S6200 - CPT Coding and Documentation
Course Director: Gregory Harris, M.D., M.P.H.
Monday, May 16, 2016
Marriott Marquis - International 7
Presenter – Gregory G. Harris, MD, MPH, DFAPA

Private Practice (insurance-based), Boston, MA
Past President, Massachusetts Psychiatric Society
Chair, Committee on RBRVS, Codes and Reimbursement, American Psychiatric Association
APA Alternate Advisor; AMA/ Specialty Society RVS Update Committee (RUC)
APA Alternate Advisor; CPT Editorial Advisory Committee
gregorygharris@sprynet.com

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This information is for educational and informational purposes only, and represents the understanding of the presenter regarding the material involved. The presenter assumes no liability or responsibility for behavior based on this presentation.

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If attendees have questions about Medicare or about actions to take in their own practices they are advised to consult with their Medicare Contractor and with their legal advisors.

CPT coding and documentation – Whose job is it?

Documentation and coding is part of physician work

You are responsible for the clinical work and equally responsible for the documentation and coding

This should not be the job of your staff!

Disclosure

Gregory G. Harris, MD, MPH, DFAPA

General Adult Psychiatrist, Brookline, MA

- Self-employed, full-time outpatient general psychiatry practice, financed primarily by health insurance, Medicare, Medicaid and also by patient pay

Past President, Massachusetts Psychiatric Society (unpaid)

Quality Advisory Committee physician advisor (paid) for BCBSMA

Alternate Advisor to AMA RUC and CPT meetings (travel expenses reimbursed)

No relevant financial relationships with the manufacturers of any commercial products or providers of commercial services discussed in this CME activity or requiring disclosure
**Purposes of Documentation**

- Forensic
- Utilization review
- Treatment planning
- Progress notes “facts” vs. process notes
- Correcting errors/omissions
- Clinically based calculated risk


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**Medicare RBRVS / CPT / RUC Cycle**

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**Medicare RBRVS**

The cost of providing each service is divided into three components:

- Physician Work
- Practice Expense
- Liability Insurance
- Cost of a Service
Components of the RBRVS
Percent of Total Relative Value

Calculating Payment - Step 1

Ingredients

Total RVU

Calculating Payment - Step 2

Conversion Factor

*Conversion Factor is a monetary payment determined by Medicare each year.
1. Adjustments are typically based on three factors:
   a. Relative Value
   b. Geographic Practice Cost Index
   c. Economic Index
2. An expenditure target “performance adjustment”
3. Miscellaneous adjustments including those for “budget neutrality”

*Conversion Factor for 2015 = $85.6505
RUC Cycle

• Step 1: CPT's new and revised codes and CMS requests to review existing codes are submitted to the RUC staff.
• Step 2: Members of the RUC Advisory Committee review and indicate their societies' level of interest in developing a relative value recommendation.
• Step 3: AMA staff distribute survey instruments for the specialty societies to evaluate the work involved in the new or revised code.
• Step 4: The specialty RVS committees conduct the surveys, review the results and prepare their recommendations to the RUC.
• Step 5: The specialty advisors present the recommendations at the RUC meeting.
• Step 6: The RUC may decide to adopt a specialty society's recommendation, refer it back to the specialty society six months before submitting it to CMS.
• Step 7: The RUC's recommendations are forwarded to CMS in approximately one month after each RUC meeting.

RUC Subcommittees

Research Subcommittee
- Develops and refines RUC methodology

Administrative Subcommittee
- Maintains RUC database, tracks RUC rules and regulations, tracks budget and finances.

Practice Expense Subcommittee
- Reviews and analyzes practice expense information, collects relevant statistical and medical data, provides input and recommendations to the development of practice expense relative value units.
RUC Workgroups

RUC Timeline

Potentially Misvalued Services Project
Screening Mechanisms for Potentially Misvalued Services

- Pre-Time Analysis
- Post-Operative Visits
- Services Surveyed by One Specialty – Now Performed by a Different Specialty
- Services with Stand-Alone PE Procedure Time
- Site of Service Anomalies
- 010-day and 090-day Global Period Anomalies
- High Level E/M visit in Global Period
- New Technology

Summary of Recommendations to Date

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>Total Number of Codes Identified</td>
<td>1,823</td>
</tr>
<tr>
<td>Codes Complained</td>
<td>1,625</td>
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<tr>
<td>Work and PE Maintained</td>
<td>566</td>
</tr>
<tr>
<td>Work Increased</td>
<td>111</td>
</tr>
<tr>
<td>Work Decreased</td>
<td>111</td>
</tr>
<tr>
<td>Current Practice Expense Revised (beyond work changes)</td>
<td>160</td>
</tr>
<tr>
<td>Deleted from CPT</td>
<td>365</td>
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<tr>
<td>Codes Under Review</td>
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<tr>
<td>Referred to CPT</td>
<td>34</td>
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<tr>
<td>RUC to Review October 2015</td>
<td>13</td>
</tr>
<tr>
<td>RUC – future review after additional data obtained</td>
<td>91</td>
</tr>
</tbody>
</table>

Calculating Budget Neutrality 1

CPT has created a bundled CPT code XXXX1:
- Codes 99061 & 77771 are reported together at the time together on the same date/same physician.

Step 1: Estimating Utilization

99061: 25,000
77771: 70,000

25,000 / 70,000 = 0.357142857

0.357142857 x 25,000 = 9,428.57
Calculating Budget Neutrality 2

Reference Code

Medicare RBRVS / CPT / RUC Cycle
Concluding Remarks:
Enjoy the Talks and Panel to come…
CPT Coding and Documentation 2016

APA Annual Meeting, May 2016

Presenter - Jeremy S. Musher, MD, DLFAAPA

- Psychiatric Healthcare Consultant
  Musher Group, LLC (www.mushergroup.com)
- Medical Director, Physician Quality and Compliance, Western Psychiatric Institute and Clinic, Department of Psychiatry, University of Pittsburgh School of Medicine
- APA Advisor, AMA/Specialty Society RVS Update Committee
- APA Advisor AMA CPT Editorial Panel
- Member, APA Committee on RBRVS, Codes and Reimbursements

Housekeeping
Disclaimer

The opinions referenced are those of the members of the RBRVS, Codes, and Reimbursement Committee of the APA and their consultants based on their coding experience. They are based on the commonly used codes in Psychiatry, which are not all inclusive. Always check with your local insurance carriers as policies vary by region. The final decision for the coding of a procedure must be made by the physician considering regulations of insurance carriers and any local, state or federal laws that apply to the physician's practice. The APA and its representatives disclaim any liability arising from the use of these opinions.

Disclosure

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E/M Code Selection and Documentation

Jeremy S. Musher, MD, DLFAPA
2013-2015 “The Years of the Codes”

CT: “It’s enough to make me relief”

ICD-9
“We’re going to stop using it... I never knew we were using it!”

ICD-10
“When’s it supposed to start??”

DSM V
“When do we start using it??”

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 should be complete & legible

“If it’s not documented, it didn’t happen.”

“If you can’t read it, it doesn’t count.”

Electronic Medical Records and Dictation create their own concerns.

