section of this book may be used to designate the services rendered by any qualified physician.”**

Recommended Reading

- American Medical Association, *Physicians Current Procedural Terminology* (published yearly, refer to most current)
- *CPT Handbook for Psychiatrists*, American Psychiatric Press Inc., Third Edition, 2004

APA's Web Site, CPT Coding Service and Additional Resources

APA CPT Coding Service

Look for timely information on coding and documentation issues on the APA's website www.psychiatry.org and in the Psychiatric News Bulletin, which is e-mailed to members weekly. New materials on APA's website are highlighted in the “APA News” Section and can also be found under “Psychiatric Practice.”

The APA is actively involved in making sure that members are correctly reimbursed for the services they provide. Working closely with the Committee on RBRVS, Codes, and Reimbursement, the APA's Office of Healthcare Systems and Financing (OHSF) has established a CPT Coding Service. Because CPT questions are very specific and often very complex, a protocol has been established for queries to ensure that there will be no misunderstanding.

APA members with CPT coding questions should:

- Write an e-mail or memo with their name, APA member number, city, state, phone number, fax number, and e-mail address.
- State the question or describe the problem thoroughly, but succinctly—a short paragraph is usually all that is necessary.
- Include any relevant correspondence from Medicare carriers, insurance companies, or third-party payers.
- Cite any actions that have been taken relating to the problem, i.e., calls made, letters written
- E-mail (hsf@psych.org), fax (907-703-1089), or mail (Office of Healthcare Systems and Financing, APA, 1000 Wilson Boulevard, # 1825, Arlington, VA, 22209) the question to the

attention of Rebecca Yowell.

All questions will be answered as quickly as possible.

Courses/Workshops

APA Annual Meeting Course and Workshop – A CPT coding CME course as well as a CPT workshop are generally held each year at the APA Annual Meeting. Check the APA Annual Meeting program for more information.

APA Medicare Advisory Network

The APA's Office of Healthcare Systems and Financing maintains an online network of psychiatrists who are involved in Medicare policy issues across the country. This network allows the APA's central office to monitor how Medicare is actually working from state to state. It alerts psychiatrists across the United States to issues that are problematic and keeps them apprised as to whether their state's carrier is in compliance with Medicare rules and regulations.

The network's membership has historically been comprised of the psychiatry representatives to each Medicare carrier's Carrier Advisory Committee (CAC). Until very recently Medicare carriers have administered Part B of Medicare (Part A has been administered by fiscal intermediaries), and the CACs have been mandated by law to ensure that carriers have input from medical practitioners when they establish local Medicare policy, specifically local coverage determinations, or LCDs; (formerly referred to as LMRPs, or local medical review policies). The psychiatry representatives to the CACs are chosen by the APA's District Branches. Medicare has almost completed the transition from carriers and fiscal intermediaries to Medicare Administrative Contractors, which oversee both Parts A and B. Thus far it appears that the CACs will continue to meet to advise these new entities just as they have Medicare carriers.

The Office of Healthcare Systems and Financing (OHSF) provides staffing for the network and provides support so that members in all regions can work together when there are issues that need to be addressed. Members of OHSF staff meet as necessary with representatives from the Centers for Medicare and Medicaid Services and with Medicare Medical Directors to solve problems communicated to them by members of the network.

For information on your local representative to the APA Medicare network representative, go to the APA web site at www.psychiatry.org. You can locate the list in the Medicare/Medicaid section under Psychiatric Practice. Medicare questions can also be directed to the attention of Ellen Jaffe in the Office of Healthcare Systems and Financing (HSF) by calling 800-343-4671 or writing her via the HSF e-mail address, hsf@psych.org.

Evaluation and Management Codes Most Likely to be Used by Psychiatrists

Category/Subcategory	Code Numbers
Office or outpatient services	
New patient	99201–99205
Established patient	99211–99215
Hospital observational services	
Observation care discharge services	99217
Initial observation care	99218–99220
Hospital inpatient services	
Initial hospital care	99221–99223
Subsequent hospital care	99231–99233
Hospital discharge services	99238–99239
Consultations	
Office consultations	99241–99245
Inpatient consultations	99251–99255
Emergency department services	
Emergency department services	99281–99288
Nursing facility services	
Initial Nursing Facility Care	99304–99306
Subsequent nursing facility care	99307–99310
Nursing facility discharge services	99315–99316
Annual Nursing Facility Assessment	99318
Domiciliary, rest home, or custodial care services	
New patient	99324–99328
Established patient	99334–99337
Home services	
New patient	99341–99345
Established patient	99347–99350

Category/Subcategory	Code Numbers
Team conference services	
Team conferences with patient/family	99366*
Team conferences without patient/family	99367
Behavior Change Interventions	
Smoking and tobacco use cessation	99406-99407
Alcohol and/or Substance abuse structured screening and brief intervention	99408-99409
Non-Face-to-Face Physician Services*	
Telephone services	99441-99443
On-Line Medical Evaluation	99444
Basic Life and/or Disability Evaluation Services	99450
Work Related or Medical Disability Evaluation Services	99455-99456
*Medicare covers only face-to-face services	

Codes and Documentation for Evaluation and Management Services

The evaluation and management (E/M) codes were introduced in the 1992 update to the fourth edition of *Physicians' Current Procedural Terminology* (CPT). These codes cover a broad range of services for patients in both inpatient and outpatient settings. In 1995 and again in 1997, the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services, or CMS) published documentation guidelines to support the selection of appropriate E/M codes for services provided to Medicare beneficiaries. The major difference between the two sets of guidelines is that the 1997 set includes a single-system psychiatry examination (mental status examination) that can be fully substituted for the comprehensive, multisystem physical examination required by the 1995 guideline. Because of this, it clearly makes the most sense for mental health practitioners to use the 1997 guidelines (see Appendix E). A practical 27-page guide from CMS on how to use the documentation guidelines can be found at http://www.cms.hhs.gov/MLNProducts/downloads/eval_mgmt_serv_guide.pdf. The American Medical Association's CPT manual also provides valuable information in the introduction to its E/M section. Clinicians currently have the option of using the 1995 or 1997 CMS documentation guidelines for E/M services, although for mental health providers the 1997 version is the obvious choice.

The E/M codes are generic in the sense that they are intended to be used by all physicians, nurse-practitioners, and physician assistants and to be used in primary and specialty care alike. All of the E/M codes are available to you for reporting your services. Psychiatrists frequently ask, "Under what clinical circumstances would you use the office or other outpatient service E/M codes in lieu of the psychiatric evaluation and psychiatric therapy codes?" The decision

to use one set of codes over another should be based on which code most accurately describes the services provided to the patient. The E/M codes give you flexibility for reporting your services when the service provided is more medically oriented or when counseling and coordination of care is being provided more than psychotherapy. (See p. 44 for a discussion of counseling and coordination of care).

Appendix K provides national data on the distribution of E/M codes selected by psychiatrists within the Medicare program. Please note that although there are many codes available to use for reporting services, the existence of the codes in the CPT manual does not guarantee that insurers will reimburse you for the services designated by those codes. Some insurers mandate that psychiatrists and other mental health providers only bill using the psychiatric codes (90801–90899). It is always smart to check with the payer when there are alternatives available for coding.

THE E/M CODES

- E/M codes are used by all physician specialties and all other duly licensed health providers.
- The definitions of *new patient* and *established patient* are important because of the extensive use of these terms throughout the guidelines in the E/M section. A *new patient* is defined as one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group within the past 3 years. An *established patient* is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group within the past 3 years. When a physician is on call covering for another physician, the decision as to whether the patient is new or established is determined by the relationship of the covering physician to the physician group that has provided care to the patient for whom the coverage is now being provided. If the doctor is in the same practice, even though she has never seen the patient before, the patient is considered established. There is no distinction made between new and established patients in the emergency department.

The other terms used in the E/M descriptors are equally as important. The terms that follow are vital to correct E/M coding (complete definitions for them can be found under Steps 4 and 5 later in this chapter):

- Problem-focused history
- Detailed history
- Expanded problem-focused history
- Comprehensive history
- Problem-focused examination
- Detailed examination
- Expanded problem-focused examination
- Comprehensive examination

- Straightforward medical decision making
- Low-complexity medical decision making
- Moderate-complexity medical decision making
- High-complexity medical decision making
- E/M codes have three to five levels of service based on increasing amounts of work.
- Most E/M codes have time elements expressed as the time “typically” spent face-to-face with the patient and/or family for outpatient care or unit floor time for inpatient care.
- For each E/M code it is noted that “Counseling and/or coordination of care with other providers or agencies is provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs.” *When this counseling and coordination of care accounts for more than 50% of the time spent, the typical time given in the code descriptor may be used for selecting the appropriate code rather than the other factors.* (See p. 44 for a discussion of counseling and coordination of care.)
- The 1995 and 1997 CMS documentation guidelines for E/M codes have become the basis for sometimes draconian compliance requirements for clinicians who treat Medicare beneficiaries. Commercial payers have adopted elements of the documentation system in a variable manner. *The fact is that the documentation guidelines cannot be ignored by practitioners.* To do so would place the practitioner at risk for audits, civil actions by payers, and perhaps even criminal charges and prosecution by federal agencies.

SELECTING THE LEVEL OF E/M SERVICE

The following are step-by-step instructions that guide you through the code selection process when providing services defined by E/M codes. Code selection is made based on the work performed.

Step 1: Select the Category and Subcategory of E/M Service

Table 4–1 lists the E/M services most likely to be used by psychiatrists. This table provides only a partial list of services and their codes. For the full list of E/M codes you will need to refer to the CPT manual.

TABLE 4–1. EVALUATION AND MANAGEMENT CODES MOST LIKELY TO BE USED BY PSYCHIATRISTS

CATEGORY/SUBCATEGORY	CODE NUMBERS
Office or outpatient services	
New patient	99201–99205
Established patient	99211–99215
Hospital observational services	
Observation care discharge services	99217
Initial observation care	99218–99220
Hospital inpatient services	
Initial hospital care	99221–99223
Subsequent hospital care	99231–99233
Hospital discharge services	99238–99239
Consultations¹	
Office consultations	99241–99245
Inpatient consultations	99251–99255
Emergency department services	
Emergency department services	99281–99288
Nursing facility services	
Initial nursing facility care	99304–99306
Subsequent nursing facility care	99307–99310
Nursing facility discharge services	99315–99316
Annual nursing facility assessment	99318
Domiciliary, rest home, or custodial care services	
New patient	99324–99328
Established patient	99334–99337
Home services	
New patient	99341–99345
Established patient	99347–99350
Team conference services	
Team conferences with patient/family ²	99366
Team conferences without patient/family	99367
Behavior change interventions	
Smoking and tobacco use cessation	99406–99407
Alcohol and/or substance abuse structured screening and brief intervention	99408–99409
Non-face-to-face physician services³	
Telephone services	99441–99443
On-line medical evaluation	99444
Basic life and/or disability evaluation services	99450
Work-related or medical disability evaluation services	99455–99456

¹Medicare no longer recognizes these codes.²For team conferences with the patient/family present, physicians should use the appropriate evaluation and management code in lieu of a team conference code.³Medicare covers only face-to-face services.

Step 2: Review the Descriptors and Reporting Instructions for the E/M Service Selected

Most of the categories and many of the subcategories of E/M services have special guidelines or instructions governing the use of the codes. For example, under the description of initial hospital care for a new or established patient, the CPT manual indicates that the inpatient care level of service reported by the admitting physician should include the services related to the admission that he or she provided in other sites of service as well as in the inpatient setting. E/M services that are provided on the same date in sites other than the hospital and that are related to the admission should *not* be reported separately.

Examples of Descriptors for CPT Codes Used Most Frequently by Psychiatrists
99221—Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components: • A detailed or comprehensive history • A detailed or comprehensive examination • Medical decision making that is straightforward or of low complexity Counseling and/or coordination of care with other providers or agencies is provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.
99222—Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components: • A comprehensive history • A comprehensive examination • Medical decision making of moderate complexity Counseling and/or coordination of care with other providers or agencies is provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.
99223—Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components: • A comprehensive history • A comprehensive examination • Medical decision making of high complexity Counseling and/or coordination of care with other providers or agencies is provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.

