

**CPT Code Changes for 2013**  
**Frequently Asked Questions**  
Last Updated 3/7/2013

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**Background**

**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.

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**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 took effect on January 1, 2013.

**4. 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.

**5. 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.

**6. Are these changes related to the ICD-10 or DSM-V changes?**

No. ICD-10 and DSM-V 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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## Reporting Deviations from CPT Guidelines

### **7. Our payers have not updated their systems to accept 2013 codes. What should we do?**

The AMA recently released two Practice Management Alerts (on [January 7th](#) and [January 8th](#)) encouraging providers to report HIPAA violations.

While payers can make benefit and reimbursement decisions, they must "use the current applicable medical data code set valid at the time the health care is furnished." This includes not making changes that are contrary to the guidelines provided in the CPT code set, even if they are using 2013 codes.

The AMA recommends filing a complaint through the [Centers for Medicare and Medicaid Services website](#) and/or through the [AMA's Health Plan Complaint Form](#). AMA members and their practice staff can also download [sample appeal letters](#) and customize them for use in their practices.

### **8. Our payers have created guidelines that are contradictory to CPT guidelines. Can they do that?**

The AMA recently released two Practice Management Alerts (on [January 7th](#) and [January 8th](#)) encouraging providers to report HIPAA violations.

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## Psychotherapy Services

### **9. What are the biggest changes to psychotherapy codes for 2013?**

The biggest changes for reporting psychotherapy services in 2013 are:

- Elimination of the distinction of place of service (same codes are to be used for inpatient, outpatient, partial hospital, and other places of services);
- Alignment of times for psychotherapy services with CPT time rules

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- Addition of codes for crisis services
- Addition of the add-on code 90785 for Interactive Complexity

**10. What code should I report if the psychotherapy provided is in between two codes? (E.g., 52 minutes of therapy; should I code that as 45 or 60 minutes?)**

The CPT time standard applies to the new psychotherapy codes. Generally speaking, the CPT time standards apply unless there are different instructions within the CPT guidelines for specific codes or code sets.

- “A unit of time is attained when the mid-point is passed. For example, an hour is attained when 31 minutes have elapsed (more than midway between zero and sixty minutes).
- “A second hour is attained when a total of 91 minutes have elapsed.
- 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.”

Please see the chart below for how to report psychotherapy sessions based on actual duration. The services must be the time spent face-to-face with the patient and does not include time spent on reporting or documentation without the patient.

**Coding Outpatient Psychotherapy Sessions Provided Without E/M Services**

Actual length of session	Code As	Code Description
0-15 minutes	Not reported	-
16-37 minutes	90832	30 minutes
38-52 minutes	90834	45 minutes
53-89 minutes	90837	60 minutes

**11. What codes should be used for extended psychotherapy sessions (e.g. 70-80 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.

Additionally, in December, the American Medical Association published [an errata](#) to the 2013 CPT Code Book regarding coding for prolonged services, including prolonged psychotherapy sessions. As a result of this correction, licensed clinical social workers and other qualified health professionals have an avenue for coding extra-long psychotherapy sessions besides the use of the

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“increased procedural services” modifier. Please see the chart below for how to code psychotherapy sessions.

As always, it is best to check with individual payers to confirm that this is actually a covered benefit.

**Coding Outpatient Psychotherapy Sessions Provided Without E/M Services**

<b>Actual length of session</b>	<b>Code As</b>	<b>Code Description</b>
0-15 minutes	Not reported	-
16-37 minutes	90832	30 minutes
38-52 minutes	90834	45 minutes
53-89 minutes	90837	60 minutes
90-134 minutes	90837 99354	60 minutes Prolonged Services
135-165 minutes	90837 99354 99355	60 minutes Prolonged Services Prolonged Services, each additional 30 minutes

**12. Do the new time requirements for psychotherapy (e.g., 90832, psychotherapy, 30 minutes) include time for documentation by the provider?**

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 (documentation performed with the patient present as a participant) has been shown to support compliance and efficiency, and therapists and clients alike find it to be helpful.