ALWAYS review your dictations
How Dragon Software hears “Psychiatrist”

“How Dragon Software hears “Psychiatrist”

“Sick Coyote Trysts”

CPT (Current Procedural Terminology)

• Code Development
  • AMA Committees: CPT Panel and RUC (RVS Update Committee) make recommendations to:
  • CMS (Centers for Medicare and Medicaid Services)
• Evaluation and Management (E&M) Codes to be used by all physicians
  • 1995 required Multi-system Exam
  • 1997 introduced Specialty-specific Exam
CODING CHOICES FOR PSYCHIATRISTS: Evaluation and Management (E&M) AND/OR Psychiatry Family of Codes

**E&M Codes**
- Inpatient
- Outpatient
- Consults
- Nursing Homes
- Residential Treatment

**Psychiatry Family of Codes**
- *Psychotherapies
- *Patient and/or family
- *Family
- *Group
- *Crisis
- *ECT
- *TMS

**EVALUATION AND MANAGEMENT (E/M)**
- National guidelines for documentation based on CMS 1995 and 1997 guidelines
- Psychiatry Specialty Exam in 1997 guidelines

**PSYCHIATRY FAMILY OF CODES**
- No national guidelines
- Guidelines based on Local Coverage Determination (LCD) written by local Medicare Carrier and on “Community Standard of Care”
Additional Documentation Requirements

- CMS Two Special Conditions of Participation (CoP) for Psychiatric Hospitals
  - Initial Psychiatric Evaluation
  - Progress Notes
  - Treatment Plan
  - Discharge Summary
  - History and Physical
- Insurance Carrier LCD (LMRP)
- Insurance specific requirements, e.g. Tricare
- State specific requirements, e.g. Medicaid
- Hospital specific requirements

Evaluation & Management Documentation for Psychiatry

Two Documentation Choices for Evaluation and Management Codes

- Documenting “By the Elements”
- Documenting by “Time”
Documenting By The Elements

Key Components of CPT Codes
- E&M CPT codes are determined by the following elements:
  - Type of Service (Initial visit, Consult, Existing patient, etc.)
  - Site of Service (Inpatient, Outpatient, Nursing facility)
  - Level of Service is determined by:
    - History, Exam, and Medical Decision Making
    - Time spent in counseling and coordination of care

The Seven (7) Components of E&M

<table>
<thead>
<tr>
<th>Key Components:</th>
<th>Contributory Components:</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td>Counseling</td>
</tr>
<tr>
<td>Examination</td>
<td>Coordination of Care</td>
</tr>
<tr>
<td>Medical Decision Making</td>
<td>Nature of Presenting Problem</td>
</tr>
<tr>
<td>Time</td>
<td>Time</td>
</tr>
</tbody>
</table>
Key Components are Further Divided:
- History and Exam:
  - Problem Focused
  - Expanded Problem Focused
  - Detailed
  - Comprehensive
- Medical Decision Making:
  - Straightforward
  - Low Complexity
  - Moderate Complexity
  - High Complexity

Key Component #1
HISTORY ELEMENTS
- Chief Complaint or Reason for encounter
- History of Present Illness (HPI):
  Location, quality, severity, duration, timing, context,
  modifying factors, and associated signs and symptoms
- Review of Systems (ROS)
  (1) Constitutional (e.g. fever, weight loss); (2) Eyes;
  (3) Ears, Nose, Mouth, Throat; (4) Cardiovascular
  (5) Respiratory; (6) Gastrointestinal; (7) Genitourinary;
  (8) Musculoskeletal; (9) Integumentary;
  (10) Neurological; (11) Psychiatric; (12) Endocrine;
  (13) Hematologic/Lymphatic; (14) Allergic/Immunologic
- Past, Family and Social history

Magic Sentence
While ___context___ the patient complained of/noticed ___symptom(s)___, which he/she described as ___quality/severity___, which lasted ___duration___, and seemed to be associated with ___associated signs and symptoms___.

Example:
While eating breakfast this morning, the patient noticed returning thoughts of cutting herself, which she described as fleeting, but intense, which lasted just for a few minutes, and seemed to be associated with thoughts of anger towards her ex-boyfriend for leaving her.
**Important Considerations for ROS and PFSH Elements**

- A Complete ROS inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional body systems. 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 ten systems must be individually documented.

- Complete PFSH, which is required for Initial Hospital Level 2 and Level 3 Care Codes, requires all 3 History Areas.

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**HISTORY CHEAT SHEET (Minimums)**

- **PROBLEM FOCUSED**
  - Chief Complaint; HPI - 1 element
- **EXPANDED PROBLEM FOCUSED**
  - Chief Complaint; HPI – 1 element; Pertinent System (ROS)
- **DETAILED**
  - Chief Complaint; HPI – 4 elements; Pertinent System + 1 Other (ROS); PFSH – 1 element
- **COMPREHENSIVE**
  - Chief Complaint; HPI – 4 elements; Complete ROS; PFSH – 2 elements

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**Key Component #2**

**Psychiatry Specialty EXAM**

**Mental Status Examination**

- Orientation to time, place and person
- Attention Span and Concentration
- Recent and Remote Memory
- Language (e.g. naming objects, repeating phrases)
- Fund of Knowledge/Estimate of Intelligence
- Speech
- Mood and Affect
- Thought Process (e.g. rate of thoughts, logical vs. illogical, abstract reasoning, computation)
- Associations (e.g. loose, tangential, circumstantial, intact)
- Thought Content (including delusions, hallucinations, suicidal, homicidal, preoccupation with violence, obsessions)
- Judgment and Insight
Psychiatry Specialty EXAM (cont’d)

CONSTITUTIONAL:
• Vital Signs (any 3 of 7):
  1. sitting or standing BP
  2. supine BP
  3. Pulse rate and regularity
  4. Respiration
  5. Temperature
  6. Height
  7. weight
AND
• General Appearance

MUSCULOSKELETAL:
• Gait and Station AND/OR
• Muscle Strength and Tone (with notation of any abnormal movements, etc.)

Determining Level of Complexity EXAM
• PROBLEM FOCUSED
  • 1 to 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

Key Component # 3

Medical Decision Making
The following table shows the progression of the elements required for each level of medical decision-making. To qualify for a given type of decision-making, all three must meet or exceed the level for new patients and two of the three elements in the table must either meet or exceed the requirements for subsequent visits.

<table>
<thead>
<tr>
<th>Type of Decision Making</th>
<th>Number of Dx or Treatment Options</th>
<th>Amount and/or complexity of Data to review</th>
<th>Risk of complications and/or morbidity or mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straight forward</td>
<td>Minimal</td>
<td>Minimal or None</td>
<td>Minimal</td>
</tr>
<tr>
<td>Low Complexity</td>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
</tr>
<tr>
<td>Moderate Complexity</td>
<td>Multiple</td>
<td>Multiple</td>
<td>Moderate</td>
</tr>
<tr>
<td>High Complexity</td>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
</tr>
</tbody>
</table>
The two categories in every encounter are:
1. **Number of Diagnoses or Management Options**
   - Diagnoses include Rule Outs
   - Management Options include “Do nothing”
2. **Level of Risk**
   - Based on the “risk table”

**SIMPLIFY**

How to Decide How Much to Document

- #1 - See the patient
- #2 - Based on “the nature of the presenting illness” (i.e. how sick is the patient), decide on the level of the visit
- #3 - Document enough to cover the required elements for History, Exam, and Medical Decision Making for that level
Documenting By Time

Alternative Approach: Documenting by “Time”

- When greater than 50% of the time on the floor/unit (inpatient/nursing home) or face-to-face (outpatient) is spent on counseling and coordination of care, TIME is the sole determining factor of the E&M code.

- The provider must document the total time related to that patient on the floor/unit (inpatient/nursing home) or face-to-face with the patient (outpatient) and must specify the time spent counseling and/or coordinating care, and a summary of the encounter.

- The key components: history, exam and medical decision making do not determine the code if TIME is used instead.