Step 3: Review the Service Descriptors and the Requirements for the Key Components of the Selected E/M Service

Almost every category or subcategory of E/M service lists the required level of history, examination, or medical decision making for that particular code. (See the list of codes later in the chapter.)

For example, for E/M code 99223 the service descriptor is “Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components” and the code requires

- Comprehensive history
- Comprehensive examination
- Medical decision making of high complexity

Each of these components are described in Steps 4, 5, and 6.

Step 4: Determine the Extent of Work Required in Obtaining the History

The extent of the history obtained is driven by clinical judgment and the nature of the presenting problem. Four levels of work are associated with history taking. They range from the simplest to the most complete and include the components listed in the sections that follow.

The elements required for each type of history are depicted in Table 4–2. Note that each history type requires more information as you read down the left-hand column. For example, a problem-focused history requires the documentation of the chief complaint (CC) and a brief history of present illness (HPI), and a detailed history requires the documentation of a CC, an extended HPI, an extended review of systems (ROS), and a pertinent past, family, and/or social history (PFSH).

The extent of information gathered for a history is dependent on clinical judgment and the nature of the presenting problem. Documentation of patient history includes some or all of the following elements.

A. CHIEF COMPLAINT (CC)

The chief complaint is a concise statement that describes the symptom, problem, condition, diagnosis, or reason for the patient encounter. It is usually stated in the patient’s own words. For example, “I am anxious, feel depressed, and am tired all the time.”

B. HISTORY OF PRESENT ILLNESS (HPI)

The history of present illness is a chronological description of the development of the patient’s present illness from the first sign and/or symptom or from the previous encounter to the present. HPI elements are:

- Location (e.g., feeling depressed)
- Quality (e.g., hopeless, helpless, worried)
- Severity (e.g., 8 on a scale of 1 to 10)
- Duration (e.g., it started 2 weeks ago)

TABLE 4–2. ELEMENTS REQUIRED FOR EACH TYPE OF HISTORY

TYPE OF HISTORY	CHIEF COMPLAINT	HISTORY OF PRESENT ILLNESS	REVIEW OF SYSTEMS	PAST, FAMILY, AND/OR SOCIAL HISTORY
Problem focused	Required	Brief	N/A	N/A
Expanded problem focused	Required	Brief	Problem pertinent	N/A
Detailed	Required	Extended	Extended	Pertinent
Comprehensive	Required	Extended	Complete	Complete

- Timing (e.g., worse in the morning)
- Context (e.g., fired from job)
- Modifying factors (e.g., feels better with people around)
- Associated signs and symptoms (e.g., loss of appetite, loss of weight, loss of sexual interest)

There are two types of HPIs, *brief* and *extended*:

1. *Brief* includes documentation of one to three HPI elements. In the following example, three HPI elements—location, severity, and duration—are documented:
 - CC: Patient complains of depression.
 - Brief HPI: Patient complains of feeling severely depressed for the past 2 weeks.
2. *Extended* includes documentation of at least four HPI elements or the status of at least three chronic or inactive conditions. In the following example, five HPI elements—location, severity, duration, context, and modifying factors—are documented:
 - CC: Patient complains of depression.
 - Extended HPI: Patient complains of feelings of depression for the past 2 weeks. Lost his job 3 weeks ago. Is worried about finances. Trouble sleeping, loss of appetite, and loss of sexual interest. Rates depressive feelings as 8/10.

C. REVIEW OF SYSTEMS (ROS)

The review of systems is an inventory of body systems obtained by asking a series of questions in order to identify signs and/or symptoms that the patient may be experiencing or has experienced. The following systems are recognized:

- Constitutional (e.g., temperature, weight, height, blood pressure)
- Eyes
- Ears, nose, mouth, throat
- Cardiovascular
- Respiratory

- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

There are three levels of ROS:

1. *Problem pertinent*, which inquires about the system directly related to the problem identified in the HPI. In the following example, one system—psychiatric—is reviewed:
 - CC: Depression.
 - ROS: Positive for appetite loss and weight loss of 5 pounds (gastrointestinal/constitutional).
2. *Extended*, which inquires about the system directly related to the problem(s) identified in the HPI and a limited number (two to nine) of additional systems. In the following example, two systems—constitutional and neurological—are reviewed:
 - CC: Depression.
 - ROS: Patient reports a 5-lb weight loss over 3 weeks and problems sleeping, with early morning wakefulness.
3. *Complete*, which inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional (minimum of 10) body systems. In the following example, 10 signs and symptoms are reviewed:
 - CC: Patient complains of depression.
 - ROS:
 - a. Constitutional: Weight loss of 5 lb over 3 weeks
 - b. Eyes: No complaints
 - c. Ear, nose, mouth, throat: No complaints
 - d. Cardiovascular: No complaints
 - e. Respiratory: No complaints
 - f. Gastrointestinal: Appetite loss
 - g. Urinary: No complaints
 - h. Skin: No complaints
 - i. Neurological: Trouble falling asleep, early morning awakening
 - j. Psychiatric: Depression and loss of sexual interest

D. PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)

There are three basic history areas required for a complete PFSH:

1. Past medical/psychiatric history: Illnesses, operations, injuries, treatments

2. Family history: Family medical history, events, hereditary illnesses
3. Social history: Age-appropriate review of past and current activities

The data elements of a textbook psychiatric history, listed below, are substantially more complete than the elements required to meet the threshold for a comprehensive or complete PFSH:

- Family history
- Birth and upbringing
- Milestones
- Past medical history
- Past psychiatric history
- Educational history
- Vocational history
- Religious background
- Dating and marital history
- Military history
- Legal history

The two levels of PFSH are:

1. *Pertinent*, which is a review of the history areas directly related to the problem(s) identified in the HPI. The pertinent PFSH must document one item from any of the three history areas. In the following example, the patient's past psychiatric history is reviewed as it relates to the current HPI:
 - Patient has a history of a depressive episode 10 years ago successfully treated with Prozac. Episode lasted 3 months.
2. *Complete*. At least one specific item from two of the three basic history areas must be documented for a complete PFSH for the following categories of E/M services:
 - Office or other outpatient services, established patient
 - Emergency department
 - Domiciliary care, established patient
 - Home care, established patient

At least one specific item from each of the three basic history areas must be documented for the following categories of E/M services:

- Office or other outpatient services, new patient
- Hospital observation services
- Hospital inpatient services, initial care
- Consultations
- Comprehensive nursing facility assessments
- Domiciliary care, new patient
- Home care, new patient

Documentation of History. Once the level of history is determined, documentation of that level of HPI, ROS, and PFSH is accomplished by listing the required number of elements for each of the three components (see Table 4–3).

TABLE 4-3. PATIENT HISTORY TAKING

Level of history is achieved when all four of the four criteria for each element are completed for that level.	LEVELS			
	Problem focused	Expanded problem focused	Detailed	Comprehensive
	CRITERIA			
ELEMENT	Chief complaint	Chief complaint	Chief complaint	Chief complaint
Chief complaint (always required): Should include a brief statement, usually in the patient's own words; symptom(s); problem; condition; diagnosis; and reason for the encounter	Chief complaint	Chief complaint	Chief complaint	Chief complaint
History of the present illness: A chronological description of the development of the patient's present illness • Associated signs and symptoms • Context • Duration • Location • Modifying factors • Quality • Severity • Timing	Brief, one to three bullets	Brief, one to three bullets	Extended, four or more bullets	Extended, four or more bullets
Review of systems: An inventory of body systems to identify signs and/or symptoms • Allergic, immunologic • Cardiovascular • Constitutional (fever, weight loss) • Ears, nose, mouth, throat • Endocrine • Eyes • Gastrointestinal • Genitourinary • Hematologic, lymphatic • Integumentary (skin, breast) • Musculoskeletal • Neurological • Psychiatric • Respiratory	None	Pertinent to problem, one system	Extended, two to nine systems	Complete, 10 or more systems or some systems with statement "all others negative"
Past, family, and/or social history: Chronological review of relevant data • Past history: Illnesses, operations, injuries, treatments • Family history: Family medical history, events, hereditary illnesses • Social history: Age-appropriate review of past and current activities	None	None	Pertinent, one history area	Complete, two or three history areas

An ROS and/or PFSH taken during an earlier visit need not be rerecorded if there is evidence that it has been reviewed and any changes to the previous information have been noted. The ROS may be obtained by ancillary staff or may be provided on forms completed by the patient. The clinician must review the ROS, supplement and/or confirm the pertinent positives and negatives, and document the review. By doing so, the clinician takes medical-legal responsibility for the accuracy of the data. If the condition of the patient prevents the clinician from obtaining a history, the clinician should describe the patient's condition or the circumstances that precluded obtaining the history. **Failure to provide and record the required number of elements of the ROS for the level of history designated is the most frequently cited deficiency in audits of clinicians' mental health records.**

See Appendix H for examples of templates that provide a structure that will ensure that the clinician's note and documentation requirements are met. The Attending Physician Admitting Note template for initial hospital case with a complete history qualifies for a comprehensive level of history. The Attending Physician Subsequent Care template for inpatient subsequent care or outpatient established care contains the required elements for three levels of inpatient subsequent care or five levels of outpatient established care.

Step 5: Determine the Extent of Work in Performing the Examination

The mental status examination of a patient is considered a single system examination. The elements of the examination are provided in Table 4–4. This definition of what composes a mental status examination was jointly published by the American Medical Association and Health Care Financing Administration (now CMS) in 1997. There are four levels of work associated with performing a mental status examination.

Table 4–4 is a summary of the four levels of examination and the number of bullets (elements) required for each level. Template examples for the mental status examination are illustrated in Appendix H. **Failure to provide and record the required number of constitutional elements (including vital signs) is the second most frequently cited deficiency in audits of clinicians' medical records.**

Step 6: Determine the Complexity of Medical Decision Making

Medical decision making is the complex task of establishing a diagnosis and selecting treatment and management options. **Medical decision making is closely tied to the nature of the presenting problem.** A *presenting problem* is a disease, symptom, sign, finding, complaint, or other reason for the encounter having been initiated.

- *Minimal*—A problem that may or may not require physician presence, but the services provided are under physician supervision.
- *Self-limited or minor*—A problem that is transient, runs a definite course, and is unlikely to permanently alter health status.

TABLE 4-4. CONTENT AND DOCUMENTATION REQUIREMENTS FOR THE SINGLE SYSTEM PSYCHIATRIC EXAMINATION

SYSTEM/BODY AREA AND ELEMENTS OF EXAMINATION	CRITERIA			
	One to five elements identified by a bullet	At least six elements identified by a bullet	At least nine elements identified by a bullet	All elements identified by a bullet
Constitutional - Measurement of any three of the following seven vital signs (may be measured and recorded by ancillary staff): - Sitting or standing blood pressure - Supine blood pressure - Pulse rate and regularity - Respiration - Temperature - Height - Weight - General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)				
Musculoskeletal - Assessment of muscle strength and tone - Examination of gait and station				
Psychiatric <i>Description of patient's</i> - Speech, including rate, volume, articulation, coherence, and spontaneity, with notation of abnormalities (e.g., perseveration, paucity of language) - Thought processes, including rate of thoughts, content of thoughts (e.g., logical versus illogical, tangential), abstract reasoning, and computation - Associations (e.g., loose tangential, circumstantial, intact) - Abnormal psychotic thoughts, including hallucinations, delusions, preoccupation with violence, homicidal or suicidal ideation, and obsessions - Mood and affect (e.g., depression, anxiety, agitation, hypomania, lability) - Judgment (e.g., concerning everyday activities and social situations) and insight (e.g., concerning psychiatric condition) <i>Complete mental status examination, including</i> - Orientation to time, place, and person - Recent and remote memory - Attention span and concentration - Language (e.g., naming objects, repeating phrases) - Fund of knowledge (e.g., awareness of current events, past history, vocabulary)				
Level of examination is achieved when the number of criteria specified for a given level is met	Problem focused	Expanded problem focused	Detailed	Comprehensive

Source. Centers for Medicare and Medicaid Services 1997 Guidelines for Documentation of Evaluation and Management Services.