**13. What is the distinction between counseling/care coordination and psychotherapy?**

CPT guidelines define counseling and psychotherapy differently.

**Psychotherapy:**

According to the 2013 CPT guidelines, “psychotherapy is the treatment of mental illness and behavioral disturbances in which the physician or other qualified health care professional, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.”

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Note: when reporting psychotherapy services, it is important to document the focus of the session and the modality used.

### Counseling

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

- Diagnostic results, impressions, and/or recommended diagnostic studies
- Prognosis
- Risks and benefits of management (treatment) options
- Instructions for management (treatment) and/or follow-up
- Importance of compliance with chosen management (treatment) options
- Risk factor reduction
- Patient and family education”

Note: when providing both an E/M service and add-on psychotherapy, time cannot be used as the controlling factor for selection of the appropriate E/M code (even if counseling is the predominate service provided in the course of the E/M services). The E/M code must be selected based on the work performed related to the exam, history, and medical decision making.

#### **14. 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)
- group psychotherapy (90853)

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**15. 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.

## Pharmacologic Management

**16. What codes should be used for Pharmacologic Management?**

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

- Physicians, Advanced Practice Registered Nurses (including NPs), Physician Assistants: Evaluation and Management (E/M) codes
- Psychologists with Prescribing Authority: +90863 (must be reported as an add-on to psychotherapy services) [Note: psychologists may not use E/M codes; only two states grant prescribing authority to psychologists (New Mexico and Louisiana)]
- All providers with prescribing authority, subject to payer policy: HCPCS code M0064: Brief office visit for monitoring or changing drug prescriptions for the treatment of mental, psychoneurotic, and personality disorders

**17. 90863 is listed in the 2013 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 not use 90863.

## Evaluation and Management Codes

**18. 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](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Evaluation_Management_Fact_Sheet_ICN905363.pdf).

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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 has held two webinars specifically on E/M coding and documentation on December 3, 2012 and January 9, 2013. Slides and recordings of the presentation are posted on the National Council's CPT Resource page at: [www.thenationalcouncil.org/cs/cpt\\_codes](http://www.thenationalcouncil.org/cs/cpt_codes)

The last section of this FAQ includes a list of the New and Established patient E/M codes for Office and Other Outpatient services.

### **19. Which practitioners are allowed to use E/M codes?**

Physicians and Non-Physician Practitioners (subject to state scope of practice laws). Non-physician practitioners include:

- Nurse practitioners;
- Clinical nurse specialists;
- Certified nurse midwives; and
- Physician assistants

### **20. How are Evaluation and Management codes selected?**

Evaluation and Management (E/M) codes are selected through one of two pathways:

1. Based on the elements (history, exam, or Medical Decision Making)
2. Based on time (when counseling is provided for more than 50% of the time spent face-to-face with the patient)

The National Council has held two webinars specifically on E/M code selection. Recordings and slides from these presentations can be found on our CPT Resource page at [www.thenationalcouncil.org/cs/cpt\\_codes](http://www.thenationalcouncil.org/cs/cpt_codes).

Additionally, the AACAP has developed an "Evaluation and Management Services Guide: Coding by Key Components," which assists in determining which code to select when basing selection on the elements (as opposed to time). These guidelines are based on CPT guidelines and [CMS' 1997 Evaluation and Management Documentation Guidelines](#).

### **21. If E/M code selection is being selected based on time, do we select the time closest to the typical time or must it minimally meet the typical time?**

Before you can accurately code on the basis of time, you must first understand how much time is typically involved in the services you are providing. CPT furnishes this information for office visits, inpatient consultations, home services, etc., and the average time guidelines are summarized below for new, established and consultation in office-based settings:

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## E/M Outpatient Services: Codes & Time

NEW PATIENT VISIT TIME		ESTABLISHED PATIENT VISIT TIME		OFFICE CONSULTATION TIME	
CODE	MINUTES	CODE	MINUTES	CODE	MINUTES
99201	10	99211	5	99241	15
99202	20	99212	10	99242	30
99203	30	99213	15	99243	40
99204	45	99214	25	99244	60
99205	60	99215	40	99245	80



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When time can be used as the basis for selecting the right E/M code, there is some debate as to whether practitioners can round their actual time spent either up or down to the nearest average or whether they must always select the lower code.