Counseling and Coordination of Care

- Counseling is defined as a discussion with the patient and/or family or other care giver 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 is defined as discussions about the patient’s care with other providers or agencies.
Counseling and Coordination of Care

Example of Time Based Billing

**OUTPATIENT**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>99202</th>
<th>99203</th>
<th>99204</th>
<th>99205</th>
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</thead>
<tbody>
<tr>
<td>Face-to-Face Time (Minutes)</td>
<td>≥ 20</td>
<td>≥ 30</td>
<td>≥ 45</td>
<td>≥ 60</td>
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</table>

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>99212</th>
<th>99213</th>
<th>99214</th>
<th>99215</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face-to-Face Time (Minutes)</td>
<td>≥10</td>
<td>≥15</td>
<td>≥25</td>
<td>≥40</td>
</tr>
</tbody>
</table>

**INPATIENT**

<table>
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<th>99222</th>
<th>99223</th>
</tr>
</thead>
<tbody>
<tr>
<td>Floor/Unit Time (Minutes)</td>
<td>≥30</td>
<td>≥50</td>
<td>≥70</td>
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</table>

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>99231</th>
<th>99232</th>
<th>99233</th>
</tr>
</thead>
<tbody>
<tr>
<td>Floor/Unit Time (Minutes)</td>
<td>≥15</td>
<td>≥25</td>
<td>≥35</td>
</tr>
</tbody>
</table>

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E/M: PUTTING IT ALL TOGETHER

- **HISTORY**
  - CHIEF COMPLAINT
  - HISTORY OF PRESENT ILLNESS (HPI)
  - REVIEW OF SYSTEMS (ROS)
  - PAST, FAMILY, SOCIAL HISTORY (PFSH)

- **EXAMINATION**
  - MENTAL STATUS EXAMINATION
  - CONSTITUTIONAL
  - MUSCULOSKELETAL
  - MEDICAL DECISION MAKING
  - NUMBER OF PROBLEMS
  - DATA REVIEWED
  - LEVEL OF RISK

**BY THE ELEMENTS:**
- Code Level Determined By:
  - Number of elements in HPI + ROS + PFSH
  - Number of Examination elements
  - Level of Medical Decision Making

**OR**

**BY TIME:**
- Code Level Determined By:
  - Time spent in Counseling and Coordination of Care (if greater than 50% of the total time of the visit)
Sites of Service
- Outpatient
- Inpatient
- Observation Unit
- Partial Hospitalization
- Nursing Home
- Residential Treatment Facility
- Consult

Learn One-Learn Them All
Same Documentation Requirements – Different Code Numbers
- New Outpatient
- New Consult
  - New Inpatient
  - New Observation Unit
  - New Nursing Home and RTF
- Subsequent Outpatient
- Subsequent NH and RTF

Outpatient Visit:
New Patient
“New Patient”
- “A new patient is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years

“Established Patient”
- “An established patient is one who has received professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years

Office New Patient
All of the Three Key Components Must Be Met or Exceeded

<table>
<thead>
<tr>
<th>History</th>
<th>Problem Focused</th>
<th>Expanded</th>
<th>Detailed</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam</td>
<td>Problem Focused</td>
<td>Expanded</td>
<td>Detailed</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>Medical Decision Making</td>
<td>Straight Forward Complexity</td>
<td>Straight Forward Complexity</td>
<td>Low Complexity</td>
<td>Moderate Complexity</td>
</tr>
</tbody>
</table>

CPT Code: 99201 99202 99203 99204 99205

Office New Patient
Example of 99203 Documentation Requirements

<table>
<thead>
<tr>
<th>History</th>
<th>Problem Focused</th>
<th>Expanded</th>
<th>Detailed</th>
<th>Comprehensive</th>
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</thead>
<tbody>
<tr>
<td>Exam</td>
<td>Problem Focused</td>
<td>Expanded</td>
<td>Detailed</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>Medical Decision Making</td>
<td>Straight Forward Complexity</td>
<td>Straight Forward Complexity</td>
<td>Low Complexity</td>
<td>Moderate Complexity</td>
</tr>
</tbody>
</table>

CPT Code: 99201 99202 99203 99204 99205
Outpatient Visit: New Patient
(SAME REQUIREMENTS AS INITIAL CONSULT)
- 99201
  - Problem Focused History
  - Problem Focused Examination
  - Straightforward Medical Decision Making
- 99202
  - Expanded Problem Focused History
  - Expanded Problem Focused Examination
  - Straightforward Medical Decision Making
- 99203
  - Detailed History
  - Detailed Examination
  - Low Complexity Medical Decision Making
- 99204
  - Comprehensive History
  - Comprehensive Examination
  - Moderate Complexity Medical Decision Making
- 99205
  - Comprehensive History
  - Comprehensive Examination
  - High Complexity Medical Decision Making

National Distribution of CPT Codes
Used by Psychiatrists (based on 2014 data)*

New Outpatient Initial Visit
- 99201 1.17 %
- 99202 **
- 99203 **
- 99204 48.73 %
- 99205 50.10 %

Alternatively, For the Initial Evaluations, You Could Bill a Diagnostic Evaluation Code

For Diagnostic Evaluations with Medical Services - use 90792
Diagnostic Evaluation with Medical Services (90792) and without Medical Services (90791)

May be reported more than once when separate evaluations are conducted with patient and informant(s)

Pros and Cons - New Outpatient E/M vs Diagnostic Evaluation with Medical Services

<table>
<thead>
<tr>
<th>New Outpatient E/M</th>
<th>Diagnostic Evaluation with Medical Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pros</td>
<td>Pros</td>
</tr>
<tr>
<td>5 levels of Complexity</td>
<td>Paid better for more complex patients</td>
</tr>
</tbody>
</table>

Outpatient Visit: Established Patient
**Office Established Patient**

*Two of the Three Key Components Must Be Met or Exceeded*

<table>
<thead>
<tr>
<th>History</th>
<th>Problem Focused</th>
<th>Expanded Problem Focused</th>
<th>Detailed</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam</td>
<td>Problem Focused</td>
<td>Expanded Problem Focused</td>
<td>Detailed</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>Medical Decision Making</td>
<td>Straight Forward Complexity</td>
<td>Low Complexity</td>
<td>Moderate Complexity</td>
<td>High Complexity</td>
</tr>
<tr>
<td>CPT Code</td>
<td>99212</td>
<td>99213</td>
<td>99214</td>
<td>99215</td>
</tr>
</tbody>
</table>

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**Office Established Patient**

*Example of 99214 Documentation Requirements*

<table>
<thead>
<tr>
<th>History</th>
<th>Problem Focused</th>
<th>Expanded Problem Focused</th>
<th>Detailed</th>
<th>Comprehensive</th>
</tr>
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<tbody>
<tr>
<td>Exam</td>
<td>Problem Focused</td>
<td>Expanded Problem Focused</td>
<td>Detailed</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>Medical Decision Making</td>
<td>Straight Forward Complexity</td>
<td>Low Complexity</td>
<td>Moderate Complexity</td>
<td>High Complexity</td>
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<tr>
<td>CPT Code</td>
<td>99212</td>
<td>99213</td>
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</tbody>
</table>

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**Office Established Patient**

*Example of 99214 Documentation Requirements*

<table>
<thead>
<tr>
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<td>Moderate Complexity</td>
<td>High Complexity</td>
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<tr>
<td>CPT Code</td>
<td>99212</td>
<td>99213</td>
<td>99214</td>
<td>99215</td>
</tr>
</tbody>
</table>
Established Patient Outpatient
(SAME REQUIREMENTS AS NURSING HOME AND RTF)

