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:

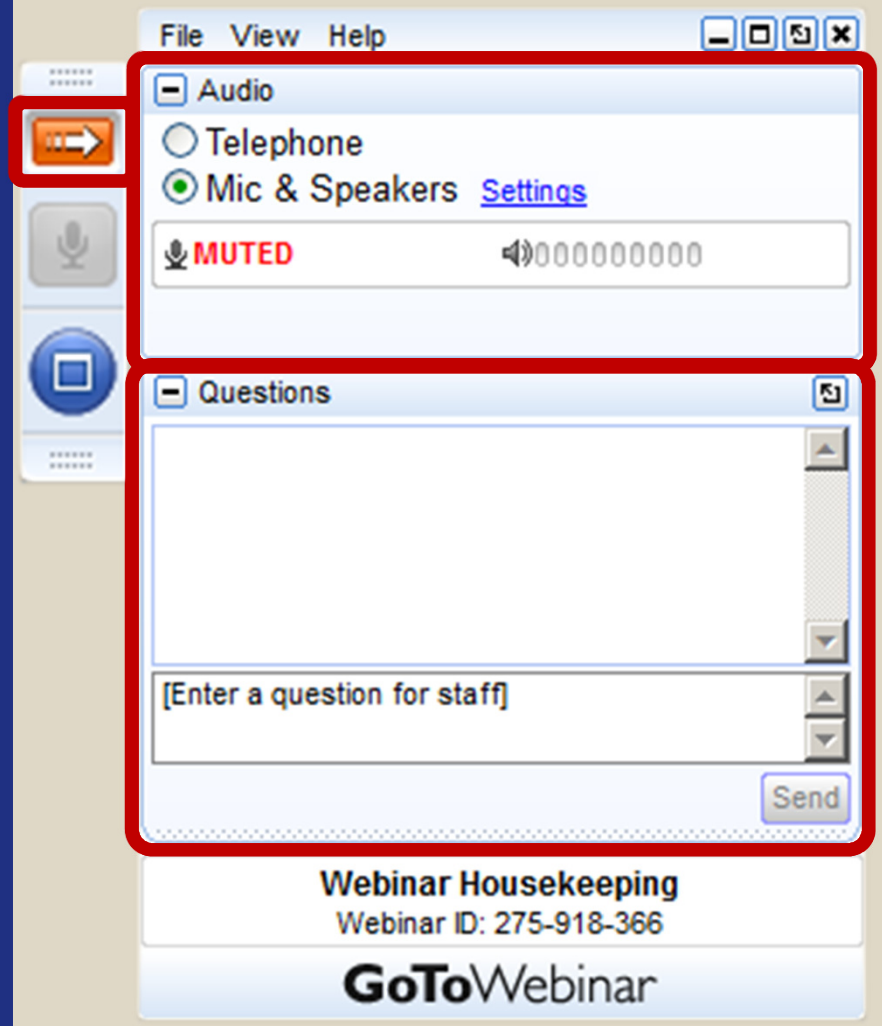
E/M 102, Level Selection and Documentation Support

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

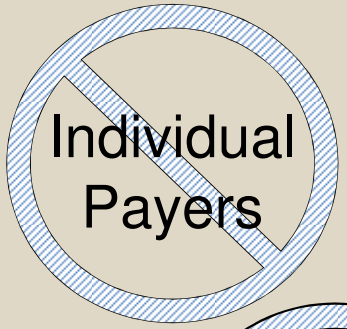
Adam Falcone, Esq.
Partner,
Feldesman Tucker Leifer Fidell LLP

afalcone@ftlf.com

CPT Codes are:

- **Procedure codes**

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



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

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

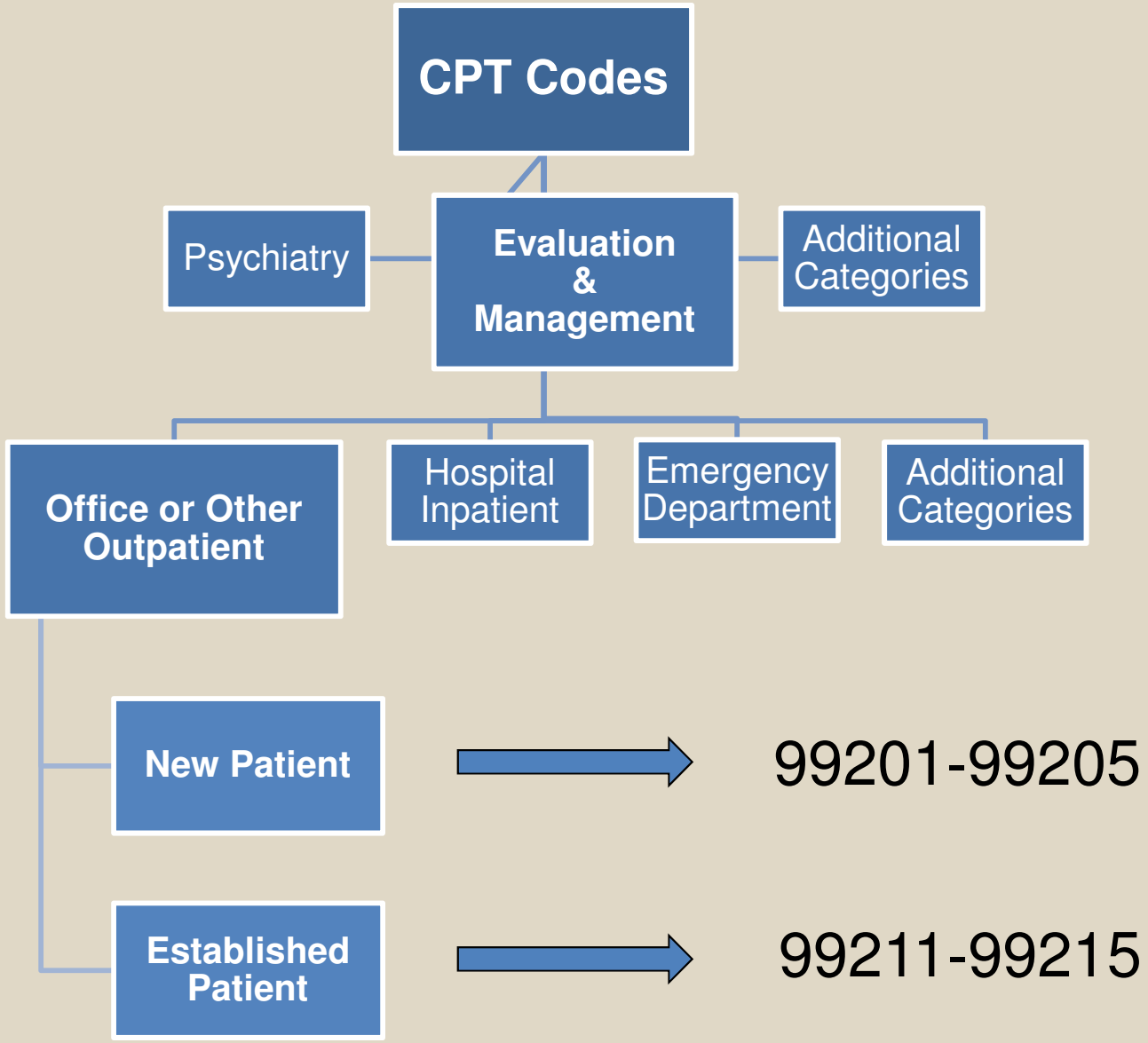
- Psychiatric Diagnostic Codes can be reported once per day.
- Cannot be reported with an E/M code on same day by same provider.
- Cannot be reported with psychotherapy service code on same day.