CPT® states this rule as, “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.”

The rule applies when reporting E/M services using time (rather than the key components of history, exam, and medical decision-making) as the controlling factor to qualify for a given level of service—that is, when counseling and/or coordination of care comprises more than half the encounter. In such a case, use CPT® “reference times,” along with patient status and place of service, to determine an appropriate E/M service level.

### 22. Why do you recommend using the 1997 guidelines over the 1995 guidelines?

1997 guidelines includes “single organ use and documentation guidelines,” (e.g., Psychiatry system only) whereas the 1995 guidelines only has guidelines for multi-system examinations. It’s very rare that a payer system would use the 1995 E/M guidelines, but it’s still advisable to always confirm with the payers you work with that they accept the 1997 E/M guidelines.

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**23. Can “bullets” be met by information collected by ancillary personnel?**

Yes, provided that you document that the medical professional reporting the service reviewed the information collected and it informed his or her decision making.

**24. 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.”](#)

The psychiatrist does not have to take the measurements her/himself but his/her documentation should include the content that was captured by the ancillary personnel and “reviewed” by the psychiatrist as part of the work.

**25. Our payer is only allowing us to use 99213, and none of the lower or higher level codes. Does that mean we can only ever do the work of a 99213?**

Unless payer policy is otherwise documented, you would have to complete and document at least the level of work necessary for a 99213. If you complete work of additional complexity, you would still need to code the visit as 99213.

Please see responses under the “Reporting Deviations from CPT Guidelines” for reporting discrepancies between payer policy and CPT guidelines.

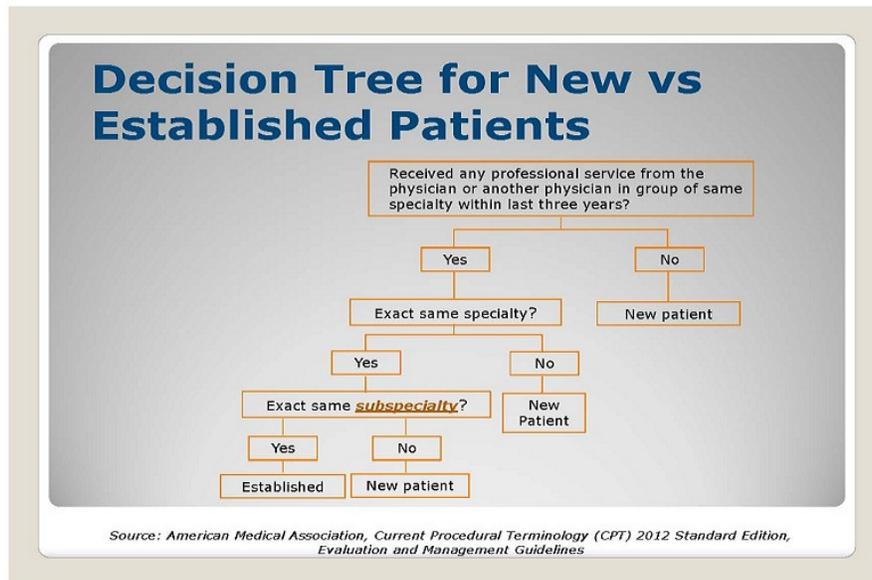
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## E/M: New vs. Established Patients

### 26. How does one distinguish between New and Established patients?

CPT 2012 states: “A new patient is one who has not received any professional services from the physician or another physician of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.”



In the instance where a physician is on call for or covering for another physician, the patient’s encounter will be classified as it would have been by the physician who is not available.

### 27. When 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. According to 2013 CPT guidelines, “[w]hen advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialties as the physician.”