- 99212
  - Problem Focused Interval History
  - Problem Focused Examination
  - Straightforward Medical Decision Making
- 99213
  - Expanded Problem Focused Interval History
  - Expanded Problem Focused Examination
  - Low Complexity Medical Decision Making
- 99214
  - Detailed Interval History
  - Detailed Examination
  - Moderate Complexity Medical Decision Making
- 99215
  - Comprehensive Interval History
  - Comprehensive Examination
  - High Complexity Medical Decision Making

Codes 2012

<table>
<thead>
<tr>
<th>Codes</th>
<th>2012 Medicare</th>
<th>2013 Medicare</th>
<th>2013 Blue Cross</th>
<th>2014 Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>99212</td>
<td>3.9</td>
<td>9.3</td>
<td>6.5</td>
<td>8.0</td>
</tr>
<tr>
<td>99213</td>
<td>27.8</td>
<td>56.6</td>
<td>62.0</td>
<td>56.4</td>
</tr>
<tr>
<td>99214</td>
<td>42.0</td>
<td>28.3</td>
<td>28.1</td>
<td>30.0</td>
</tr>
<tr>
<td>99215</td>
<td>16.8</td>
<td>3.75</td>
<td>3.0</td>
<td>3.8</td>
</tr>
</tbody>
</table>

'' One Blue Cross Carrier

Established Outpatient Visit

- 99212
  - Problem Focused Interval History
  - Problem Focused Examination
  - Straightforward Complexity Medical Decision Making
- 99213
  - Expanded Problem Focused Interval History
  - Expanded Problem Focused Examination
  - Low Complexity Medical Decision Making
- 99214
  - Detailed Interval History
  - Detailed Examination
  - Moderate Complexity Medical Decision Making
- 99215
  - Comprehensive History
  - Comprehensive Examination
  - High Complexity Medical Decision Making
Office visit for an established patient with an irritated skin tag for reassurance (Dermatology)

Office visit for a 65-year-old, established patient, with eruptions on both arms from poison oak exposure (Internal Medicine)

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.

Office visit for a 16-year-old female, established patient, with intermittent moderate depression.

Office visit for a 48-year-old male, established patient, with bipolar disorder, marital problems, chronic insomnia, and several medical conditions. Mild psychiatric symptoms and minimal medication side effects.

Office visit for a 13-year-old male, established patient, with depression, anxiety, and anger outbursts.

Office visit for a 22-year-old female, established patient, with bipolar disorder and obesity. The patient wants to stop the medication because of resulting weight gain.
“By the Elements” Clinical Examples
99215

- Office visit for a 28-year-old female, established patient, who is abstinent from previous cocaine dependence but reports progressive panic attacks and chest pain
- 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 27-year-old female, established patient, with bipolar disorder who was stable on lithium carbonate and monthly supportive psychotherapy but now has developed symptoms of hypomania

Evaluation and Management
CPT Codes

Inpatient/Hospital:
- Initial Hospital…………………… 99221 - 99223
- Subsequent Inpatient……… 99231 - 99233
- Hospital Discharge………….. 99238 - 99239
Initial Hospital Care
(Also used for Partial Hospital)
Initial Psychiatric Evaluation

- 99221 (Level 1)
  - Detailed or Comprehensive History
  - Detailed or Comprehensive Examination
  - Straightforward or Low Complexity Decision Making
- 99222 (Level 2)
  - Comprehensive History
  - Comprehensive Examination
  - Moderate Complexity Medical Decision Making
- 99223 (Level 3)
  - Comprehensive History
  - Comprehensive Examination
  - High Complexity Medical Decision Making

National Distribution of CPT Codes Used by Psychiatrists (based on 2014 data)

Initial Hospital Care
- 99221 14.56 %
- 99222 41.41 %
- 99223 44.03%

Initial Observation Unit Care
- 99218 28.74 %
- 99219 35.81 %
- 99220 35.45 %
National Distribution of CPT Codes Used by Psychiatrists (based on 2014 data)

Initial Nursing Home and Psychiatric Residential Treatment Facility

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>99304</td>
<td>9.88%</td>
</tr>
<tr>
<td>99305</td>
<td>37.80%</td>
</tr>
<tr>
<td>99306</td>
<td>52.33%</td>
</tr>
</tbody>
</table>

Initial Visit Inpatient/PHP – History

- Level 1 Visit (CPT 99221) - History must be documented at a detailed level, meaning:
  - 4+ elements of HPI.
  - 2-9 ROS.
  - 1 PFSH element.
- Level 2 & 3 Visit (CPT 99222-99223) - History must be documented at comprehensive level, meaning:
  - 4+ elements of HPI.
  - 10 or more ROS.
  - All 3 PFSH elements.

Initial Visit Inpatient/PHP - Exam

<table>
<thead>
<tr>
<th>Level of Exam</th>
<th>Performed and Documented</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem focused</td>
<td>One to five items</td>
<td>99221</td>
</tr>
<tr>
<td>Expanded Problem Focused</td>
<td>Six to eight items</td>
<td></td>
</tr>
<tr>
<td>Detailed</td>
<td>At least nine items</td>
<td></td>
</tr>
<tr>
<td>Comprehensive</td>
<td>At least one item in the musculoskeletal box AND every item in the Constitutional and Psychiatry box</td>
<td>99222 &amp; 99223</td>
</tr>
</tbody>
</table>
**Initial Visit Inpatient/PHP – Medical Decision Making**

<table>
<thead>
<tr>
<th>Level Of MDM</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straightforward</td>
<td>99221</td>
</tr>
<tr>
<td>Low</td>
<td>99221</td>
</tr>
<tr>
<td>Moderate</td>
<td>99222</td>
</tr>
<tr>
<td>High</td>
<td>99223</td>
</tr>
</tbody>
</table>

**SIMPLIFY**

The two categories in every encounter are:
1. Number of Diagnoses or Management Options
   - Diagnoses include Rule Outs
   - Management Options include “Do nothing”
2. Level of Risk
   - Based on the “risk table”

<table>
<thead>
<tr>
<th>Level of Medical Decision Making</th>
<th>Diagnoses or Management Options</th>
<th>Level of Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>4</td>
<td>High (Eg. Suicidal; extensive monitoring of drug therapy)</td>
</tr>
<tr>
<td>Moderate</td>
<td>3</td>
<td>Moderate (Prescription Drugs: chronic illness with mild exacerbation or side effects; two stable chronic illnesses)</td>
</tr>
<tr>
<td>Low</td>
<td>2</td>
<td>Low (stable chronic illness)</td>
</tr>
<tr>
<td>Straightforward</td>
<td>1</td>
<td>Minimal (minor problem)</td>
</tr>
</tbody>
</table>
## Level of Medical Decision Making

<table>
<thead>
<tr>
<th>Code Level (E.g. Outpatient)</th>
<th>Level of Medical Decision Making</th>
<th>Diagnoses or Management Options</th>
<th>Level of Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>High</td>
<td>4 High (e.g., Suicidal; Extensive monitoring of drug therapy)</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Moderate</td>
<td>3 Moderate (Prescription Drugs; chronic illness with mild exacerbation or side effects; two stable chronic illnesses)</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Low</td>
<td>2 Low (stable chronic illness)</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Straightforward</td>
<td>1 Minimal (minor problem)</td>
<td></td>
</tr>
</tbody>
</table>

## Level of Medical Decision Making

<table>
<thead>
<tr>
<th>Code Level (E.g. Inpatient)</th>
<th>Level of Medical Decision Making</th>
<th>Diagnoses or Management Options</th>
<th>Level of Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>High</td>
<td>4 High (e.g., Suicidal; Extensive monitoring of drug therapy)</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Moderate</td>
<td>3 Moderate (Prescription Drugs; chronic illness with mild exacerbation or side effects; two stable chronic illnesses)</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Low</td>
<td>2 Low (stable chronic illness)</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Straightforward</td>
<td>1 Minimal (minor problem)</td>
<td></td>
</tr>
</tbody>
</table>