- *Low severity*—A problem of low morbidity, no risk of mortality, and expectation of full recovery with no residual functional incapacity.
- *Moderate severity*—A problem with moderate risk of morbidity and/or mortality without treatment, uncertain outcome, and probability of prolonged functional impairment.
- *High severity*—A problem of high to extreme morbidity without treatment, moderate to high risk of mortality without treatment, and/or probability of severe, prolonged functional impairment.

Medical decision making is based on three sets of data:

1. *The number of diagnoses and management options:* As specified in Table 4–5, this is the first step in determining the type of medical decision making.

TABLE 4–5. NUMBER OF DIAGNOSES AND MANAGEMENT OPTIONS

	MINIMAL	LIMITED	MULTIPLE	EXTENSIVE
Diagnoses	One established	One established [and] one rule-out or differential	Two rule-out or differential	More than two rule-out or differential
Problem(s)	Improved	Stable Resolving	Unstable Failing to change	Worsening Marked change
Management options	One or two	Two or three	Three changes in treatment plan	Four or more changes in treatment plan

Note. To qualify for a given type of decision making, two of three elements must be met or exceeded.

2. *The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed:* Table 4–6 lists the elements and criteria that determine the level of decision making for this set of data.

TABLE 4–6. AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED

	MINIMAL	LIMITED	MODERATE	EXTENSIVE
Medical data	One source	Two sources	Three sources	Multiple sources
Diagnostic tests	Two	Three	Four	More than four
Review of results	Confirmatory review	Confirmation of results with another physician	Results discussed with physician performing tests	Unexpected results, contradictory reviews, requires additional reviews

Note. To qualify for a given type of decision making, two of three elements must be met or exceeded.

3. *Risk of complications and/or morbidity or mortality as well as comorbidities:* As with the two previous tables, Table 4–7 provides the elements and criteria used to rate this particular data set.

TABLE 4-7. TABLE OF RISK

LEVEL OF RISK	PRESENTING PROBLEM(S)	DIAGNOSTIC PROCEDURE(S) ORDERED	MANAGEMENT OPTIONS SELECTED
Minimal	One self-limited problem (e.g., medication side effect)	Laboratory tests requiring venipuncture Urinalysis	Reassurance
Low	Two or more self-limited or minor problems or one stable, chronic illness (e.g., well-controlled depression) or acute uncomplicated illness (e.g., exacerbation of anxiety disorder)	Psychological testing Skull film	Psychotherapy Environmental intervention (e.g., agency, school, vocational placement) Referral for consultation (e.g., physician, social worker)
Moderate	One or more chronic illness with mild exacerbation, progression, or side effects of treatment or two or more stable chronic illnesses or undiagnosed new problem with uncertain prognosis (e.g., psychosis)	Electroencephalogram Neuropsychological testing	Prescription drug management Open-door seclusion Electroconvulsive therapy, inpatient, outpatient, routine; no comorbid medical conditions
High	One or more chronic illnesses with severe exacerbation, progression, or side effect of treatment (e.g., schizophrenia) or acute illness with threat to life (e.g., suicidal or homicidal ideation)	Lumbar puncture Suicide risk assessment	Drug therapy requiring intensive monitoring (e.g., tapering diazepam for patient in withdrawal) Closed-door seclusion Suicide observation Electroconvulsive therapy; patient has comorbid medical condition (e.g., cardiovascular disease) Rapid intramuscular neuroleptic administration Pharmacological restraint

Source. Modified from CMS 1997 Guidelines for Psychiatry Single System Exam.

DETERMINING THE OVERALL LEVEL OF MEDICAL DECISION MAKING

Table 4–8 provides a grid that includes the components of the three preceding tables and level of complexity for each of those three components. The overall level of decision making is decided by placing the level of each of the three components into the appropriate box in a manner that allows them to be summed up to rate the overall decision making as *straightforward*, *low complexity*, *moderate complexity*, or *high complexity*.

DOCUMENTATION

The use of templates, either preprinted forms or embedded in an electronic patient record (see Appendix H), is an efficient means of addressing the documentation of decision making. Rather than counting or scoring the elements of the three components and actually filling out a grid like the one in the Table 4–8, a template can be constructed in collaboration with the compliance officer of your practice or institution to include prompts that capture the required data necessary to document complexity. Solo practitioners may require the assistance of their specialty association or a consultant to develop appropriate templates.

The templates in Appendix H fulfill the documentation requirements for both clinical and compliance needs. The fifth page of the Attending Physician Admission Note template includes all of the elements necessary for addressing Step 6 of the E/M decision-making process. Similarly, the second page of the daily note for inpatient or outpatient care also includes the elements for documenting medical decision making.

Remember: Clinically, there is a close relationship between the nature of the presenting problem and the complexity of medical decision making. For example:

- Patient A comes in for a prescription refill—straightforward decision making
- Patient B presents with suicidal ideation—decision making of high complexity

TABLE 4–8. ELEMENTS AND TYPE OF MEDICAL DECISION MAKING

	TYPE OF DECISION MAKING			
	Straightforward	Low complexity	Moderate complexity	High complexity
Number of diagnoses or management options (Table 4–5)	Minimal	Limited	Multiple	Extensive
Amount and/or complexity of data to be reviewed (Table 4–6)	Minimal or none	Limited	Moderate	Extensive
Risk of complications and/or morbidity or mortality (Table 4–7)	Minimal	Low	Moderate	High

Note. To qualify for a given type of decision making, two of three elements must be met or exceeded.

Step 7: Select the Appropriate Level of E/M Service

As noted earlier, each category of E/M service has three to five levels of work associated with it. Each level of work has a descriptor of the service and the required extent of the three key components of work. For example:

99223 **Descriptor:** Initial hospital care, per day for the evaluation and management of a patient, which requires these three key components:

- A comprehensive history
- A comprehensive examination
- Medical decision making that is of high complexity

For new patients, the three key components (history, examination, and medical decision making) must meet or exceed the stated requirements to qualify for each level of service for office visits, initial hospital care, office consultations, initial inpatient consultations, confirmatory consultations, emergency department services, comprehensive nursing facility assessments, domiciliary care, and home services.

For established patients, two of the three key components (history, examination, and medical decision making) must meet or exceed the stated requirements to qualify for each level of service for office visits, subsequent hospital care, follow-up inpatient consultations, subsequent nursing facility care, domiciliary care, and home care.

WHEN COUNSELING AND COORDINATION OF CARE ACCOUNT FOR MORE THAN 50% OF THE FACE-TO-FACE PHYSICIAN–PATIENT ENCOUNTER

When counseling and coordination of care account for more than 50% of the face-to-face physician–patient encounter, then time becomes the key or controlling factor in selecting the level of service. Note that counseling or coordination of care must be documented in the medical record. The definitions of counseling, coordination of care, and time follow.

Counseling is a discussion with a patient or the patient’s family concerning one or more of the following issues:

- Diagnostic results, impressions, and/or recommended diagnostic studies
- Prognosis
- Risks and benefits of management (treatment) options
- Instructions for management (treatment) and/or follow-up
- Importance of adherence to chosen management (treatment) options
- Risk factor reduction
- Patient and family education

Coordination of care is not specifically defined in the E/M section of the CPT manual. A working definition of the term could be as follows: Services provided by the physician responsible for the direct care of a patient when he or she coordinates or controls access to care or initiates or supervises other healthcare ser-

vices needed by the patient. Outpatient coordination of care must be provided face-to-face with the patient. Coordination of care with other providers or agencies without the patient being present on that day is reported with the case management codes.

TIME

For the purpose of selecting the level of service, time has two definitions.

1. For office and other outpatient visits and office consultations, *intraservice time* (time spent by the clinician providing services with the patient and/or family present) is defined as face-to-face time. Pre- and post-encounter time (non-face-to-face time) is not included in the average times listed under each level of service for either office or outpatient consultative services. The work associated with pre- and post-encounter time has been calculated into the total work effort provided by the physician for that service.
2. Time spent providing inpatient and nursing facility services is defined as *unit/floor time*. Unit/floor time includes all work provided to the patient while the psychiatrist is on the unit. This includes the following:
 - Direct patient contact (face-to-face)
 - Review of charts
 - Writing of orders
 - Writing of progress notes
 - Reviewing test results
 - Meeting with the treatment team
 - Telephone calls
 - Meeting with the family or other caregivers
 - Patient and family education

Work completed before and after direct patient contact and presence on the unit/floor, such as reviewing X-rays in another part of the hospital, has been included in the calculation of the total work provided by the physician for that service. Unit/floor time may be used to select the level of inpatient services by matching the total unit/floor time to the average times listed for each level of inpatient service. For instance:

99221

Descriptor: Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components:

- A detailed or comprehensive history
- A detailed or comprehensive examination
- Medical decision making that is straightforward or of low complexity

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.

Table 4–9 provides an example of an auditor's worksheet employed in making the decision of whether to use time in selecting the level of service. The three questions are prompts that assist the auditor (usually a nurse reviewer) in assessing whether the clinician 1) documented the length of time of the patient encounter, 2) described the counseling or coordination of care, and 3) indicated that more than half of the encounter time was for counseling or coordination of care.

Important: If you elect to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter should be documented and the record should describe the counseling and/or services or activities performed to coordinate care.

TABLE 4–9. CHOOSING LEVEL BASED ON TIME

	YES	NO
Does documentation reveal total time? Time: Face-to-face in outpatient setting; unit/floor in inpatient setting		
Does documentation describe the content of counseling or coordinating care?		
Does documentation suggest that more than half of the total time was counseling or coordinating of care?		

Note. If all answers are yes, select level based on time.

For examples and vignettes of code selection in specific clinical settings, see Chapter 5.

EVALUATION AND MANAGEMENT CODES MOST LIKELY TO BE USED BY PSYCHIATRISTS AND OTHER APPROPRIATELY LICENSED MENTAL HEALTH PROFESSIONALS

It is vital to read the explanatory notes in the CPT manual for an accurate understanding of when each of these codes should be used.

Note: For each of the following codes it is noted that: "Counseling and/or coordination of care with other providers or agencies is provided consistent with the nature of the problem(s) and the patient's and/or family's needs." As stated earlier, when this counseling and coordination of care accounts for more than 50% of the time spent, the typical time given in the code descriptor may be used for selecting the appropriate code rather than the other factors.

Office or Other Outpatient Services

NEW PATIENT

99201—The three following components are required:

- Problem-focused history
- Problem-focused examination
- Medical decision making that is straightforward

Presenting problem(s): Self-limited or minor

Typical time: 10 minutes face-to-face with patient and/or family

99202—The three following components are required:

- Expanded problem-focused history
- Expanded problem-focused examination
- Medical decision making that is straightforward

Presenting problem(s): Low to moderate severity

Typical time: 20 minutes face-to-face with patient and/or family

99203—The three following components are required:

- Detailed history
- Detailed examination
- Medical decision making of low complexity

Presenting problem(s): Moderate severity

Typical time: 30 minutes face-to-face with patient and/or family

99204—The three following components are required:

- Comprehensive history
- Comprehensive examination
- Medical decision making of moderate complexity

Presenting problem(s): Moderate to high severity

Typical time: 45 minutes face-to-face with patient and/or family

99205—The three following components are required:

- Comprehensive history
- Comprehensive examination
- Medical decision making of high complexity

Presenting problem(s): Moderate to high severity

Typical time: 60 minutes face-to-face with patient and/or family

ESTABLISHED PATIENT

99211—This code is used for a service that may not require the presence of a physician. Presenting problems are minimal, and 5 minutes is the typical time that would be spent performing or supervising these services.

