



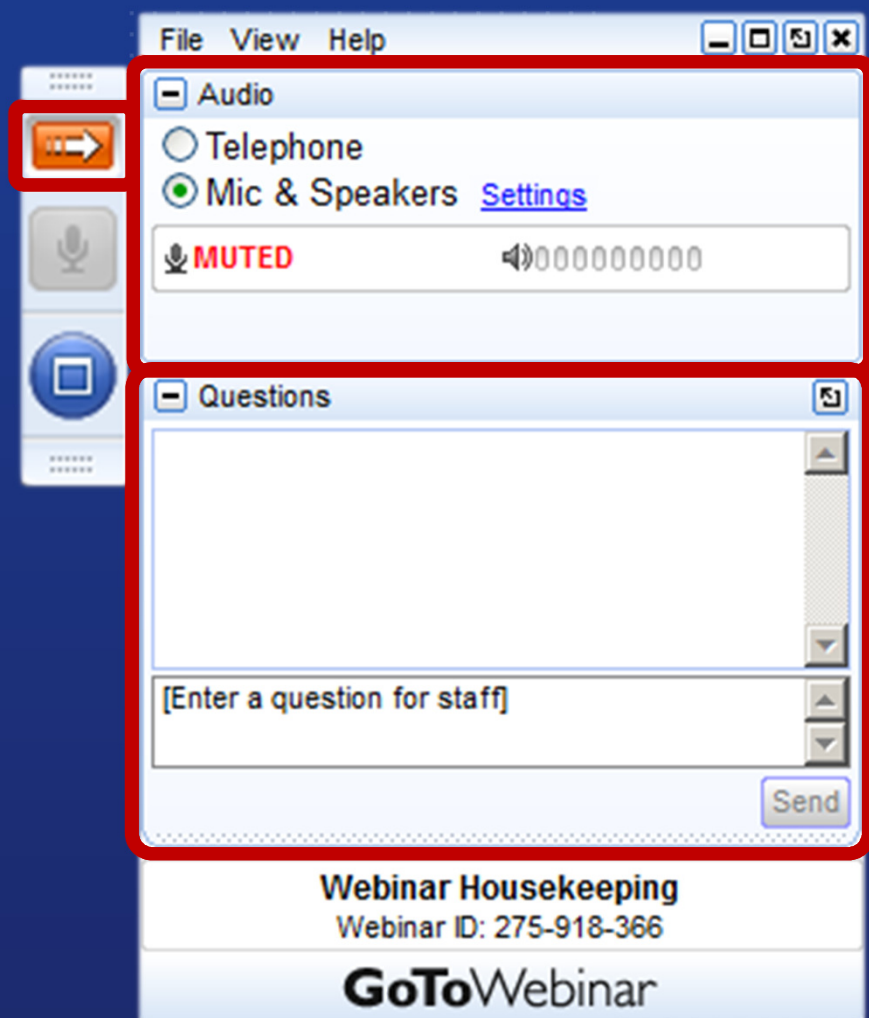
NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

NATIONAL COUNCIL LIVE

Webinars

CPT Code Changes for 2013: Impact on Behavioral Health

November 9, 2012



Open and close your control panel

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Note: Today’s presentation is being recorded and will be provided within 48 hours.



Today's Agenda

- > **Psychiatry Family of Codes Update**
Jeremy Musher, MD, DFAPA; President and CEO, Musher Group
- > **Readiness for New Compliance Requirements**
Adam J. Falcone, Esq.; Partner, Feldesman Tucker Leifer Fidell
- > **2013 CPT Code Changes in Detail**
David R. Swann, MA, LCAS, CCS, LPC, NCC;
Senior Healthcare Integration Consultant, MTM Services
- > **Preparing Your HIT**
- > **Additional Resources**
- > **Q&A**



Psychiatry Family of Codes Update

Jeremy Musher, MD, DFAPA
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MusherGroup.com



CPT Codes

- > **CPT Codes** are the numeric codes used for billing purposes

Not to be confused with:

- > **ICD-10** are the numeric codes used for diagnoses
- > Two different sets of numeric indicators



Revisions to CPT Codes

- > Every year there are new or revised codes within CPT
- > Periodically existing codes are reviewed by CPT
 - Compelling evidence must exist for changes to be considered
- > The last major change to the Psychiatry family of Codes was 1998
- > 2013 brings major changes to the entire family of psychiatry codes



Revisions Timeline

2011 through Summer 2012:

CPT Meetings:

Workgroup Recommendations reported to CPT
Panel

CPT Panel votes and forwards recommendations to
CMS

RUC Meeting:

Societies present data from member surveys and
expert panel recommendations.

RUC votes and forwards recommendations to CMS



Revisions Timeline, cont.