## Subsequent Hospital Care

*(Progress Notes)*

- 99231 (Level 1) (Usually the patient is stable, recovering, or improving)
  - Problem Focused Interval History (1-3 HPI elements)
  - Problem Focused Examination (1-5 items identified by a bullet)
  - Straightforward or low complexity Medical Decision Making

- 99232 (Level 2) (Usually the patient is responding inadequately to therapy or has developed a minor complication)
  - Expanded Problem Focused Interval History (1-3 HPI elements, Pertinent System in ROS)
  - Expanded Problem Focused Examination (6-8 items identified by a bullet)
  - Moderate Complexity Medical Decision Making
Subsequent Hospital Care
(Progress Notes continued)

- 99233 (Level 3) (Usually the patient is unstable or has developed a significant complication or a significant new problem)
  - Detailed Interval History (4 or more HPI elements, Pertinent System in ROS and at least one other, and at least one specific item from the PFSH)
  - Detailed Examination (9 or more items identified by a bullet)
  - High complexity Medical Decision Making

National Distribution of CPT Codes
Used by Psychiatrists (based on 2014 data)

Subsequent Hospital Care
- 99231 29.94%
- 99232 54.92%
- 99233 15.14%
Hospital Discharge Services
Key Considerations for Code Selection

- These codes (CPT 99238 and 99239) are to be utilized by the physician to report all services provided to a patient on the date of discharge, if other than the initial date of inpatient status.
- These codes include, as appropriate, final examination of the patient (or pronouncement of death), discussion of the hospital stay, even if the time spent by the physician on that day is not continuous, instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions and referral forms.

- CPT Code 99239 is considered a "time based code." As such, more than 30 minutes of service must be clearly documented in the medical record by time and content to be considered reasonable and necessary.

- A hospital discharge service (e.g., 99238) and a hospital visit service (e.g., 99231) may not be billed for the same date of service.

Discharge Summary CMS Conditions of Participation (CoP) Requirements

- Must include a "recapitulation of the patient’s hospitalization"
  - Summary of the circumstances and rationale for admission
  - Synopsis of accomplishments achieved as reflected through the treatment plan
  - Includes: reasons for admission, treatment achieved during hospitalization, baseline of the psychiatric, physical, and social functioning of the patient at the time of discharge, and evidence of the patient/family response to the treatment interventions
Discharge Summary

- Reasons for Admission
- Course in Hospital
- Lab/Procedure Findings
- MSE on Discharge
- Discharge Diagnoses
- Discharge Risk Factors
- All discharge medications, dosing, Rx
- Aftercare plans

National Distribution of CPT Codes
Used by Psychiatrists (based on 2014 data)

Hospital Discharge Services
- 99238  63.42 %  ≤ 30 min
- 99239  36.58 %  > 30 min

Initial Nursing Facility and Psychiatric Residential Treatment Facility
(Same Requirements as Initial Inpatient, Observation, PHP)
- 99304  Detailed or Comprehensive History
  Detailed or Comprehensive Examination
  Straightforward or Low Complexity Medical Decision Making
- 99305  Comprehensive History
  Comprehensive Examination
  Moderate Complexity Medical Decision Making
- 99306  Comprehensive History
  Comprehensive Examination
  High Complexity Medical Decision Making
National Distribution of CPT Codes Used by Psychiatrists (based on 2014 data)

Initial Nursing Home and Psychiatric Residential Treatment Facility

<table>
<thead>
<tr>
<th>Code</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>99304</td>
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<td>37.80%</td>
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<tr>
<td>99306</td>
<td>55.33%</td>
</tr>
</tbody>
</table>

Subsequent Nursing Home and Psychiatric Residential Treatment Facility

<table>
<thead>
<tr>
<th>Code</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>99307</td>
<td>17.66%</td>
</tr>
<tr>
<td>99308</td>
<td>52.64%</td>
</tr>
<tr>
<td>99309</td>
<td>25.00%</td>
</tr>
<tr>
<td>99310</td>
<td>4.71%</td>
</tr>
</tbody>
</table>

Consultations
Consults

- Must have an order requesting the consult from another physician
- Must respond in writing
- If planning to accept responsibility for ongoing management of the patient’s entire care or of a specific problem or condition, must say so
- Medicare no longer pays for Consults
  - If you are the consultant, for inpatient use the corresponding initial care code (e.g. 99221-99223); for outpatient use the corresponding new patient code (e.g. 99201-99205)
  - If you are the patient’s attending, use modifier AI

Consults

- For Consult Follow-up (also known as Subsequent Care) visits:
  - Use the appropriate established or subsequent care codes.
    - for an inpatient consult, use the inpatient subsequent care codes (99231-99233)
    - for an outpatient consult, use the outpatient subsequent care codes (99211-99215)

Inpatient Consultation
(SAME REQUIREMENTS AS NEW OUTPATIENT)

- 99251 (Level 1)
  - Problem Focused History
  - Problem Focused Examination
  - Straightforward Medical Decision Making
- 99252 (Level 2)
  - Expanded Problem Focused History
  - Expanded Problem Focused Examination
  - Straightforward Medical Decision Making
- 99253 (Level 3)
  - Detailed History
  - Detailed Examination
  - Low Complexity Medical Decision Making
Inpatient Consultation

- 99254 (Level 4)
  - Comprehensive History
  - Comprehensive Examination
  - Moderate Complexity Medical Decision Making
- 99255 (Level 5)
  - Comprehensive History
  - Comprehensive Examination
  - High Complexity Medical Decision Making

Inpatient Consult – History

- **Level 1 Visit** (CPT 99251) - *History* must be documented at a **problem focused** level, meaning:
  - At least 1 element of HPI.
  - 0 ROS.
  - 0 PFSH elements.

- **Level 2 Visit** (CPT 99252) - *History* must be documented at **expanded problem focused** level, meaning:
  - At least 1 element of HPI.
  - Problem pertinent ROS.
  - 0 PFSH elements.

- **Level 3 Visit** (CPT 99253) - *History* must be documented at a **detailed** level, meaning:
  - At least 4 elements of HPI.
  - 2 ROS.
  - Complete PFSH

- **Level 4 Visit** (CPT 99254) - *History* must be documented at **expanded problem focused** level, meaning:
  - At least 4 elements of HPI.
  - Complete (at least 10) ROS.**
  - Complete PFSH

- **Level 5 Visit** (CPT 99255) - *History* must be documented at **detailed** level, meaning:
  - At least 4 elements of HPI.
  - Complete (at least 10) ROS.**
  - Complete PFSH

**All other systems negative**
### Specialty Exam for Psychiatry

<table>
<thead>
<tr>
<th>Level of Exam</th>
<th>Performed and Documented</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem focused</td>
<td>One to five items</td>
<td>99251</td>
</tr>
<tr>
<td>Expanded Problem Focused</td>
<td>Six to eight items</td>
<td>99252</td>
</tr>
<tr>
<td>Detailed</td>
<td>At least nine items</td>
<td>99253</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>At least one item in the musculoskeletal box AND every item in the Constitutional and Psychiatric box</td>
<td>99254 &amp; 99255</td>
</tr>
</tbody>
</table>

### Medical Decision Making

<table>
<thead>
<tr>
<th>Level of Medical Decision Making</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straightforward</td>
<td>99251</td>
</tr>
<tr>
<td>Straightforward</td>
<td>99252</td>
</tr>
<tr>
<td>Low Complexity</td>
<td>99253</td>
</tr>
<tr>
<td>Moderate Complexity</td>
<td>99254</td>
</tr>
<tr>
<td>High Complexity</td>
<td>99255</td>
</tr>
</tbody>
</table>