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**28. How is a group practice defined?**

Tax ID.

**29. New vs. Established Patient Examples**

**Example #1: Last year, Jane saw Dr. Brown, a general psychiatrist, who practices at ABC Medical Group.**

- Dr. Brown has since moved his practice to XYZ Medical Group.
- Today Jane sees Dr. Brown at XYZ Medical Group. She has never been to XYZ Medical Group.
- Is Jane a new patient?

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

**Example #2: Last year, Jane saw Dr. Brown, a general psychiatrist, who practices at ABC Medical Group.**

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

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

**Example #3: While Dr. Brown is on vacation, he arranges for Dr. Green, a psychiatrist who works at a medical practice on the other side of town, to cover for him.**

- Jane sees Dr. Green when Dr. Brown is on vacation.
- Is Jane a new patient?

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

**Example# 4: Joe, age 12, sees Dr. Kirk, a child psychologist, at Neighborhood Health Services.**

- Four years earlier, Joe had also seen Dr. Kirk at Neighborhood Health Services.
- Is Joe a new patient?

The new vs. established patient distinction does not apply. The psychologist is not considered to be providing a medical service, so the service cannot be coded as an E/M service.

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**Example #5: John, a new patient, sees Dr. Brown at XYZ Medical Group.**

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

Yes. Dr. Smith is a sub-specialist.

**Example #6: Over the last month, Chris has been receiving psychotherapy services from a L.C.S.W. at a community behavioral health organization.**

- Today he sees Dr. White, a psychiatrist, for the first time for an office visit.
- Is Chris a new patient?

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

**Example #7: Julie is seen by a Psychiatric Nurse Practitioner who prescribes a new medication for Julie.**

- At subsequent visits, Julie is seen by Dr. Green, a psychiatrist.
- Is Julie a new patient for Dr. Green?

No. When advanced practice nurses (including Nurse Practitioners) and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialties as the physician.

**Example #8: John is seen by a psychiatrist for a psychiatric diagnostic evaluation with medical services reported as 90792.**

- At subsequent visits, the psychiatrist reports services provided with E/M codes.
- Is John a new patient?

No. John received professional services at a previous visit by the same physician, even though it was not reported with an E/M code.

**Example #9: Agency XYZ has never reported E/M codes before 2013. Should Agency XYZ report all of its patients as “New patients” for their first visit in 2013?**

No. If patients received a professional service by a practitioner of the same specialty and sub-specialty within the previous three years, they are considered Established Patients (even if previous services were not reported with E/M codes).

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**Example #10: 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 90792 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

**30. Can a center bill a medical E/M service and psychotherapy service on same day by different providers?**

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

**31. Does Medicare have any variation to its “new patient” definition?**

Medicare’s definition of a new vs. established patient is slightly different. It includes the requirement that patient have received a face-to-face service from the physician or physician group practice within the previous three years. Consultation services are not counted.

From CMS FAQ, “What is the definition of ‘new patient’ for billing evaluation and management (E/M) services?”

“Interpret the phrase “new patient” to mean a patient who has not received any professional services, i.e., evaluation and management service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous three years. For example, if a professional component of a previous procedure is billed in a 3-year time-period, e.g., a lab interpretation is billed and no E/M service or other face-to-face service with the patient is performed, then this patient remains a new patient for the initial visit. An interpretation of a diagnostic test, reading an x-ray or EKG etc., in the absence of an E/M service or other face-to-face service with the patient does not affect the designation of a new patient. Beginning in 2012, the AMA CPT instructions for billing new patient visits include physicians in the same specialty and subspecialty. However, for Medicare E/M services the same specialty is determined by the physician's or practitioner's primary specialty enrollment in Medicare. Recognized Medicare specialties can be found in the Medicare Claims Processing Manual, chapter 26

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(<http://www.cms.gov/manuals/downloads/clm104c26.pdf>). You may contact your Medicare claims processing contractor to confirm your primary Medicare specialty designation. (FAQ1969)”