99212—Two of the three following components are required:

- Problem-focused history
- Problem-focused examination
- Medical decision making that is straightforward

Presenting problem(s): Self-limited or minor

Typical time: 10 minutes face-to-face with patient and/or family

99213—Two of the three following components are required:

- Expanded problem-focused history
- Expanded problem-focused examination
- Medical decision making of low complexity

Presenting problem(s): Low to moderate severity

Typical time: 15 minutes face-to-face with patient and/or family

99214—Two of the three following components are required:

- Detailed history
- Detailed examination
- Medical decision making of moderate complexity

Presenting problem(s): Moderate to high severity

Typical time: 25 minutes face-to-face with patient and/or family

99215—Two of the three following components are required:

- Comprehensive history
- Comprehensive examination
- Medical decision making of high complexity

Presenting problem(s): Moderate to high severity

Typical time: 40 minutes face-to-face with patient and/or family

Hospital Observational Services

OBSERVATION CARE DISCHARGE SERVICES

99217—This code is used to report all services provided on discharge from “observation status” if the discharge occurs after the initial date of “observation status.”

INITIAL OBSERVATION CARE

99218—The three following components are required:

- Detailed or comprehensive history
- Detailed or comprehensive examination
- Medical decision making of straightforward or of low complexity

Presenting problem(s): Low severity

Typical time: None listed

99219—The three following components are required:

- Comprehensive history
- Comprehensive examination
- Medical decision making of moderate complexity

Presenting problem(s): Moderate severity

Typical time: None listed

99220—The three following components are required:

- Comprehensive history
- Comprehensive examination
- Medical decision making of high complexity

Presenting problem(s): High severity

Typical time: None listed

Hospital Inpatient Services

Services provided in a partial hospitalization setting would also use these codes. (With the elimination of the consultation codes as of January 1, 2010, CMS has created a new modifier A1, that is used to denote the admitting physician.)

INITIAL HOSPITAL CARE FOR NEW OR ESTABLISHED PATIENT

99221—The three following components are required:

- Detailed or comprehensive history
- Detailed or comprehensive examination
- Medical decision making that is straightforward or of low complexity

Presenting problem(s): Low severity

Typical time: 30 minutes at the bedside or on the patient's floor or unit

99222—The three following components are required:

- Comprehensive history
- Comprehensive examination
- Medical decision making of moderate complexity

Presenting problem(s): Moderate severity

Typical time: 50 minutes at the bedside or on the patient's floor or unit

99223—The three following components are required:

- Comprehensive history
- Comprehensive examination
- Medical decision making of high complexity

Presenting problem(s): High severity

Typical time: 70 minutes at the bedside or on the patient's floor or unit

SUBSEQUENT HOSPITAL CARE

99231—Two of the three following components are required:

- Problem-focused interval history
- Problem-focused examination
- Medical decision making that is straightforward or of low complexity

Presenting problem(s): Patient usually stable, recovering, or improving

Typical time: 15 minutes at the bedside or on the patient's floor or unit

99232—Two of the three following components are required:

- Expanded problem-focused interval history
- Expanded problem-focused examination
- Medical decision making of moderate complexity

Presenting problem(s): Patient responding inadequately to therapy or has developed a minor complication

Typical time: 25 minutes at the bedside or on the patient's floor or unit

99233—Two of the three following components are required:

- Detailed interval history
- Detailed examination
- Medical decision making of high complexity

Presenting problem(s): Patient unstable or has developed a significant new problem

Typical time: 35 minutes at the bedside or on the patient's floor or unit

HOSPITAL DISCHARGE SERVICES

99238—Time: 30 minutes or less

99239—Time: More than 30 minutes

Consultations

Medicare no longer pays for the consultation codes. When coding for Medicare or for commercial carriers that have followed Medicare's lead, 90801 may be used for both inpatient and outpatient consults. Psychiatrists who choose to use E/M codes to report outpatient consults should use the outpatient new patient codes (99201–99205). For inpatient consults, the codes to use are hospital inpatient services, initial hospital care for new or established patients (99221–99223). For consults in nursing homes, initial nursing facility care codes should be used (99304–99306); if the consult is of low complexity, the subsequent nursing facility codes may be used (99307–99310). As with all E/M codes, the selection of the specific code is based on the complexity of the case and the amount of work required. Medicare has created a new modifier, A1, to denote the admitting physician so that more than one physician may use the initial hospital care codes.

OFFICE OR OTHER OUTPATIENT CONSULTATIONS**99241—The three following components are required:**

- Problem-focused history
- Problem-focused examination
- Medical decision making that is straightforward

Presenting problem(s): Self-limited or minor

Typical time: 15 minutes face-to-face with patient and/or family

99242—The three following components are required:

- Expanded problem-focused history
- Expanded problem-focused examination
- Medical decision making that is straightforward

Presenting problem(s): Low severity

Typical time: 30 minutes face-to-face with patient and/or family

99243—The three following components are required:

- Detailed history
- Detailed examination
- Medical decision making of low complexity

Presenting problem(s): Moderate severity

Typical time: 40 minutes face-to-face with patient and/or family

99244—The three following components are required:

- Comprehensive history
- Comprehensive examination
- Medical decision making of moderate complexity

Presenting problem(s): Moderate to high severity

Typical time: 60 minutes face-to-face with patient and/or family

99245—The three following components are required:

- Comprehensive history
- Comprehensive examination
- Medical decision making of high complexity

Presenting problem(s): Moderate to high severity

Typical time: 80 minutes face-to-face with patient and/or family

INPATIENT CONSULTATIONS**99251—The three following components are required:**

- Problem-focused history
- Problem-focused examination
- Medical decision making that is straightforward

Presenting problem(s): Self-limited or minor

Typical time: 20 minutes at the bedside or on the patient's floor or unit

99252—The three following components are required:

- Expanded problem-focused history
- Expanded problem-focused examination
- Medical decision making that is straightforward

Presenting problem(s): Low severity

Typical time: 40 minutes at the bedside or on the patient's floor or unit

99253—The three following components are required:

- Detailed history
- Detailed examination
- Medical decision making of low complexity

Presenting problem(s): Moderate severity

Typical time: 55 minutes at the bedside or on the patient's floor or unit

99254—The three following components are required:

- Comprehensive history
- Comprehensive examination
- Medical decision making of moderate complexity

Presenting problem(s): Moderate to high severity

Typical time: 80 minutes at the bedside or on the patient's floor or unit

99255—The three following components are required:

- Comprehensive history
- Comprehensive examination
- Medical decision making of moderate complexity

Presenting problem(s): Moderate to high severity

Typical time: 110 minutes at the bedside or on the patient's floor or unit

Emergency Department Services

No distinction is made between new and established patients in this setting. There are no typical times provided for emergency E/M services.

99281—The three following components are required:

- Problem-focused history
- Problem-focused examination
- Medical decision making that is straightforward

Presenting problem(s): Self-limited or minor

99282—The three following components are required:

- Expanded problem-focused history
- Expanded problem-focused examination
- Medical decision making of low complexity

Presenting problem(s): Low or moderate severity

99283—The three following components are required:

- Expanded problem-focused history
- Expanded problem-focused examination
- Medical decision making of moderate complexity

Presenting problem(s): Moderate severity

99284—The three following components are required:

- Detailed history
- Detailed examination
- Medical decision making of moderate complexity

Presenting problem(s): High severity

99285—The three following components are required:

- Comprehensive history
- Comprehensive examination
- Medical decision making of high complexity

Presenting problem(s): High severity and pose(s) an immediate and significant threat to life or physiological function

Nursing Facility Services

INITIAL NURSING FACILITY CARE

99304—The three following components are required:

- Detailed or comprehensive history
- Detailed or comprehensive examination
- Medical decision making that is straightforward or of low complexity

Problem(s) requiring admission: Low severity

Typical time: 25 minutes with patient and/or family or caregiver

99305—The three following components are required:

- Comprehensive history
- Comprehensive examination
- Medical decision making of moderate complexity

Problem(s) requiring admission: Moderate severity

Typical time: 35 minutes with patient and/or family or caregiver

99306—The three following components are required:

- Comprehensive history
- Comprehensive examination
- Medical decision making of high complexity

Problem(s) requiring admission: High severity

Typical time: 45 minutes with patient and/or family or caregiver

SUBSEQUENT NURSING FACILITY CARE**99307—Two of the three following components are required:**

- Problem-focused interval history
- Problem-focused examination
- Medical decision making that is straightforward

Presenting problem(s): Patient usually stable, recovering, or improving

Typical time: 10 minutes with patient and/or family or caregiver

99308—Two of the three following components are required:

- Expanded problem-focused interval history
- Expanded problem-focused examination
- Medical decision making of low complexity

Presenting problem(s): Patient usually responding inadequately to therapy or has developed a minor complication

Typical time: 15 minutes with patient and/or family or caregiver

99309—Two of the three following components are required:

- Detailed interval history
- Detailed examination
- Medical decision making of moderate complexity

Presenting problem(s): Patient usually has developed a significant complication or a significant new problem

Typical time: 25 minutes with patient and/or family or caregiver

99310—Two of the three following components are required:

- Comprehensive interval history
- Comprehensive examination
- Medical decision making of high complexity

Presenting problem(s): Patient may be unstable or may have developed a significant new problem requiring immediate physician attention

Typical time: 35 minutes with patient and/or family or caregiver

NURSING FACILITY DISCHARGE SERVICES**99315—Time: 30 minutes or less****99316—Time: More than 30 minutes****ANNUAL NURSING FACILITY ASSESSMENT****99318—The three following components are required:**

- Detailed interval history
- Comprehensive examination
- Medical decision making of low to moderate complexity

Presenting problem(s): Patient usually stable, recovering, or improving

Typical time: 30 minutes with patient and/or family or caregiver

Domiciliary, Rest Home, or Custodial Care Services

The following codes are used to report E/M services in a facility that provides room, board, and other personal services, usually on a long-term basis. They are also used in assisted living facilities.

NEW PATIENT

99324—The three following components are required:

- Problem-focused history
- Problem-focused examination
- Medical decision making that is straightforward

Presenting problem(s): Low severity

Typical time: 20 minutes with patient and/or family or caregiver

99325—The three following components are required:

- Expanded problem-focused history
- Expanded problem-focused examination
- Medical decision making of low complexity

Presenting problem(s): Moderate severity

Typical time: 30 minutes with patient and/or family or caregiver

99326—The three following components are required:

- Detailed history
- Detailed examination
- Medical decision making of moderate complexity

Presenting problem(s): Moderate to high severity

Typical time: 45 minutes with patient and/or family or caregiver

99327—The three following components are required:

- Comprehensive history
- Comprehensive examination
- Medical decision making of moderate complexity

Presenting problem(s): High severity

Typical time: 60 minutes with patient and/or family or caregiver

99328—The three following components are required:

- Comprehensive history
- Comprehensive examination
- Medical decision making of high complexity

Presenting problem(s): Patient usually has developed a significant new problem requiring immediate physician attention

Typical time: 75 minutes with patient and/or family or caregiver

ESTABLISHED PATIENT

99334—Two of the three following components are required:

- Problem-focused interval history
- Problem-focused examination
- Medical decision making that is straightforward

Presenting problem(s): Self-limited or minor

Typical time: 15 minutes with patient and/or family or caregiver

99335—Two of the three following components are required:

- Expanded problem-focused interval history
- Expanded problem-focused examination
- Medical decision making of low complexity

Presenting problem(s): Low to moderate severity

Typical time: 25 minutes with patient and/or family or caregiver

99336—Two of the three following components are required:

- Detailed interval history
- Detailed examination
- Medical decision making of moderate complexity

Presenting problem(s): Moderate to high severity

Typical time: 40 minutes with patient and/or family or caregiver

99337—Two of the three following components are required:

- Comprehensive interval history
- Comprehensive examination
- Medical decision making of moderate to high complexity

Presenting problem(s): Patient may be unstable or has developed a significant new problem requiring immediate physician attention

Typical time: 60 minutes with patient and/or family or caregiver

Home Services

These codes are used for E/M services provided to a patient in a private residence, in other words, for home visits.