### Diagnosis or Management Options

<table>
<thead>
<tr>
<th>Level of Medical Decision Making</th>
<th>Code</th>
<th>Level of Risk</th>
<th>Diagnosis or Management Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>High</td>
<td>4</td>
<td>High (EG. Suicidal; Extensive monitoring of drug therapy)</td>
</tr>
<tr>
<td>4</td>
<td>Moderate</td>
<td>3</td>
<td>Moderate (Prescription Drugs chronic illness with mild exacerbation or side effects; two stable chronic illnesses)</td>
</tr>
<tr>
<td>3</td>
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<td>2</td>
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</tr>
<tr>
<td>2</td>
<td>Straightforward</td>
<td>1</td>
<td>Minimal (minor problems)</td>
</tr>
</tbody>
</table>
Psychiatry Family of Codes

Psychotherapy
• **Add On Code:**
  - A code that describes the work that is performed in addition to the primary service
  - It is never reported alone
    - **Two or more** codes billed: Primary and Add On(s)

• Psychotherapy service codes are **time based**.
  - The patient must be present for all or some of the service (may include family members or others in the treatment process)
    - “Psychotherapy with Patient and/or Family vs Individual Psychotherapy”
  - When reported alone, they will be coded as 30, 45, or 60 minutes (90832, 90834, 90837)
  - When reported with an E/M service by a qualified practitioner they will be coded as an **Add On Code** for 30, 45, or 60 minutes (+90833, +90836, +90838)

---

**CPT Time Rule**

“A unit of time is attained when the mid-point is passed”

“When codes are ranked in sequential typical times and the actual time is between two typical times, the code with the typical time closest to the actual time is used.”

As an example, codes of 30, 45, and 60 minutes are billed at 16-37 mins, 38-52 mins, and 53-67 mins.
For Psychotherapy Times, the CPT Time Rule Applies:

- 30-minute psychotherapy codes (90832 and +90833) can be used starting at **16 minutes**
- 45-minute psychotherapy codes (90834 and +90836) can be used starting at **38 minutes**
- 60-minute psychotherapy codes (90837 and +90838) can start to be used at **53 minutes**

How to Use Psychotherapy Add On Codes

- “Significant and separately identifiable”
- Select the appropriate E/M service (type and level)
- The level of the E/M must be “based on the elements.” You cannot use “time” (counseling and coordination of care) as the basis of the E/M code level
- Then, without using any time devoted to the E/M portion of the service, determine the psychotherapy time and code the appropriate Add On psychotherapy code

Psychotherapy Documentation

- Significant and Separately Identifiable
- Time spent in psychotherapy
- Modality (e.g., CBT, Supportive, Insight oriented, etc.)
- Target symptoms, goals, how monitoring outcomes
- Patient’s capacity to participate in, and benefit from psychotherapy
- Focus of therapy in this session
**What Seems Reasonable When patients are seen weekly for 45 minute psychotherapy and med management sessions:**

<table>
<thead>
<tr>
<th>45 minute weekly psychotherapy appointments</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Common</strong></td>
<td></td>
</tr>
<tr>
<td>99212 +90836 (38-52 mins)</td>
<td>[10+38=48]</td>
</tr>
<tr>
<td>99214 +90833 (16-37 mins)</td>
<td>[25+16=41]</td>
</tr>
<tr>
<td><strong>Sometimes</strong></td>
<td></td>
</tr>
<tr>
<td>99213 +90836 (38-52 mins)</td>
<td>[15+38=53]</td>
</tr>
<tr>
<td><strong>Rarely</strong></td>
<td></td>
</tr>
<tr>
<td>99214 +90836 (38-52 mins)</td>
<td>[25+38=63]</td>
</tr>
</tbody>
</table>

**CPT Typical Times:**
- 99212 (10 mins)
- 99213 (15 mins)
- 99214 (25 mins)

---

**Family Psychotherapy 90846, 90847, 90849**

- The focus of family psychotherapy is the family or subsystems within the family, e.g., the parental couple or the children, although the service is always provided for the benefit of the patient.

- This is a distinguishing characteristic from the Psychotherapy with Patient or Family codes where the focus is on the individual patient with possible occasional involvement of family members.

---

**Family and Group Psychotherapy**

- Use **90846** to report a service when the patient is not physically present.

- Use **90847** to report a service that includes the patient some or all of the time. Couples therapy is reported with code **90847**.

- Use **90849** to report Multiple-Family Group Psychotherapy.

- Use **90853** to report Group Psychotherapy.
Interactive Complexity
+90785

When specific factors interfere with the therapist’s ability to provide the service during the session

Interactive Complexity - +90785

• May only be used with psychotherapy codes. Never with E/M codes alone
• May be used with the Diagnostic Evaluation Codes (90791, 90792)
• May be used with any of the Psychotherapy Codes (stand-alone or add-on)
• May be used with Group Psychotherapy but not with Family Psychotherapy or Multifamily Psychotherapy

When Interactive Complexity Can Be Used:
• When using physical aids, translators, or interpreters*
• When using play therapy
• Arguing or emotional family members in a session that interfere with providing the service
• Third party involvement with the patient, including parents, guardians, courts, schools, that interferes with providing the service
• Need for mandatory reporting of a sentinel event with discussion in the session*

*Medicare will not pay for translators or interpreters because they view these as already covered under the ADA.
Is This What You Mean by “Interactive Complexity? Complexity”?  

Interactive Complexity in a Group 
Psychotherapy Setting 
- Use Interactive Complexity add-on code +90785 with 90853 to report for 1 or more group members 
Examples: 
- A group of 4 pre-school children, all of whom have witnessed traumatic events, are being treated in a group setting through the use of play therapy techniques. 
  All participants may be billed as 90853, +90785 
- A group of 8 adults is being seen in a CBT Group, with the addition of an interpreter for one patient with a hearing impairment who utilizes sign-language interpreter. 
  Only the one patient utilizing an interpreter may be billed 90853, +90785 

Psychotherapy for Crisis (90839, +90840) 
Rationale: 
- When psychotherapy services are provided to a patient who presents in high distress with complex or life threatening circumstances that require urgent and immediate attention
Psychotherapy for Crisis

- 90839 is a stand-alone code not to be reported with psychotherapy or psychiatric diagnostic evaluation codes, the interactive complexity code, or any other psychiatry section code.

- +90840 is an add-on code that should be reported for each additional 30 minutes of service.

Psychotherapy for Crisis Example:

36-year-old woman being treated for a Generalized Anxiety Disorder and relationship problems with Cognitive Behavior Therapy, calls and leaves a message that she is planning to commit suicide because she “can’t stand it anymore.” Her therapist is able to reach her on the phone and she agrees to come in for an urgent session in one hour. She arrives with her husband. The therapist attempts to defuse the crisis, meeting individually with the patient, and jointly with the husband. The patient remains suicidal, and agrees to hospitalization. The therapist makes arrangements for hospitalization and the patient is transported by ambulance. Total time spent on working with the patient and arranging for hospitalization is 95 minutes.

Codes: 90839, +90840

• Report 90839 for the first 30-74 minutes of psychotherapy for crisis on a given date.

• Psychotherapy for crisis of less than 30 min. total should be reported with 90832 or 90833.

• Report 90839 only once per date even if time spent by the physician/QHCP is not continuous on that date.

