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## AVOIDING COMMON PROCEDURE CODING PROBLEMS

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The key to appropriate insurance reimbursement lies in accurate procedure coding. Although correct coding is extremely important, it can also be extremely frustrating. As practices expand to include new treatment modalities and new sites of service, the possibility of using the wrong code increases. In addition, the American Medical Association's *Physicians' Current Procedural Terminology* (CPT) manual the most widely used procedure coding system in the country, is revised and updated annually, which further complicates the process.

Coding mistakes can lead to delayed payment or rejection of submitted claims. Consistent errors can trigger audits, demands that payments be refunded, charges of fraud and abuse, and removal from managed care networks. The following tips will help to minimize coding mistakes.

### **KEEP CURRENT WITH THE CPT**

The AMA publishes an updated and revised edition of the *CPT* manual each year. It may seem unnecessary to purchase a new manual every year, but the changes can be significant, and it is in your best interest to use the most current information. For example, the 2007 *CPT* manual will contain changes to codes used for evaluation and management. Without current code information, you are almost guaranteed delays in claims payment.

Many organizations and publications disseminate information about new codes and coding practices. While these are often good sources that can help you manage your practice more effectively, always verify their information with the current *CPT* manual, which is the ultimate authority on procedure coding. You can buy a copy of the manual by calling the AMA at (800) 621-8335; the price for 2007 (published in October 2006) when purchasing directly from the AMA is \$72.95 for AMA members and \$98.95 for nonmembers. Electronic versions are also available.

### **BECOME FAMILIAR WITH ALL CODES**

As a physician, you are entitled to use *all* of the codes in the *CPT* manual, not just the psychiatry codes. *CPT* contains an entire section of neurology codes, as well as evaluation and management (E/M) codes that include outpatient visits, hospital visits, and consultations. Depending on the nature of your practice, other sections of the *CPT* manual may also be useful to you.

It is extremely important that you use the codes that most accurately reflect the service you provide rather than using the same one or two codes for all services in an attempt to simplify your billing. Become familiar with all of the psychiatric codes and any others that describe services you typically provide. When your documentation supports the code you have chosen, you substantially reduce the likelihood of future problems with the payer (documentation tips follow).

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## **CODES DO NOT ALWAYS EQUAL REIMBURSEMENT**

Although physicians are entitled to use all of the CPT codes, the fact that a code exists does not guarantee that a payer will reimburse you for it. The primary purpose of the codes is to accurately describe all of the services provided to patients.

With the implementation of the Transactions Rule of the Health Insurance Portability and Accountability Act (HIPAA) in October 2003, all insurance companies, government health programs, and managed care organizations now must use the CPT codes for reporting services provided to patients (most of them were using them already).

There is, however, a great deal of variability in how payers use the codes. For example, some payers want psychiatric services billed using E/M codes (992xx-994xx), while others require psychiatrists to use only the codes in the psychiatry section of the CPT manual (908xx). Other payers, including Medicare, will only pay for services provided with the patient present, so codes that describe the review or preparation of reports will not be reimbursed. Still other payers may specifically exclude or restrict the use of particular procedure codes, such as those for family therapy.

If you are providing a unique service or want to bill with an unusual code, you should contact the payer directly before reporting such a service. You'll want to reach an agreement about: 1.) the payer's willingness to reimburse you for the service and 2) the payer's preferred method for reporting the service. Taking a proactive approach increases the likelihood that your claim will be processed promptly and correctly. In addition, such an approach gives you the opportunity to establish a positive, collegial working relationship with the payer, which may help you if future problems develop.

## **DOCUMENTATION IS VITAL**

As mentioned above, documentation supporting the use of the CPT code you have submitted can help you defend your selection if it's challenged by the payer. If you are using a psychiatric code (908xx series), your documentation should include at least the following information:

- Date of service
- Length of encounter
- Description of the patient's mental state
- Description of the service provided
- Treatments implemented
- Response to treatment
- Legible signature

For documenting evaluation and management services (E/M), you also need to consult the CPT manual. It contains a section of E/M guidelines to assist you in selecting and documenting the proper code and level of service.

## **BE PROACTIVE**

If you experience reimbursement problems despite coding and documenting correctly, there are a number of steps you can take.

- Fill out all forms completely and legibly. Stamp or write on any attachments: **PLEASE DO NOT**

**SEPARATE ATTACHMENTS.**

- Call the payer's provider relations department for feedback and information on policies.
- Contact the chair of the Insurance or Managed Care Committee of your local psychiatric society. He or she may be able put you in touch with colleagues with similar problems, assist you in accessing APA resources, sponsor legislation, and/or organize and sponsor legal actions.
- Call the APA's Managed Care Help Line, (800) 343-4671, to find out how to access the CPT Coding Network that is available to APA members.

**Recommended Reading**

- American Medical Association, *Physicians Current Procedural Terminology* (published yearly, refer to most current)
- *CPT Handbook for Psychiatrists*, American Psychiatric Press Inc., 3<sup>rd</sup> edition, 2004.

**APA'S RESOURCES**

**APA CPT CODING SERVICE**

The APA maintains a CPT coding network to answer members' specific coding questions, and 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](mailto:hsf@psych.org)), fax (907-703-1089), or mail (Office of Healthcare Systems and Financing, APA, 1000 Wilson Boulevard, MS 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 COMMITTEE**

The APA's Medicare Advisory Committee (MAC) is a network of psychiatrists who are involved in Medicare policy issues across the country. The MAC 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 MAC's membership is comprised of the psychiatry representatives to each Medicare carrier's Carrier Advisory Committee (CAC). Medicare carrier's administrate Part B of Medicare (Part A is administered by fiscal intermediaries), and the CACs are mandated by law to ensure that carrier's have input from medical practitioners when they establish local Medicare policy, specifically local carrier decisions, or LCDs. The psychiatry representatives to the CAC are chosen by the APA's District Branches.

The APA's Office of Healthcare Systems and Financing (OHSF) provides staffing for the MAC 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 often with representatives from the Centers for Medicare and Medicaid Services and with carrier Medical Directors to solve problems communicated to them by members of the MAC.

To find out which carrier administrates Part B in your state go to the Centers for Medicare and Medicaid (CMS) website at <http://www.cms.hhs.gov/contacts/incardir.asp>. For information on your APA Medicare Advisory Committee representative, go to the APA web site at [www.psych.org](http://www.psych.org). You can locate the list under the "Practice of Psychiatry" section. Medicare questions can also be directed to the attention of Ellen Jaffe in the Office of Healthcare Systems and Financing (OHSF) by calling 800-343-4671 or writing her via the OHSF e-mail address, [hsf@psych.org](mailto:hsf@psych.org).