NEW PATIENT

99341—The three following components are required:

- Problem-focused history
- Problem-focused examination
- Medical decision making that is straightforward

Presenting problem(s): Low severity

Typical time: 20 minutes face-to-face with patient and/or family

99342—The three following components are required:

- Expanded problem-focused history
- Expanded problem-focused examination
- Medical decision making of low complexity

Presenting problem(s): Moderate severity

Typical time: 30 minutes face-to-face with patient and/or family

99343—The three following components are required:

- Detailed history
- Detailed examination
- Medical decision making of moderate complexity

Presenting problem(s): Moderate to high severity

Typical time: 45 minutes face-to-face with patient and/or family

99344—The three following components are required:

- Comprehensive history
- Comprehensive examination
- Medical decision making of moderate complexity

Presenting problem(s): High severity

Typical time: 60 minutes face-to-face with patient and/or family

99345—The three following components are required:

- Comprehensive history
- Comprehensive examination
- Medical decision making of high complexity

Presenting problem(s): Patient unstable or has developed a significant new problem that requires immediate physician attention

Typical time: 75 minutes face-to-face with patient and/or family

ESTABLISHED PATIENT**99347—Two of the three following components are required:**

- Problem-focused interval history
- Problem-focused examination
- Medical decision making that is straightforward

Presenting problem(s): Self-limited or minor

Typical time: 15 minutes face-to-face with patient and/or family

99348—Two of the three following components are required:

- Expanded problem-focused interval history
- Expanded problem-focused examination
- Medical decision making of low complexity

Presenting problem(s): Low to moderate severity

Typical time: 25 minutes face-to-face with patient and/or family

99349—Two of the three following components are required:

- Detailed interval history
- Detailed examination
- Medical decision making of moderate complexity

Presenting problem(s): Moderate to high severity

Typical time: 40 minutes face-to-face with patient and/or family

99350—Two of the three following components are required:

- Comprehensive interval history
- Comprehensive examination
- Medical decision making of moderate to high complexity

Presenting problem(s): Moderate to high severity—patient may be unstable or may have developed a significant new problem requiring immediate physician attention

Typical time: 60 minutes face-to-face with patient and/or family

Case Management Services

MEDICAL TEAM CONFERENCES

99366—To be used when patient and/or family is present*

Physicians should use the appropriate code from the “Evaluation and Management” section when reporting this service.

99367—To be used when there is no face-to-face contact with the patient and/or family

Preventive Medicine Services

COUNSELING RISK FACTOR REDUCTION AND BEHAVIOR CHANGE INTERVENTION

99406—Time: 3–10 minutes

99407—Time: More than 10 minutes

99408—Time: 15–30 minutes, includes the administration of an alcohol and/or substance abuse screening tool and brief intervention

99409—Time: 30 minutes or more

NON-FACE-TO-FACE SERVICES

Medicare does not pay for these.

Telephone Services

99441—Time: 5–10 minutes of medical discussion

99442—Time: 11–20 minutes of medical discussion

99443—Time: 21–30 minutes of medical discussion**On-Line Medical Evaluation**

99444—For an established patient, guardian, or healthcare provider; may not have originated from a related E/M service provided within the previous 7 days.

Special Evaluation and Management Services

Medicare does not pay for these.

BASIC LIFE AND/OR DISABILITY EVALUATION SERVICES**99450—The four following elements are required:**

- Measurement of height, weight, and blood pressure
- Completion of a medical history following a life insurance pro forma
- Collection of blood sample and/or urinalysis complying with “chain of custody” protocols
- Completion of necessary documentation/certificates

WORK-RELATED OR MEDICAL DISABILITY EVALUATION SERVICES**99455—Work-related medical disability examination done by the treating physician; the five following elements are required:**

- Completion of medical history commensurate with the patient’s condition
- Performance of an examination commensurate with the patient’s condition
- Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment
- Development of future medical treatment plan
- Completion of necessary documentation/certificates, and report

99456—Work-related medical disability examination done by provider other than the treating physician. Must include the same five elements listed for previous code.

This is just a partial list of codes found in the “Evaluation and Management” section of the CPT manual. We advise all psychiatrists and other mental health clinicians to purchase a copy of the manual to ensure access to information on the full range of codes.

QUESTIONS AND ANSWERS

Q. *Who may use E/M codes?*

A. Psychiatrists and appropriately licensed nurses and physician assistants may use the E/M codes.

- Q.** *Is a unit treatment team conference on an inpatient unit a service for which one may code?*
- A.** Treatment team conferences can be coded for but should be considered part of overall coordination of care. The time spent providing that service is a component of the total unit/floor time. Team conferences should not be coded as a separate service but rather as a component of the total services provided to the patient on any given day.
- Q.** *If I have a patient in the hospital whom I see for rounds in the morning and again when I am called to the ward in the afternoon because of a problem, do I code for two subsequent hospital care visits?*
- A.** No. One code should be selected that incorporates all of the hospital inpatient services provided that day.
- Q.** *What are the documentation requirements associated with inpatient and outpatient consultations?*
- A.** The request for the consultation must be documented in the patient's medical record. The consultant's opinion and any services that are performed also must be documented in the patient's medical record and communicated in writing to the requesting physician.
- Q.** *What codes should be used for psychiatric services provided in partial hospital settings, residential treatment facilities, and nursing homes?*
- A.** The codes for partial hospitalization services are the same as those used for hospital inpatient settings (99221–99239). The codes for residential treatment services are the same as those used for nursing facility services (99301–99316).
- Q.** *When would I use the pharmacological management code (90862) rather than one of the E/M outpatient codes?*
- A.** Your decision should be based on which code most accurately reports the services provided. Code 90862 is valued slightly less in relative value units than 99213, but 90862 is used specifically for psychopharmacological management. Code 99213 denotes more general medical services and might include consideration of comorbid medical conditions.
- Q.** *Is it necessary for the provider to record the examination him- or herself or can a checklist be used for the patient to record past history?*
- A.** A checklist is acceptable if the clinician provides a narrative report of the important positive and relevant negative findings. Abnormal findings should be described in the report. A notation of an abnormal finding without a description is not sufficient.
- Q.** *Can a checklist be used for an ROS?*
- A.** Yes, but pertinent positive and negative findings that are relevant to the presenting problem must be commented on by the examining clinician. Failure to document the appropriate number of systems for each level of service is the most common reason for downcoding by claims auditors, resulting in a lower level of reimbursement.

- Q.** *Now that Medicare no longer pays for consultation codes, how do I code for a consultation request from a colleague and what are the reporting requirements?*
- A.** When you are coding for Medicare or for commercial carriers that have followed Medicare's lead, 90801 may be used for both inpatient and outpatient consults. Psychiatrists who choose to use E/M codes to report outpatient consults should use the outpatient new patient codes (99201–99205). For inpatient consults, the codes to use are hospital inpatient services, initial hospital care for new or established patients (99221–99223). For consults in nursing homes, initial nursing facility care codes should be used (99304–99306); if the consult is of low complexity, the subsequent nursing facility codes may be used (99307–99310). As with all E/M codes, the selection of the specific code is based on the complexity of the case and the amount of work required. Medicare has created a new modifier, A1, to denote the admitting physician so that more than one physician may use the initial hospital care codes. It is still necessary to report back to the referring physician, but it is not necessary to write a report. The report can be done by telephone or the patient record can be sent to the referring physician.
- Q.** *Is it permissible to use a template or checklist to record the mental status examination?*
- A.** Yes.
- Q.** *If my mode of practice for inpatient services is to have an internist or family practitioner do a medical history and a physical examination and I then do the psychiatric evaluation and mental status examination within a 24-hour period, how can we code so we will both be paid?*
- A.** The typical way to code for this situation is to have the internist or family practitioner use a new patient E/M code and a medical diagnosis code and for the psychiatrist use a hospital service code for first day and a psychiatric diagnosis code.

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Appendix E

1997 CMS Documentation Guidelines for Evaluation and Management Services (Abridged and Modified for Psychiatric Services)

I. INTRODUCTION

A. What Is Documentation and Why Is It Important?

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history, including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high-quality care. The medical record facilitates:

- the ability of the physician and other healthcare professionals to evaluate and plan the patient's immediate treatment, and to monitor his or her healthcare over time;
- communication and continuity of care among physicians and other healthcare professionals involved in the patient's care;
- accurate and timely claims review and payment;
- appropriate utilization review and quality of care evaluations; and
- collection of data that may be useful for research and education.

An appropriately documented medical record can reduce many of the "hassles" associated with claims processing and may serve as a legal document to verify the care provided, if necessary.

B. What Do Payers Want and Why?

Because payers have a contractual obligation to enrollees, they may require reasonable documentation that services are consistent with the insurance coverage provided. They may request information to validate:

- the site of service;
- the medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or
- that services provided have been accurately reported.

II. GENERAL PRINCIPLES OF MEDICAL RECORD DOCUMENTATION

The principles of documentation listed here are applicable to all types of medical and surgical services in all settings. For evaluation and management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service, and the patient's status. The general principles listed here may be modified to account for these variable circumstances in providing E/M services.

1. The medical record should be complete and legible.
2. The documentation of each patient encounter should include:
 - reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results;
 - assessment, clinical impression, or diagnosis;
 - plan for care; and
 - date and legible identity of the observer.
3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
4. Past and present diagnoses should be accessible to the treating and/or consulting physician.
5. Appropriate health risk factors should be identified.
6. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.
7. The Current Procedural Terminology (CPT) and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

III. DOCUMENTATION OF E/M SERVICES

This publication provides definitions and documentation guidelines for the three key components of E/M services and for visits that consist predominantly of counseling or coordination of care. The three *key* components—history, examination, and medical decision making—appear in the descriptors for office and other outpatient services, hospital observation services, hospital inpatient ser-

vices, consultations, emergency department services, nursing facility services, domiciliary care services, and home services. While some of the text of CPT has been repeated in this publication, the reader should refer to CPT for the complete descriptors for E/M services and instructions for selecting a level of service. Documentation guidelines are identified by the symbol ♦ *DG*.

The descriptors for the levels of E/M services recognize seven components that are used in defining the levels of E/M services:

- History
- Examination
- Medical decision making
- Counseling
- Coordination of care
- Nature of presenting problem
- Time

The first three of these components (i.e., history, examination, and medical decision making) are the key components in selecting the level of E/M services. In the case of visits that consist predominantly of counseling or coordination of care, time is the key or controlling factor to qualify for a particular level of E/M service.

Because the level of E/M service is dependent on two or three key components, performance and documentation of one component (e.g., examination) at the highest level does not necessarily mean that the encounter in its entirety qualifies for the highest level of E/M service.

These Documentation Guidelines for E/M services reflect the needs of the typical adult population. For certain groups of patients, the recorded information may vary slightly from that described here. Specifically, the medical records of infants, children, adolescents, and pregnant women may have additional or modified information recorded in each history and examination area.

As an example, newborn records may include under history of the present illness the details of mother's pregnancy and the infant's status at birth; social history will focus on family structure; and family history will focus on congenital anomalies and hereditary disorders in the family. In addition, the content of a pediatric examination will vary with the age and development of the child. Although not specifically defined in these documentation guidelines, these patient group variations on history and examination are appropriate.

A. Documentation of History

The levels of E/M services are based on four types of history (problem focused, expanded problem focused, detailed, and comprehensive). Each type of history includes some or all of the following elements:

- Chief complaint (CC)
- History of present illness (HPI)
- Review of systems (ROS)
- Past, family, and/or social history (PFSH)

The extent of HPI, ROS, and PFSH that is obtained and documented is dependent on clinical judgment and the nature of the presenting problem(s).

The chart below shows the progression of the elements required for each type of history. To qualify for a given type of history all three elements in the table must be met. (A CC is indicated at all levels.)

History of present illness (HPI)	Review of systems (ROS)	Past, family, and/or social history (PFSH)	Type of history
Brief	N/A	N/A	Problem focused
Brief	Problem pertinent	N/A	Expanded problem focused
Extended	Extended	Pertinent	Detailed
Extended	Complete	Complete	Comprehensive

- ♦ *DG: The CC, ROS, and PFSH may be listed as separate elements of history or may be included in the description of the history of the present illness.*
- ♦ *DG: An ROS and/or a PFSH obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his or her own record or in an institutional setting or group practice where many physicians use a common record. The review and update may be documented by*
 - *describing any new ROS and/or PFSH information or noting there has been no change in the information; and*
 - *noting the date and location of the earlier ROS and/or PFSH.*
- ♦ *DG: The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.*
- ♦ *DG: If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance that precludes obtaining a history.*

Definitions and specific documentation guidelines for each of the elements of history are listed in the following sections.