• When service results in additional time, report +90840 with 90839 once for every additional 30 minutes of time beyond the first 74 minutes.
Medical Necessity
- Criteria available from Payer
- Inpatient Criteria Typically:
  - Dangerousness and inability to maintain safety outside of an acute care setting that has 24 hour nursing care
  - Failure of lower levels of care, e.g. voicing suicidal plan while attending PHP
  - Primary psychiatric illness (in PA can’t admit primary substance use disorder patient to inpatient psychiatry)
  - Must be able to benefit from inpatient treatment (e.g. questionable for some patients with dementia)
  - Physicians must write an admission order and for Medicare, Medicaid patients be able to certify:
    - Inpatient admission is medically necessary for either treatment that is reasonably expected to improve the patient’s condition or for diagnostic study.
    - Estimate Length of Stay
    - Meet the 2 midnight rule (Medicare)

Medical Necessity (cont’d)
- PHP Criteria Typically:
  - Same criteria for Inpatient but able to maintain safety outside of hospital setting
  - Physician must write an admission order and be able to certify that without PHP level of care, the patient would require inpatient level of care

Compliance Issues (Audit and Survey Findings)
- Adequate documentation to justify the level of the code billed
- Inpatient Treatment Planning documentation – not individualized
- Lack of code distribution, e.g. all 99212 or 99215
- Overuse of higher codes
  - 99214 or 99215 +45min add on psychotherapy repeatedly
Time to Practice What You’ve Learned

Clinical Vignette

Pam XXXXX     MRN#: 123-45-6789
MAY 1, 2012      2:00PM

HISTORY [Expanded Problem Focused]
CC: Follow-up for depression and poor concentration
HPI: mood improved, but times when feel like crying, out of the blue, not at work, 2x in past 2 mos. In the evening, no ppt. Talking to daughter helps, and stays inside, walks the dog. No desire to do fun reading. Able to do job. Not hopeless, “just feels sad”
[Extended HPI: Duration, Context, Modifying Factors, Associated Signs and Symptoms]

ROS: Psychiatry: sleep, initial OK, mid night awakening and hard to fall back asleep; No Audio/Visual Hallucinations
[ Pertinent system – Expanded Problem Focused ]

PFSH:
• 123 [No PFSH]
EXAMINATION:
- Appearance: Appropriately dressed and groomed
- Attention and concentration: Good attention, some complaint of difficulty concentrating, particularly at work; spells “GLOBE” forward and backwards
- Memory: 3/3, remote intact based on answers to interview questions
- Speech: Normal rate and rhythm, without pressured quality
- Mood and affect: “OK, a little nervous because I’m here,” sad affect
- Thought process: No complaints of slowed thinking
- Thought content: Denies SI, no delusions, AVH, worried not doing job as good as she can

MEDICAL DECISION MAKING
Problem #1: Mood
Comment: Continues with persistent sadness; difficulty concentrating; lack of pleasure
Plan: (1) Increase Prozac to 60mg daily (from 40mg)
(2) Consider CBT if no improvement in 6-8 weeks

99213 Example + Psychotherapy Add On

Psychotherapy with Patient or Family
Example of E/M visit with psychotherapy
48-year old man was recently discharged from a brief inpatient psychiatric hospitalization after an overdose attempt. He has Bipolar disorder, mixed type and is currently on mood stabilizing, antidepressant, and antipsychotic medications, as well as an antihypertensive and medicine for GERD.

E/M: He is evaluated for suicide risk, manic and depressive behavior, and symptoms; beneficial effects, side effects, and med-med interactions; with concerns about elevations in his blood pressure since dosage changes on his psychiatric medications. A psychiatric specialty exam is completed and decisions made about modifications in his medication regimen. Risks and benefits are discussed.
Psychotherapy with Patient or Family

Example of E/M visit with psychotherapy (cont'd)

**Psychotherapy:**
Psychotherapy focused on his concerns about his ability to return to work and “face his co-workers” as well as concerns that his children will “look down upon [him]” for being “weak.” Cognitive Behavioral Therapy (CBT) strategies were reviewed and agreed upon.

**Coding:**
The nature of the presenting problem and documentation of the elements meets criteria for 99213

Time spent in psychotherapy was 25 mins

**Codes:** 99213, +90833

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99214 Example: E/M + Psychotherapy Add On

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Patient: Robert Smith
MR#: 00223456
Date: November 12, 2013
Time: 1:45pm

**CC:** Due to old mode seen for follow-up of mood and behavior problems. Visit attended by patient and father.

**BP:** Patient and father report increasing, moderate sadness that seems to be present only at home and tends to be associated with yelling and punching the wall at greater frequency, at least once per week, when patient is stressed. Anxiety has been improving and intermittent, with no evident trigger.

**SH:** Attending eighth grade without problem; fair grades

**ROS:** Psychiatric: no problems with sleep or attention; Neurological: no headaches

**Exam:** Appearance: appropriate dress; appears stated age; Speech: normal rate and tone; Thought Process: intact; Thought content: no SI/HI or psychotic symptoms; Orientation: G. A. O. X; Attention and Concentration: good; Mood: euthymic and full and appropriate; Thought content: no SI/HI or psychotic symptoms; Orientation: x3; Attention and Concentration: good; Mood: euthymic and full and appropriate; Thought content: no SI/HI or psychotic symptoms; Orientation: x3; Attention and Concentration: good; Mood: euthymic and full and appropriate; Thought content: no SI/HI or psychotic symptoms;

**Assessment/Plan:**
Problem #1: depression
Comment: worsening
Plan: increase dose of SSRIs; write script; CBT therapy; return visit in two weeks

Problem #2: anxiety
Comment: improving
Plan: patient to work on identifying context in therapy

Problem #3: anger outbursts
Comment: worsening associated with lack of structure
Plan: consider mood stabilizing medication if no improvement in 1-2 months

**Psychotherapy:** approx. 20 minutes

Notes: Reviewed prior plan and walked through steps to take when he notices mood getting worse. Identified context for anxiety and developed plan. Provided workbook to complete and bring to next visit.
Psychotherapy with Patient or Family

Example of E/M visit with psychotherapy and interactive complexity

13-year-old in treatment for depression and alcohol abuse, on an antidepressant and an inhaler for her asthma, presents with both parents, who are divorced and arguing over how to address the patient’s recent alcohol binge. One parent wants to “send her away” to a boarding school. The other parent wants to follow the previously agreed upon course of treatment.

E/M: An interval history is obtained from parents and the patient, including details of recent alcohol use, along with exploration of other drug use, medication compliance, side effects, and beneficial effects. Suicide risk is explored. A psychiatric specialty exam is completed and decisions made about her medications. Risks and benefits are discussed.

Psychotherapy:
Psychotherapy focuses on her feelings about her father’s “new rules” at home during her weekends with him, and her anger at him for “embarrassing” her in front of her friends when he was drunk.

Interactive Complexity:
The intensity of work during the session is increased by the parents arguing with each other over the treatment recommended by the psychiatrist.
Psychotherapy with Patient or Family

Example of E/M visit with psychotherapy and interactive complexity (cont’d)

Coding:
The nature of the presenting problem and documentation of the elements meets criteria for a 99212
50 minutes is spent providing psychotherapy
The delivery of the service is complicated by the maladaptive communication involving the parents during the session

Codes: 99212, +90836, +90785

Patient: Robert Smith
MR: 00023456
Date: November 12, 2013
Time: 1:45pm

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.

HPI: Patient and father report increasing, moderate sadness that seems to be present only at home and tends to be associated with yelling and punching the walls at greater frequency, at least once per week, when patient frustrated. Anxiety has been improving and炙heuristics, with no evident trigger.

SH: Attending eighth grade without problem; fair grades

ROS: Psychiatric: no problems with sleep or appetite. Neurological: no headaches.