## **90791 and 90792: Psychiatric Diagnostic Evaluations**

### **32. What is the difference between 90791 and 90792?**

**90791:** psychiatric diagnostic evaluation (without medical services), is an “integrated biopsychosocial assessment, including history, mental status, and recommendations. The evaluation may include communication with family or other sources and review and ordering of diagnostic studies.” (CPT 2013 guidelines)

**90792:** psychiatric diagnostic evaluation with medical services is “an integrated biopsychosocial and medical assessment, including history, mental status, other physical examination elements as indicated, and recommendations. The evaluation may include communication with family or other sources, prescription of medications, and review and ordering of laboratory or other diagnostic studies.” (CPT 2013 guidelines)

### **33. 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.

### **34. Can 90791 and 90792 be used even if a patient has been seen within the past three years?**

Yes, the “past three years” restriction applies only to the use of New Patient Evaluation and Management codes, and does not apply to the psychiatric codes 90791 and 90792.

However, payers may establish benefit limitations on the frequency of assessments and reassessments.

### **35. 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?**

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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.

**36. Can our patients see a Psychiatric Nurse Practitioner for medication review, and then see their therapist following that appointment for psychotherapy?**

Yes, however, you cannot report a psychiatric diagnostic procedure (90791 or 90792) on the same day as psychotherapy. Instead, the nurse practitioner’s service could be reported with 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).

## Add-On Codes

**37. 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)

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

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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. Please see slide #46 of our [webinar held on November 9, 2012](#) for an example.

**39. Add-on Codes: On the CMS 1500, do we show separate charges for the add-on codes, or do we do one lump charge for the principal code and zero charge for the add-on?**

Check with your payers. They have likely assigned a rate to the add-on code; if they have assigned a rate and you have a zero, you would be undercompensated for your services.

**40. Can psychiatrists bill “add-on” codes with their E/M codes if they are not the primary clinician providing the client’s psychotherapy?**

Add-on codes can only be reported if the same practitioner delivers the E/M code and the add-on service. The work and documentation would need to support the reporting of the add-on code.

Note: the add-on interactive complexity code (90785) can only be added to an E/M code when the practitioner also adds the psychotherapy add-on code.

## Interactive Complexity

**41. 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.

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

For additional information about interactive complexity, please see:

- Slides 73-79 of [CPT Code Changes for 2013](#)

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- The AACAP's [Interactive Complexity Guide](#) for use of +90785,

#### **42. Can Interactive Complexity be reported for translation and interpretation services?**

While need for translation and interpretation service is among the criteria listed in CPT guidelines for interactive complexity, CMS has stated, “90785 generally should not be billed solely for the purpose of translation or interpretation services” as that may be a violation of federal statute.

### **Crisis Services**

#### **43. What are the new codes for crisis services?**

90839: Psychotherapy for crisis; first 60 minutes

+90840: each additional 30 minutes (listed separately in addition to the code for primary services) \*this is an add-on code

#### **44. Does the CPT time rule apply to the codes for crisis services?**

Yes. According to CPT guidelines, “90839 is used to report the first 30-74 minutes of psychotherapy for crisis on a given dates... Psychotherapy for crisis of less than 30 minutes total duration on a given date should be reported with 90832 or 90833 (when provided with evaluation and management services). Code 90840 is used to report additional block(s) of time, of up to 30 minutes each beyond the first 74 minutes.”

#### **45. 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.

### **Reimbursement Rates**

#### **46. Where can we find rates for each of these codes?**

Rates for individual services are 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.

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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](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.

## Other

### **46. How do we code for Telehealth or Telemedicine services?**

Coverage of such services should be confirmed with individual payer policy. CMS has developed guidelines for telehealth services that includes: which services are covered, allowed originating sites, covered practitioners, types of communication systems permitted, and billing and payment information.