CHIEF COMPLAINT (CC)

The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter, usually stated in the patient's words.

- ♦ *DG: The medical record should clearly reflect the CC.*

HISTORY OF PRESENT ILLNESS (HPI)

The HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. It includes the following elements:

- Location
- Quality
- Severity
- Duration
- Timing
- Context
- Modifying factors
- Associated signs and symptoms

Brief and *extended* HPIs are distinguished by the amount of detail needed to accurately characterize the clinical problem(s).

A *brief* HPI consists of one to three elements of the HPI.

- ♦ *DG: The medical record should describe one to three elements of the present illness.*

An *extended* HPI consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions.

- ♦ *DG: The medical record should describe at least four elements of the present illness or the status of at least three chronic or inactive conditions.*

REVIEW OF SYSTEMS (ROS)

An ROS is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced.

For purposes of the ROS, the following systems are recognized:

- Constitutional symptoms (e.g., fever, weight loss)
- Eyes
- Ears, nose, mouth, throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematological/Lymphatic
- Allergic/Immunologic

A *problem pertinent* ROS inquires about the system directly related to the problem(s) identified in the HPI.

- ♦ **DG:** *The patient's positive responses and pertinent negatives for the system related to the problem should be documented.*

An *extended* ROS inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems.

- ♦ **DG:** *The patient's positive responses and pertinent negatives for two to nine systems should be documented.*

A *complete* ROS inquires about the system(s) directly related to the problem(s) identified in the HPI *plus* all additional body systems.

- ♦ **DG:** *At least 10 organ systems must be reviewed. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least 10 systems must be individually documented.*

PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)

The PFSH consists of a review of three areas:

- Past history (the patient's past experiences with illnesses, operations, injuries, and treatments)
- Family history (a review of medical events in the patient's family, including diseases that may be hereditary or place the patient at risk)
- Social history (an age-appropriate review of past and current activities)

For certain categories of E/M services that include only an interval history, it is not necessary to record information about the PFSH. Those categories are subsequent hospital care, follow-up inpatient consultations, and subsequent nursing facility care.

A *pertinent* PFSH is a review of the history area(s) directly related to the problem(s) identified in the HPI.

- ♦ **DG:** *At least one specific item from any of the three history areas must be documented for a pertinent PFSH.*

A *complete* PFSH is of a review of two or all three of the PFSH history areas, depending on the category of the E/M service. A review of all three history areas is required for services that by their nature include a comprehensive assessment or reassessment of the patient. A review of two of the three history areas is sufficient for other services.

- ♦ **DG:** *At least one specific item from two of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services, established patient; emergency department; domiciliary care, established patient; and home care, established patient.*

- ♦ *DG: At least one specific item from each of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services, new patient; hospital observation services; hospital inpatient services, initial care; consultations; comprehensive nursing facility assessments; domiciliary care, new patient; and home care, new patient.*

B. Documentation of Examination

The levels of E/M services are based on four types of examination:

- *Problem focused*—A limited examination of the affected body area or organ system.
- *Expanded problem focused*—A limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s).
- *Detailed*—An extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s).
- *Comprehensive*—A general multisystem examination or complete examination of a single organ system and other symptomatic or related body area(s) or organ system(s).

These types of examinations have been defined for general multisystem and the following single organ systems:

- Cardiovascular
- Ears, nose, mouth, and throat
- Eyes
- Genitourinary (female)
- Genitourinary (male)
- Hematological/Lymphatic/Immunological
- Musculoskeletal
- Neurological
- **Psychiatric**
- Respiratory
- Skin

A general multisystem examination or a single organ system examination may be performed by any physician regardless of specialty. The type (general multisystem or single organ system) and content of examination are selected by the examining physician and are based upon clinical judgment, the patient's history, and the nature of the presenting problem(s).

The content and documentation requirements for each type and level of examination are summarized here and described in detail in the tables that appear later in this appendix. In the first table (see pp. 123), organ systems and body areas recognized by CPT for purposes of describing examinations are shown in the left column. The content, or individual elements, of the examination pertaining to that body area or organ system are identified by bullets (•) in the right column.

Parenthetical examples “(e.g., ...)” have been used for clarification and to provide guidance regarding documentation. Documentation for each element must satisfy any numeric requirements (such as “Measurement of *any three of the following seven*...”) included in the description of the element. Elements with multiple components but with no specific numeric requirement (such as “Examination of *liver and spleen*”) require documentation of at least one component. It is possible for a given examination to be expanded beyond what is defined here. When that occurs, findings related to the additional systems and/or areas should be documented.

- ♦ **DG:** *Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of “abnormal” without elaboration is insufficient.*
- ♦ **DG:** *Abnormal or unexpected findings of the examination of any asymptomatic body area(s) or organ system(s) should be described.*
- ♦ **DG:** *A brief statement or notation indicating “negative” or “normal” is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).*

[DELETED: GUIDELINES FOR “GENERAL MULTI-SYSTEM EXAMINATIONS”]

SINGLE ORGAN SYSTEM EXAMINATIONS

The single organ system examinations recognized by CPT are described in detail. [Authors’ note: We are only including the psychiatric examination.] Variations among these examinations in the organ systems and body areas identified in the left columns and in the elements of the examinations described in the right columns reflect differing emphases among specialties. To qualify for a given level of single organ system examination, the following content and documentation requirements should be met:

- *Problem focused examination*—Should include performance and documentation of one to five elements identified by a bullet (•), whether in a box with a shaded or unshaded border.
- *Expanded problem focused examination*—Should include performance and documentation of at least six elements identified by a bullet (•), whether in a box with a shaded or unshaded border.
- *Detailed examination*—Examinations other than the eye and psychiatric examinations should include performance and documentation of at least 12 elements identified by a bullet (•), whether in box with a shaded or unshaded border.

Eye and psychiatric examinations should include the performance and documentation of at least nine elements identified by a bullet (•), whether in a box with a shaded or unshaded border.

- *Comprehensive examination*—Should include performance of all elements identified by a bullet (•), whether in a shaded or unshaded box. Documentation of every element in each box with a shaded border and at least one element in each box with an unshaded border is expected.

CONTENT AND DOCUMENTATION REQUIREMENTS

[DELETED: CONTENT AND DOCUMENTATION REQUIREMENTS FOR GENERAL MULTI-SYSTEM EXAMINATION AND ALL SINGLE-SYSTEM REQUIREMENTS OTHER THAN PSYCHIATRY]

PSYCHIATRIC EXAMINATION	
SYSTEM/ BODY AREA	ELEMENTS OF EXAMINATION
Constitutional	• Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (may be measured and recorded by ancillary staff) • General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	
Eyes	
Ears, Nose, Mouth, and Throat	
Neck	
Respiratory	
Cardiovascular	
Chest (Breasts)	
Gastrointestinal (Abdomen)	
Genitourinary	
Lymphatic	
Musculoskeletal	• Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements • Examination of gait and station
Extremities	
Skin	
Neurological	

PSYCHIATRIC EXAMINATION (CONTINUED)	
SYSTEM/ BODY AREA	ELEMENTS OF EXAMINATION
Psychiatric	• Description of speech, including rate, volume, articulation, coherence, and spontaneity with notation of abnormalities (e.g., perseveration, paucity of language) • Description of thought processes, including rate of thoughts; content of thoughts (e.g., logical vs. illogical, tangential); abstract reasoning; and computation • Description of associations (e.g., loose, tangential, circumstantial, intact) • Description of abnormal or psychotic thoughts, including hallucinations, delusions, preoccupation with violence, homicidal or suicidal ideation, and obsessions • Description of the patient's judgment (e.g., concerning everyday activities and social situations) and insight (e.g., concerning psychiatric condition) Complete mental status examination, including • Orientation to time, place, and person • Recent and remote memory • Attention span and concentration • Language (e.g., naming objects, repeating phrases) • Fund of knowledge (e.g., awareness of current events, past history, vocabulary) • Mood and affect (e.g., depression, anxiety, agitation, hypomania, lability)

CONTENT AND DOCUMENTATION REQUIREMENTS	
LEVEL OF EXAMINATION	PERFORM AND DOCUMENT
Problem focused	One to five elements identified by a bullet.
Expanded problem focused	At least six elements identified by a bullet.
Detailed	At least nine elements identified by a bullet.
Comprehensive	Perform all elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

C. Documentation of the Complexity of Medical Decision Making

The levels of E/M services recognize four types of medical decision making: straightforward, low complexity, moderate complexity, and high complexity. *Medical decision making* refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- the number of possible diagnoses and/or the number of management options that must be considered;
- the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and
- the risk of significant complications, morbidity, and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

The following chart shows the progression of the elements required for each level of medical decision making. To qualify for a given type of decision making, two of the three elements in the table must be either met or exceeded.

Number of diagnoses or management options	Amount or complexity of data to be reviewed	Risk of complications and/or morbidity or mortality	Type of decision making
Minimal	Minimal or none	Minimal	<i>Straightforward</i>
Limited	Limited	Low	<i>Low complexity</i>
Multiple	Moderate	Moderate	<i>Moderate complexity</i>
Extensive	Extensive	High	<i>High complexity</i>

Each of the elements of medical decision making is described below.

NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS

The number of possible diagnoses and/or the number of management options that must be considered is based on the number and types of problems addressed during the encounter, the complexity of establishing a diagnosis, and the management decisions that are made by the physician.

Generally, decision making with respect to a diagnosed problem is easier than that for an identified but undiagnosed problem. The number and type of diagnostic tests employed may be an indicator of the number of possible diagnoses. Problems that are improving or resolving are less complex than those that are worsening or failing to change as expected. The need to seek advice from others is another indicator of the complexity of diagnostic or management problems.

- ♦ ***DG:** For each encounter, an assessment, clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.*
- *For a presenting problem with an established diagnosis, the record should reflect whether the problem is a) improved, well controlled, resolving, or resolved or b) inadequately controlled, worsening, or failing to change as expected.*
- *For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of differential diagnoses or as a "possible," "probable," or "rule out" (R/O) diagnosis.*

- ♦ *DG: The initiation of, or changes in, treatment should be documented. Treatment includes a wide range of management options including patient instructions, nursing instructions, therapies, and medications.*
- ♦ *DG: If referrals are made, consultations requested, or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom the advice is requested.*

AMOUNT AND COMPLEXITY OF DATA TO BE REVIEWED

The amount and complexity of data to be reviewed are based on the types of diagnostic testing ordered or reviewed. A decision to obtain and review old medical records and/or obtain history from sources other than the patient increases the amount and complexity of data to be reviewed.

Discussion of contradictory or unexpected test results with the physician who performed or interpreted the test is an indication of the complexity of data being reviewed. On occasion the physician who ordered a test may personally review the image, tracing, or specimen to supplement information from the physician who prepared the test report or interpretation; this is another indication of the complexity of data being reviewed.

- ♦ *DG: If a diagnostic service (test or procedure) is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service (e.g., laboratory work or X-ray) should be documented.*
- ♦ *DG: The review of laboratory, radiology, and/or other diagnostic tests should be documented. A simple notation such as “white blood cells elevated” or “chest X-ray unremarkable” is acceptable. Alternatively, the review may be documented by initialing and dating the report containing the test results.*
- ♦ *DG: A decision to obtain old records or to obtain additional history from the family, caretaker, or other source to supplement that obtained from the patient should be documented.*
- ♦ *DG: Relevant findings from the review of old records and/or the receipt of additional history from the family, caretaker, or other source to supplement that obtained from the patient should be documented. If there is no relevant information beyond that already obtained, that fact should be documented. A notation of “old records reviewed” or “additional history obtained from family” without elaboration is insufficient.*
- ♦ *DG: The results of discussion of laboratory, radiology, or other diagnostic tests with the physician who performed or interpreted the study should be documented.*
- ♦ *DG: The direct visualization and independent interpretation of an image, tracing, or specimen previously or subsequently interpreted by another physician should be documented.*

RISK OF SIGNIFICANT COMPLICATIONS, MORBIDITY, AND/OR MORTALITY

The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the presenting problem(s), the diagnostic procedure(s), and the possible management options.