Assessment and Plan:
Problem #1: depression
Comment: worsening; appears associated with lack of structure
Plan: increase dose of SSRI; write script; CBT therapy; return visit in two weeks

Problem #2: anxiety
Comment: improving
Plan: patient to work on identifying sources in therapy

Problem #3: anger outbursts
Comment: worsening; related to depression but may represent new dysregulation
Plan: consider mood stabilizing medication if no improvement in 1-2 months
Office visit for a 13-year-old male, established patient, with depression, anxiety, and anger outbursts.

**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.

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 =

PFSH: Attending 8th grade without problem; fair grades

PFSH scoring: 1 element: social =

ROS: Psychiatric: no problems with sleep or attention; Neurological: no headaches

ROS scoring: 2 systems =

**EXAM**

Const Appearance: appropriate dress, appears stated age

MS N/A

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 =

**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 =

**Data scoring**: Obtain history from other (2); Decision to obtain history from other (1); total of 3 =

**Risk scoring**: One or more chronic illnesses with mild exacerbation, progression; and Prescription drug management =

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**Inpatient 99232 Example**

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**INPATIENT**

Sandra XXXXX  MRN#: 123-45-6789

FEB 5, 2014  2:00PM

**HISTORY** [Expanded Problem Focused]

CC: Follow-up for depressive symptoms and suicidal ideation

HPI: Continues to experience low mood, particularly when speaking with her husband about finances, but able to brighten when distracted by news of their son’s activities. Suicidal thoughts now more intermittent, associated with ruminations of all she still has to face when she goes home.

[Extended HPI: Duration, Context, Modifying Factors, Associated Signs and Symptoms]

**ROSS:**

Psychiatric: sleep continues with middle night awakening and hard to fall back asleep; No Audio/Visual Hallucinations

[Peritent system – Expanded Problem Focused]

**PFSH:**

[No PFSH]
EXAMINATION: [8 bulleted items needed for EXPANDED PROBLEM FOCUSED EXAM]

APPEARANCE: no make up, wearing pjs in the middle of the day
ATTENTION AND CONCENTRATION: adequate for both, but distracted at times by outside noises
MEMORY: 3/3, remote intact based on answers to interview questions
SPEECH: normal rate and rhythm, without pressured quality
MOOD AND AFFECT: “still pretty down,” sad affect
THOUGHT PROCESS: no complaints of slowed thinking
THOUGHT CONTENT: Suicidal thoughts intermittent, usually 2-3X per day, No delusions

MEDICAL DECISION MAKING

Problem #1: Mood
Comment: Continues with persistent sadness; difficulty concentrating; lack of pleasure
Plan: Increase Prozac to 60mg daily (from 40mg). Consider CBT if no improvement in 6-8 weeks.

CODE: 99232
History=Expanded Problem Focused
Exam=Expanded Problem Focused
MDM=High (suicidal)
Best 2 out of 3 = 99232

APA Resources/Additional Assistance

Where to learn more

APA has developed educational materials and opportunities for APA members that can be found on the APA website at www.psychiatry.org/practice

Things such as:
• A CPT coding crosswalk
• On-line course on E/M coding and documentation
• Live and recorded Webinars on E/M coding
• APA CPT Coding Network [for questions by email]
Contact APA for Additional Help
You can reach CPT coding staff in the APA’s Office of Healthcare Systems and Financing:

- Call the Practice Management HelpLine
  - 1-800-343-4671
  or
- Email – hsf@psych.org

Questions?
Psychiatric Billing, Coding and Documentation for Academic Medical Centers

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Professor and Associate Chair
Department of Psychiatry
John A. Burns School of Medicine
University of Hawaii

Disclosure

• The opinions referenced are those of a member of the RBRVS, Codes, and Reimbursement Committee of the APA based on coding experience. They are based on the commonly used codes in Psychiatry, which are not all inclusive. Always check with your local insurance carriers as policies vary by region. The final decision for the coding of a procedure must be made by the physician considering regulations of insurance carriers and any local, state or federal laws that apply to the physicians practice. The APA and its representatives disclaim any liability arising from the use of these opinions.
• Opinion of presenter and not UCERA (University of Hawaii Practice Plan)

General coding and billing issues in academic psychiatry

• Historically residents not taught about billing
• Faculty with poor knowledge
• Billing and coding now part of psychiatry milestones for residency training
• Faculty now must teach residents about billing and coding
Payment for physician services in teaching hospitals

- Patient care by non-resident physician (attending)
- Resident with teaching physician present for key portion of the exam ("direct supervision")
- Resident under primary care exception (attending not physically present but available for supervision, usually does not apply to psychiatry except for rare cases of comprehensive treatment of chronically mentally ill patients, "indirect supervision").
- No billing for other instances of indirect supervision. Cannot bill for resident services without attending seeing patient.

Resident documentation requirements

- Clinical evaluation of patient
- Resident must document attending involvement ("Patient seen and discussed with attending Dr. ***")

The teaching physician must document:

1. That he/she performed the service or was physically present during the key or critical portions of the service when performed by the resident (includes one way mirror, live audio/video, telepsychiatry); and
2. His/her participation in the management of the patient.
3. The combined entries into the medical record by the teaching physician and the resident must support the medical necessity for the service.
Examples of PATH Note (Attending Documentation)

PATH – Physicians at Teaching Hospitals
Psychiatry Attending
1) “Patient seen, chart reviewed, case discussed with Dr. ***
   Please see full note from resident physician for additional
details. I agree with resident physician documentation as
noted.”
2) "I was present with the resident during the history and
   exam. I discussed the case with the resident and agree
   with the findings and plan as documented in the
   resident’s note.”
   Note: I typically add brief history, exam, assessment and
   plan to customize my PATH note.

Unacceptable documentation

- Seen with above
- Rounded, reviewed, agree
- Seen and agree
- Patient seen and evaluated
- Signature alone.

Cannot determine whether attending saw patient or
involved in treatment.

Medical Students

- Cannot use student note for exam or medical decision
  making
For E/M billing purposes may refer to student note for:
- Vital signs (ancillary staff)
- Review of Systems (ROS)
- Past Family Social History (PFSH)
Examples of academic billing (patient care with residents)

- Non time based – new patient evaluations (90792), E/M based on bullets
- Time based – E/M with counseling and coordination of care (attending time)
- Time based – psychotherapy, crisis code (attending time)
- Time based – E/M (bullets) + psychotherapy (attending time)

*Sum of resident + attending documentation must support the billing code.*

Billing by attending time

- E/M - Attending (not resident) spends >50% of time for counseling and coordination of care
- Resident/student teaching time is not included in coordination of care unless direct patient teaching
- Psychotherapy – attending time face-to-face (e.g. either in room with resident, viewing resident psychotherapy through one way mirror or watching concurrent audio/video)
- Time = attending time whether for counseling and coordination of care or psychotherapy

Psychotherapy + E/M

**Scenario:** Resident documents follow up of patient encounter using E/M (bullets, not time) and 30 minutes for psychotherapy

- Attending affirms E/M findings but does not directly observe psychotherapy. Can bill E/M only.
- Attending affirms E/M and directly observes 16+ minutes of psychotherapy. Can bill E/M + psychotherapy for 30 minutes.
Other general requirements

- GC modifier added to billing claims for billing with resident involvement, GT modifier for telepsychiatry
- Be careful re copy, cut and paste. Medicare has posted warnings. Must have unique note for each encounter.

Final comments

- Academic billing and coding much more complicated than private practice
- Compliance with rules is critical
- Larger “target” since academic medical departments have many faculty in one group
- Potential fine of $11,000/incident for billing fraud. Major institutions have had multimillion dollar fines.