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


CPT Codes
Psychiatry
Evaluation & Management
Additional Categories
Office or Other Outpatient
Hospital Inpatient
Emergency Department
Additional Categories
New Patient
99201-99205
Established Patient
99211-99215

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.

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

www.mtmservices.org

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

TABLE OF CONTENTS

"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

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)
			Problem pertinent (1 system)	*Expanded problem focused* (EPF)
	Extended (4 elements or 3 chronic conditions)	*Pertinent* (1 element)	*Extended* (2-9 systems)	*Detailed* (DET)
		Complete (2 elements (est) or 3 elements (new/initial))	*Complete* (10-14 systems)	*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 from *American Psychiatric Association*

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 from *American Psychiatric Association*

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

Example from *American Psychiatric Association*

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 sxs.
- 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, mange 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

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, 990847, 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

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

Prolonged Service codes corrected 1/11/13

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

CONFERENCE '13

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

APRIL 8-10, 2013 | LAS VEGAS

2013 National Council Conference

April 8 – 10, 2013

Las Vegas, NV

Celebrating Our Legacy
50th Anniversary of the
1963 Community
Mental Health Act

Join a community of healthcare executives, mental health and addictions professionals, clinicians, advocates, policy makers, researchers, and technology leaders.

www.TheNationalCouncil.org/Conference

Pre-Conference:

Health Reform Toughens Up on Compliance,
Register today!

Q&A

Presenter Contact Information

Adam J. Falcone, Esq.
Partner, Feldesman Tucker Leifer Fidell LLP
Email: afalcone@ftlf.com Phone: (202) 466-8960

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

National Council

CPT Resource Page: www.TheNationalCouncil.org/CS/CPT_Codes
Nina Marshall: ninam@thenationalcouncil.org, (202) 684-7457 x 280

Introduction to Evaluation and Management (E/M) Coding for the Child and Adolescent Psychiatrist

Benjamin Shain, MD, PhD
David Berland, MD
Sherry Barron-Seabrook, MD

Overview

2

E/M Learning Tips

- Recognize that there *is* a lot of information and it is likely not something you can learn without effort
- Go through this presentation and others first with an eye to learning the system rather than rather than remembering details
- Later, "cheat sheets" and templates may be helpful.
- Memorize portions related to the small number of codes you use every day

3

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

4

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

5

PAYMENT

6

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

7

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

8

DOCUMENTATION

9

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

10

11

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

12

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

13

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

14

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

15

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

17

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

18

E/M Components

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

19

KEY COMPONENT OVERVIEW

20

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

21

Physical Examination

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

22

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

23

HISTORY DETAIL

24

History

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

25

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."

26

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

27

HPI Example

The patient reports intermittent[1] emotional[2] problems of moderate[3] sadness[4] starting with a romantic breakup[5] six months ago[6], now more so when alone[7] and associated with poor sleep and appetite[8].

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

28

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

29

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

30

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)

31

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

32

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

33

History Type

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

*No PFSH required with subsequent hospital visits

34

History Type

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

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

35

Physical Examination Detail

36

Physical Examination

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

37

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

38

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

39

Psychiatric Exam
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

40

41

Psychiatric Examination

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

42

MEDICAL DECISION MAKING DETAIL

43

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

44

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

45

Number of Diagnoses or Management Options

- Minimal
- Limited
- Multiple
- Extensive

46

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

47

Number of Diagnoses or Management Options

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

48

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

49

Amount and/or Complexity of Data to be Reviewed

- Minimal or None
- Limited
- Moderate
- Extensive

50

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

51

Amount and/or Complexity of Data to be Reviewed

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

52

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

53

54

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

55

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***

56

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***

57

TIME

58

"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

59

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

60

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

62

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

64

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

65

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.

66