- ♦ *DG: Comorbidities/Underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.*
- ♦ *DG: If a surgical or invasive diagnostic procedure is ordered, planned, or scheduled at the time of the E/M encounter, the type of procedure (e.g., laparoscopy) should be documented.*
- ♦ *DG: If a surgical or invasive diagnostic procedure is performed at the time of the E/M encounter, the specific procedure should be documented.*
- ♦ *DG: The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied.*

The table on p. 128 may be used to help determine whether the risk of significant complications, morbidity, and/or mortality is *minimal*, *low*, *moderate*, or *high*. Because the determination of risk is complex and not readily quantifiable, the table includes common clinical examples rather than absolute measures of risk. The assessment of risk of the presenting problem(s) is based on the risk related to the disease process anticipated between the present encounter and the next one. The assessment of risk of selecting diagnostic procedures and management options is based on the risk during and immediately following any procedures or treatment. The highest level of risk in any one category (presenting problem[s], diagnostic procedure[s], or management options) determines the overall risk.

D. Documentation of an Encounter Dominated by Counseling or Coordination of Care

In the case in which counseling and/or coordination of care dominates (more than 50%) the physician/patient and/or family encounter (face-to-face time in the office or other or outpatient setting, floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E/M services.

- ♦ *DG: If the physician elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter (face-to-face or floor time, as appropriate) should be documented, and the record should describe the counseling and/or activities to coordinate care.*

TABLE OF RISK
(MODIFIED FOR PSYCHIATRY FROM THE 1997 CMS GUIDELINES)

LEVEL OF RISK	PRESENTING PROBLEM(S)	DIAGNOSTIC PROCEDURE(S) ORDERED	MANAGEMENT OPTIONS SELECTED
Minimal	1 self-limited problem (e.g., medication side effect)	Laboratory tests requiring venipuncture Urinalysis	Reassurance
Low	2 or more self-limited or minor problems; or 1 stable chronic illness (e.g., well-controlled depressions); or Acute uncomplicated illness (e.g., exacerbation of anxiety disorder)	Psychological testing Skull film	Psychotherapy Environmental intervention (e.g., agency, school, vocational placement) Referral for consultation (e.g., physician, social worker)
Moderate	1 or more chronic illnesses with mild exacerbation, progression, or side effects of treatment; or 2 or more stable chronic illnesses; or Undiagnosed new problem with uncertain prognosis (e.g., psychosis)	Electroencephalogram Neuropsychological testing	Prescription drug management Open-door seclusion ECT, inpatient, outpatient, routine; no comorbid medical conditions
High	1 or more chronic illnesses with severe exacerbation, progression, or side effect of treatment (e.g., schizophrenia); or Acute illness with threat to life (e.g., suicidal or homicidal ideation)	Lumbar puncture Suicide risk assessment	Drug therapy requiring intensive monitoring (e.g., tapering diazepam for patient in withdrawal) Closed-door seclusion Suicide observation ECT; patient has comorbid medical condition (e.g., cardiovascular disease) Rapid intramuscular neuroleptic administration Pharmacological restraint (e.g., droperidol)

Appendix F

Vignettes for Evaluation and Management Codes

OFFICE VISIT, NEW PATIENT

99203 A 27-year-old woman with a history of depression who is visiting the area is seen in an initial office visit. She is currently under treatment in her hometown. History taking focuses on a review of her past psychiatric history, present illness, and interval history since her last visit to her treating psychiatrist. Her medication history is reviewed, as is her side-effect history. A mental status examination focuses on her current affective state, ability to attend and concentrate, and insight. A prescription for an antidepressant is provided, along with education on its use and side effects.

Explanation for code choice: Although a new patient to the examining psychiatrist, this patient has an existing treatment source. The psychiatrist obtains a detailed history and performs a detailed mental status examination. (A detailed history requires a detailed [two to nine elements] review of symptoms.) The provision of a prescription requires medical decision making of low complexity.

99205 A 38-year-old man brought by his parents for evaluation of paranoid delusions and alcohol abuse is seen in an initial office visit. History taking focuses on the family history of mental illness. The past medical and psychiatric history, history of present illness, and social history of the patient are taken. The results of a mental status examination reveal a poorly groomed individual, poor eye contact, no spontaneity to speech, flat affect, no hallucinations, paranoid delusions about the police, no suicidal/homicidal ideation, and intact cognitive status. The patient has no history of current medical problems. The patient denies alcohol use. The parents are interviewed and provide a history of the patient that includes at least 5 years of binge drinking. Routine blood studies are ordered. The patient's vital signs are taken. A prescription for a neuroleptic is

given, and education about medication is provided to the patient and the parents. Referrals to a dual-diagnosis treatment program and Alcoholics Anonymous are made.

Explanation for code choice: This initial evaluation requires complex medical decision making because of the psychotic symptoms in the context of alcohol abuse. The psychiatrist must complete a comprehensive history and examination. The comprehensive history includes a complete review of systems.

OFFICE VISIT, ESTABLISHED PATIENT

99213 A 42-year-old male established patient with a history of bipolar II disorder, last seen 2 months prior, is seen for an office visit. Interval history taking focuses on the presence/absence of symptoms, the patient's level of social/vocational function, and the patient's adherence to the medication regimen. A mental status examination focuses on the patient's affective state. The patient's lithium blood level is reviewed. The side effects of the medication are reviewed, and prescriptions for the same medications are provided.

Explanation for code choice: In order to make a decision about medications, the psychiatrist must do an expanded problem-focused history and examination. An expanded problem-focused history includes one to three elements of a review of systems. The actual medical decision to continue the medication regimen is of low complexity.

HOSPITAL INPATIENT SERVICES—INITIAL HOSPITAL CARE

99221 A 32-year-old woman is seen for initial hospital care. The woman had been discharged from the same psychiatric unit 3 days earlier after a 5-day stay precipitated by threats of suicide in the context of alcohol intoxication. The patient had received diagnoses of adjustment disorder with depressed mood and suicidal ideation, alcohol abuse, and mixed personality disorder with borderline features. Her interval history revealed that the patient had returned home after discharge from the hospital and within 24 hours became involved in verbally violent arguments with her husband, drank an unspecified amount of vodka, and threatened to kill him. Her blood alcohol level in the emergency department is 160 mg/dL. The results of a physical examination are within normal limits, as are the results of the remainder of the laboratory studies. The results of a toxicology screening are negative. The mental status examination reveals a patient who is crying, angry, and accusing her husband of infidelity. She is difficult to redirect, and her affect is labile and irritable. Her mood is depressed. She shows no psychotic symptoms and is cognitively intact. She demonstrates little to no insight. The patient is admitted to the hospital voluntarily. The social work staff is asked to provide an evaluation of the husband and the family situation. Discharge planning is begun.

Explanation for code choice: The lowest level of initial hospital care is appropriate because this is a readmission with no change in the history database and because the medical decision making is straightforward.

99222 A 40-year-old man discharged 12 days before the current admission with a diagnosis of schizophrenia had been given instructions to attend follow-up visits at an outpatient clinic to monitor his neuroleptic medication. He now presents with auditory hallucinations and paranoid ideation with violent thoughts toward his neighbors. His interval history reveals that he never attended the outpatient clinic and that he immediately discontinued taking the neuroleptic medication after discharge. The patient's brother reports that the patient's symptoms reappeared 4 days before the current admission. The patient also has a history of diabetes mellitus controlled by oral medications and had discontinued taking his diabetes medication. A mental status examination reveals a poorly groomed individual with auditory hallucinations that are threatening toward the patient and paranoid delusions that involve neighbors trying to hurt him. He admits to violent thoughts toward his neighbors and states that he might have to harm or kill them. He appears to be cognitively intact. A physical examination reveals a moderately obese individual. The results of his laboratory studies are normal except for an elevated glucose level. The results of repeat finger-stick tests indicate glucose levels above 400 mg/dL. A new neuroleptic regimen is begun for the patient. The treatment team devises a strategy to help the patient's family assist him in adhering to this regimen after discharge.

Explanation for code choice: Although this case is also a readmission, the nature of the presenting problem involves psychotic symptoms, violent thoughts, and symptomatic diabetes. The level of history taking and examination are comprehensive, and the medical decision making is moderately complex.

99223 Initial psychiatric hospital services are provided for a 17-year-old female transferred from the medical intensive care unit after treatment for ingestion of a large amount of acetaminophen and aspirin. Her family history reveals that her mother and a maternal uncle have been treated for depression. The patient has been doing poorly in school for 6 months and has been experimenting with drugs and alcohol. She has been rebellious at home, and 2 months ago she reported that she might be pregnant. One week before her admission, her boyfriend of 1 year left her for another schoolmate. She has no history of significant medical or surgical problems. Her last menstrual period was 3 weeks ago. The patient is admitted voluntarily. A mental status examination reveals a barely cooperative, sullen teenager whose speech is not spontaneous but is logical and coherent. She shows no psychotic symptoms. The patient refuses to comment on current suicidal thoughts or ideation. She is cognitively intact. The results of a physical examination and laboratory tests are all within normal limits. The social work staff is asked to assess the patient's family situation. The patient is placed on close observation as a suicide precaution.

Explanation for code choice: Suicidal behaviors always require highly complex medical decision making supported by a comprehensive history and comprehensive mental status examination. Be sure to complete a full review of systems.

99223 Initial hospital care is provided for a 35-year-old woman with a 3-month history of withdrawn, bizarre behavior. Two days before her admission she became disorganized and aggressive toward her family and started talking to herself. Her

family history reveals a maternal grandfather with a diagnosis of schizophrenia. The patient had two prior episodes of psychosis and had received a diagnosis of schizophrenia. She dropped out of treatment 5–6 months ago, and since then she has not taken any medications. There are no current medical or surgical problems. The patient is admitted involuntarily. The results of a mental status examination reveal the patient to be uncooperative and poorly groomed and to make poor eye contact. Her speech is rambling and tangential. The patient appears to be responding to internal stimuli and is easily distracted and blocked. Her affect is flat and blunted. The patient is oriented to time, place, and person. The results of a physical examination and laboratory tests are within normal limits. The patient is placed on every-15-minute observation status. She is assessed for neuroleptic treatment. The social work staff is asked to assess the family situation. The occupational therapy/recreational therapy staff is asked to assess the patient's ability to perform activities of daily living.

Explanation for code choice: This is an example of a typical admission for a patient with a major psychiatric disorder and severe acute symptoms. The history and mental status examination must be comprehensive. A complete review of systems is required, and the medical decision making is highly complex.

99223

Initial hospital care is provided for an 8-year-old boy whose parents requested admission because of a 1-week history of repeated attempts to cut and hit himself. The patient's family history reveals that his father is in treatment for bipolar disorder. The patient is the second of three children. The siblings are reported to be doing well. The parents admit to having recent marital problems for which they have sought counseling. The patient is described as generally well behaved but moody with a bad temper. His schoolwork has been deteriorating for the past 3 months, and there have been reports of minor behavioral misconduct. One week before admission, the parents denied the patient a puppy. Since then he has been out of control and has been cutting, scratching, and hitting himself. A mental status examination reveals a withdrawn, depressed-appearing child who answers all questions with yes or no. He is cognitively intact. A physical examination reveals scratches and bruises over the patient's arms and legs. The results of laboratory studies are within normal limits. The social work staff is asked to begin a family assessment. The patient is placed on close observation.

Explanation for code choice: The out-of-control self-harm behavior requires highly complex medical decision making supported by a complete review of systems and a comprehensive history and examination.

