NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

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 a 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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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 <u>different</u> 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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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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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.