In general, “You, the distant site practitioner, should submit claims for telehealth services using the appropriate CPT or HCPCS code for the professional service along with the telehealth modifier GT, ‘via interactive audio and video telecommunications systems’ (e.g., 99201 GT). By coding and billing the GT modifier with a covered telehealth procedure code, you are certifying that the beneficiary was present at an eligible originating site when the telehealth service was furnished.”

Read the full guidance: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/telehealthsrvcfsctsht.pdf>

## Additional Resources

### **47. 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](http://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](http://www.amabookstore.com) or (800) 621-8335.

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**48. Can I get a copy of the National Council’s webinar recordings and slides?**

The presentation slides and audio are all available on the National Council website.  
[www.thenationalcouncil.org/cs/cpt\\_codes](http://www.thenationalcouncil.org/cs/cpt_codes).

**49. 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](mailto:david.swann@mtmservices.org)  
Phone: (336) 710-3585

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## 2012 to 2013 Crosswalk for Major Psychiatry Codes

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](http://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)
<b>Diagnostic Procedures</b>						
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
<b>Psychotherapy</b>						
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
<b>Interactive Psychotherapy</b>						
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
<b>Other</b>						

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(None)	New code	<b>90839:</b> psychotherapy for crisis, first 60 minutes	+	<b>90840:</b> psychotherapy for crisis, each additional 30 min.		No
<b>90857:</b> interactive group psychotherapy	Deleted	<b>90853:</b> group psychotherapy (other than multiple-family group)	+	n/a	+	<b>90785</b>
<b>90862:</b> pharmacologic management	Deleted	Appropriate <b>E/M code</b>	+	<b>Yes</b> , according to psychotherapy time		No

## Evaluation and Management Codes for Office or Other Outpatient Services

From *Procedure Coding Handbook for Psychiatrists, Fourth Edition*, Chapter 4:  
 “Codes and Documentation for Evaluation and Management Services.” Retrieved from:  
<http://www.psych.org/File%20Library/Practice/Managing%20a%20Practice/CPT/Codes-Doc-forE-M-wVignettes.pdf>

### NEW PATIENT Office or Other Outpatient Services

**99201**— The three following components are required:

- Problem-focused history
- Problem-focused examination
- Medical decision making that is straightforward

Presenting problem(s): Self-limited or minor

Typical time: 10 minutes face-to-face with patient and/or family

**99202**— The three following components are required:

- Expanded problem-focused history
- Expanded problem-focused examination
- Medical decision making that is straightforward

Presenting problem(s): Low to moderate severity

Typical time: 20 minutes face-to-face with patient and/or family

**99203**— The three following components are required:

- Detailed history
- Detailed examination
- Medical decision making of low complexity

Presenting problem(s): Moderate severity

Typical time: 30 minutes face-to-face with patient and/or family

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**99204**— The three following components are required:

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

Presenting problem(s): Moderate to high severity

Typical time: 45 minutes face-to-face with patient and/or family

**99205**— The three following components are required:

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

Presenting problem(s): Moderate to high severity

Typical time: 60 minutes face-to-face with patient and/or family

### **ESTABLISHED PATIENT Office or Other Outpatient Services**

**99211**— This code is used for a service that may not require the presence of a physician. Presenting problems are minimal, and 5 minutes is the typical time that would be spent performing or supervising these services.

**99212**— Two of the three following components are required:

- Problem-focused history
- Problem-focused examination
- Medical decision making that is straightforward

Presenting problem(s): Self-limited or minor

Typical time: 10 minutes face-to-face with patient and/or family

**99213**— Two of the three following components are required:

- Expanded problem-focused history
- Expanded problem-focused examination
- Medical decision making of low complexity

Presenting problem(s): Low to moderate severity

Typical time: 15 minutes face-to-face with patient and/or family

**99214**— Two of the three following components are required:

- Detailed history
- Detailed examination

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- Medical decision making of moderate complexity

Presenting problem(s): Moderate to high severity

Typical time: 25 minutes face-to-face with patient and/or family

**99215**— Two of the three following components are required:

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

Presenting problem(s): Moderate to high severity

Typical time: 40 minutes face-to-face with patient and/or family

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