99223

Initial hospital care is provided for a 75-year-old man with a 2-month history of depression, a 2-week history of auditory hallucinations, and recent suicidal ideation. The patient has a history of diabetes mellitus and is dehydrated. The psychiatric history focuses on past history of episodes of depression, family history of depression, and the patient's current social support system. A mental status examination reveals poor grooming, poor eye contact, lack of spontaneity, slowed speech, psychomotor retardation, depressed affect, present suicidal ideation with no plan, and auditory hallucinations telling the patient that he is no good. The patient is cognitively intact. The patient is admitted voluntarily. A medical consul-

tation is requested. Complete blood count, SMA-12, and thyroid laboratory tests are ordered. The patient and the family are instructed about the probable need for electroconvulsive therapy. The consent process for electroconvulsive therapy is explained, and signatures are obtained. Exploration of discharge placement is begun. The patient is placed on close observation as a suicide precaution.

Explanation for code choice: Severe depression with psychotic symptoms and suicidal ideation in an elderly patient requires a comprehensive history and examination as well as a complete review of systems. Treatment considerations, taking into account medical comorbidities and including electroconvulsive therapy, demand highly complex medical decision making.

HOSPITAL INPATIENT SERVICES— SUBSEQUENT HOSPITAL CARE

99231 A 14-year-old female admitted for depression and suicidal ideation is seen in a subsequent hospital visit. The patient has been in the hospital for 12 days and is behaviorally stable. Her condition is improving. The attending psychiatrist interviews the patient; meets with the treatment team; reviews notes prepared by nursing, occupational therapy/recreational therapy, and social work staff; writes an order for as-needed medication for headache; and writes the daily progress note.

Explanation for code choice: This level of subsequent hospital care is appropriate because the patient is stable and approaching discharge. The medical decision making for this day's work is straightforward.

99232 A 36-year-old man admitted for hallucinations and delusions and now in his third hospital day is seen for a subsequent hospital visit. The attending psychiatrist interviews the patient, takes an interval history, does a mental status examination, and then meets with the treatment team. The team reviews notes prepared by nursing, occupational therapy/recreational therapy, and social work staff. The attending psychiatrist orders an increase in the patient's neuroleptic medication. The attending psychiatrist discusses discharge planning with social work staff, talks with the patient's mother by phone, and writes the daily progress note.

Explanation for code choice: This example of subsequent hospital care is typical of a mid-hospital-course day of work. The history and examination are at the expanded problem-focused level, and the medical decision making is moderately complex. The expanded problem-focused history requires one to three elements of a review of systems.

99233 A 72-year-old man admitted for depression with suicidal ideation and paranoid delusions is seen for a subsequent hospital visit. The patient is in his seventh hospital day. The attending psychiatrist interviews the patient and does a mental status examination, noting minor changes in orientation. The attending psychiatrist meets with the treatment team and reviews notes prepared by nursing, occupational therapy/recreational therapy, and social work staff. Although the patient is taking antidepressants, the team does not believe the patient has shown

progress. His sleep and appetite are poor, and he must be encouraged to shower and groom. The attending psychiatrist reviews discharge planning with social work staff and writes the daily progress note. Later the same day the attending psychiatrist is notified that the patient has become combative with staff and is confused and disoriented. The attending psychiatrist returns to the unit and orders as-needed lorazepam and open-door seclusion. The patient's vital signs are taken, and a modest increase in temperature is observed. The attending psychiatrist orders a medical consultation and an evaluation for the fever and prepares an addendum to the progress note.

Explanation for code choice: The reason the highest level of subsequent hospital care is recommended in this case is the abrupt change in mental state requiring a return to the unit and a detailed evaluation of the situation, with a detailed examination and medical decision making of high complexity. Although the subsequent hospital care codes require only two of the three key components, it is not a bad idea to do a detailed (two to nine elements) review of systems when using these codes.

OFFICE OR OTHER OUTPATIENT CONSULTATIONS

Note: As of January 1, 2010, Medicare does not reimburse for these codes. See Chapter 4 for alternative coding.

99244 A 7-year-old boy referred by his pediatrician is seen in an initial office consultation. The patient was referred because of his short attention span, easy distractibility, and hyperactivity. The history taken during the parents' interview focuses on the patient's family history and psychosocial context, the mother's pregnancy, the patient's early childhood development, and the parents' description of the onset and progression of the symptoms and behaviors. The mental status examination focuses on the patient's affective state, ability to attend and concentrate during the evaluation and observation, and behavior during the session. The patient is scheduled for neuropsychological testing and a return visit with his parents.

Explanation for code choice: The consultation requires a comprehensive history and examination. The medical decision making is moderately complex. Do not forget that a review of systems is required.

99245 An 81-year-old woman referred by her internist is seen in an initial office consultation for evaluation of her mental state. Her family had reported her activity as being markedly decreased and that she was having difficulty maintaining independent self-care. The patient's history reveals that she has congestive heart failure and chronic obstructive pulmonary disease that is in fair control. She had two episodes of depression in her 50s and was treated successfully with antidepressants. The patient reports feelings of general malaise, loss of interest, trouble sleeping, decreased appetite, and problems with memory over a 4-week period. The patient denies awareness of an inability to maintain her home or independent self-care. A mental status examination reveals a poorly groomed, cooperative woman

with moderate psychomotor retardation and no speech abnormalities. She appears sad and expresses feelings of depression and has flat affect. Her Mini-Mental State Examination score is 25 of 30 points, with poor recall, attention and concentration deficits, and distortion of figure drawing. A family member is interviewed and confirms most of the history. Neuropsychological testing is ordered, and the patient's case is discussed with the referring physician.

Explanation for code choice: This case involves mental disorder with significant comorbid medical conditions. The medical decision making is highly complex, supported by a comprehensive history and examination. The history must include a complete review of systems.

INITIAL INPATIENT CONSULTATIONS

Note: As of January 1, 2010, Medicare does not reimburse for these codes. See Chapter 4 for alternative coding.

99253 An initial hospital consultation is provided for a 35-year-old woman referred by obstetrics/gynecology staff after she had a normal vaginal delivery and had asked to talk to a psychiatrist about feelings of depression. A review of her chart reveals an uncomplicated neonatal course and a normal delivery of a healthy baby girl. History taking focuses on symptom onset and progression and the patient's current family/social context. The patient reports that her husband is out of work and is drinking and arguing with her frequently. Two other children are doing well. A mental status examination reveals a cooperative, friendly individual with normal speech, moderately depressed mood (which she relates to her marital stress), full affect, and no psychotic or anxiety symptoms. She is cognitively intact. Her insight is fair, and her judgment is intact. Her desire for marital counseling is supported, and she is given a referral for this service.

Explanation for code choice: This consultation for a medically stable patient required a detailed history and examination. The medical decision making is of low complexity. The history must include a detailed review of systems (two to nine elements).

99254 An initial hospital consultation is provided for a 19-year-old female referred by department of medicine staff after treatment for ingestion of acetaminophen and alcohol. A review of her chart reveals that symptomatic management was used to treat ingestion of alcohol (her blood alcohol level was 120 mg/dL) and a nonlethal amount of acetaminophen. The patient has no history of medical or surgical problems. History provided by the patient includes a recent breakup with her boyfriend of 3 years, loss of her job, and fighting with her mother. Her family history includes alcohol abuse by the father and two brothers. The patient reports that she has experimented with street drugs, has used alcohol regularly since age 16 years, and has had a history of binge drinking. There is no history of blackouts or delirium tremens. The patient has no current legal problems. A mental status examination reveals a cooperative individual with good eye con-

tact. She asks “When can I get out of here?” and states “I did a stupid thing.” The patient is remorseful, and her affect is bright, with a moderate level of depression. She is cognitively intact. She expresses concerns about her boyfriend and states that she probably needs some counseling. She agrees to treatment of alcohol abuse. The patient is cleared for discharge and given a referral to a community psychiatry program for dually diagnosed patients.

Explanation for code choice: The suicide attempt was committed impulsively, and the patient is remorseful and ready for outpatient follow-up. A detailed history and examination are performed, and medical decision making is moderately complex. The history must include a complete review of systems.

99255

An initial hospital consultation is provided for an 82-year-old man referred by department of medicine staff because of bizarre behavior that resulted in his requiring a sitter. The patient has high blood pressure, renal insufficiency, congestive heart failure, and chronic obstructive pulmonary disease. He is taking 12 medications, including as-needed lorazepam and haloperidol for “behavioral control.” Notes prepared by nursing staff indicate that the patient has periods of lucidity intermixed with confused, uncooperative behavior, usually in the evenings. The patient began receiving antibiotics in the previous 12 hours for a urinary tract infection. The social worker reports that the patient lives with his wife and was in good health and maintained a wide range of activities before this admission. The wife reports some slippage in the patient’s memory, but the patient denies that there are any problems whatsoever. The mental status examination reveals the patient to be resting in his hospital bed and receiving intravenous fluids and intranasal oxygen. The patient is irritable, and his irritability increases during the course of the evaluation. He denies any psychological symptoms. The patient knows who he is and where he is but does not know the day, the date, or the month. He cannot do serial 7s. The patient reports having had a visit by several of his children the night before, but nursing staff report no such visit took place. The findings are reviewed with the nursing staff and the attending physician. Lorazepam is discontinued, and orientation strategies are discussed with the nursing staff and the attending physician.

Explanation for code choice: This case is typical for an acute geriatric medical admission: multiple comorbidities and multiple medications complicated by delirium. The consulting psychiatrist must do a comprehensive history and examination. The medical decision making is highly complex. The history must include a complete review of systems.

Appendix G

Most Frequently Missed Items in Evaluation and Management (E/M) Documentation



National Government Services, Inc.
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A CMS Contracted Agent

Medicare

Most Frequently Missed Items in Evaluation and Management (E/M) Documentation

History

- History is too brief and lacks the reason for the encounter or minimal documentation of the reason for the encounter.
- Documentation for the Review of Systems is too minimal.
- If billing for a Complete Review of Systems – either must individually document ten (10) or more systems **OR** may document pertinent (some) systems and make the statement in the progress note “all other systems negative.”
- Lacks any documentation in support of why elements of the history or the entire history was unobtainable; would also apply to documenting the work done to attempt to obtain history from sources other than the patient if it was unobtainable from the patient.
- Insufficient documentation of the Past, Family and Social history; no reference to dates or any documentation to support obtaining the information.
- If you wish to refer to a Review of Systems and/or a PFSH documented in a progress note of a previous date and update it with today’s information (e.g., unchanged from ROS of 1/4/07 except patient has stopped smoking) – you must specifically indicate the previous date you are referring to in today’s note and you must include a photocopy of the previous ROS or PFSH you have referred to if you are asked to send documentation for today’s note. Make sure your staff is also aware of this if they will photocopy and send documentation to Medicare.

Physical Exam

- Physical exam documentation is too brief.
- 1997 Specialty exams, billed at the comprehensive level, do not meet all of the required elements for that level.
- For the 1995 Comprehensive exam – required to count **ONLY** organ systems and not body areas; must be eight (8) or more organ systems only.
- Can choose to perform and document either the 1995 or 1997 physical exam but findings show that most physicians do better with documentation based upon the 1995 guidelines.

Medical Decision Making

- Lack of sufficient evidence that labs, X-rays, etc., were performed to credit in this section (Amount and/or Complexity of Data Reviewed or in Table of Risk of Complications and/or Morbidity or Mortality).
- Lack of sufficient documentation of items which could be credited to Reviewed Data (Amount and/or Complexity of Data Reviewed) such as the decision to obtain old records or obtain history from someone other than the patient, review and summarization of old records, discussion of case with another health care provider.
- Remember, in this section, need only two (2) elements of the three and need only the highest, single item available and appropriate in one box of the chart for Risk of Complications and/or Morbidity or Mortality.

Time Based Codes

- In choosing a code based upon time for counseling and coordination of care, total time may be documented but there is not quantification that more than 50 percent of the time was spent on counseling and there is also no documentation of what the coordination of care was or what the counseling was.
- No documentation of time for critical care.
- No documentation of time for discharge day management.

General

- Missing the order for a consultation in hospitals and SNFs.
- Illegible documentation.
- Lack of a physician signature on the note.
- Missing patient names.
- Incorrect dates of service.
- Lack of any note for a billed date of service.
- Lack of the required two (2) or three (3) key elements to bill an E/M service.

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