August 31, 2012:

CMS released electronic files to insurers on 2013 codes which makes new CPT codes “public”

November 1, 2012:

CMS released the Final Rule which made RVUs public for the new codes

January 1, 2013:

New codes go into effect



Roles

> AMERICAN MEDICAL ASSOCIATION

- **CPT** (Current Procedural Terminology Advisory Committee)
 - Where codes are created or revised
- **RUC** (Specialty Society RVS Update Committee)
 - Where codes are valued
- Both committees have CMS representation

> **CMS** (Centers for Medicare and Medicaid Services)

- Accepts recommendations from these AMA committees and makes final decision on codes and values



Reason for changes:

- > Last major update to Psychiatry Codes: 1998
- > Dramatic changes in the practice of psychiatry and behavioral health since 1998
- > Increased intensity of services due to increase in patient co-morbidities,
- > Shift from inpatient to outpatient settings with higher intensity of work,



Reason for changes

- > Inadequate code structure to account for
 - Varying levels of psychotherapy and medical management
 - Work differential performed by physicians and other qualified health care professionals
- > Interactive psychotherapy narrowly defined and inadequate to describe the work



Will the implementation be delayed?

NO!

HIPAA requires that CPT codes be implemented



Overview of New Codes

E/M Level Flexibility

- The OLD Psychotherapy Codes with Evaluation and Management (E/M), e.g. 90805, 90807, etc. →
 - time based for the psychotherapy,
 - E/M component was fixed at the lowest E/M level – equivalent to the E/M work that a nurse could do without a physician present
- The NEW codes allow for different levels of both psychotherapy work and E/M work



Overview of New Codes

Add On Codes

- Add On codes will be used for psychotherapy with E/M services
- Add On codes allow for a second code to be billed with a primary service code.
- *Interactive Complexity* Add On expands on interactive codes



Overview of New Codes

- All codes can be used in any site of service
- Psychotherapy codes remain time-based
- *90862 eliminated and replaced* by Evaluation and Management codes
- New *Crisis Psychotherapy* codes
- Final rule established “carrier pricing” for
 - Crisis Psychotherapy Codes



IMPACT

- Use of E/M codes is new to many behavioral health providers
 - Impact on documentation (national guidelines to be followed)
 - Contracts with payers
 - Billing systems
- Will small insurers and carve outs be ready for the changes January 1, 2013?



Readiness for New Compliance Requirements

Adam Falcone, Esq.

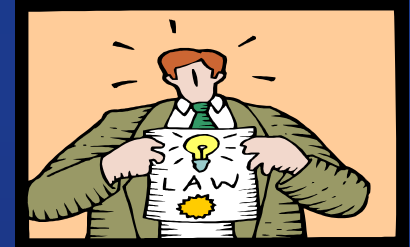
Partner,

Feldesman Tucker Leifer Fidell LLP

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Federal Requirements



- > Statute: Congress established the 60-day Overpayments Rule in the Affordable Care Act.
 - Effective date: upon enactment.
 - Codified at 42 U.S.C. § 1320a-7k(d).

- > Regulation: CMS issued a proposed rule on the 60-Day overpayment rule.
 - Applies only to Medicare Parts A and B, not Medicaid.
 - 77 Fed. Reg. 9179 (Feb. 16, 2012).



Statutory Requirements

- > What must providers do when they identify an “overpayment”?
 - 1) Report and return the overpayment to HHS, the State, an intermediary, a carrier, or a contractor, as appropriate; and
 - 2) Notify the entity in writing the reason for the overpayment.
- > When must providers report and return the overpayment?
 - 60 days from “identification” of the overpayment
 - Due date for corresponding cost report (if applicable)
 - Whichever is later.



Definition of Overpayments

- The definition of “overpayments” in the statute has three elements:
 - 1) Funds that a person receives or retains
 - 2) Payable under the Medicare or Medicaid programs
 - 3) To which the person, after applicable reconciliation, is not entitled.

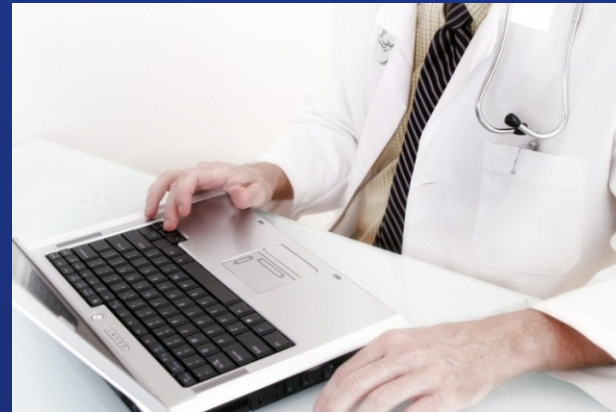




Definition of Overpayments

> What does it mean to be “not entitled” to funds?

- Proposed rule examples:
 - Incorrect service date
 - Duplicate payment
 - Incorrect CPT code
 - Insufficient documentation
 - Lack of medical necessity
- Does every technical violation result in an overpayment?
- What about violations of Anti-Kickback Statute, Stark?





Definition of Overpayments

> What does it mean to retain funds “after applicable reconciliation”?

- Proposed rule states that “applicable reconciliation” occurs with the provider’s submission of a cost report.
- Means that overpayments of any interim payments cannot exist before submission of the cost report.

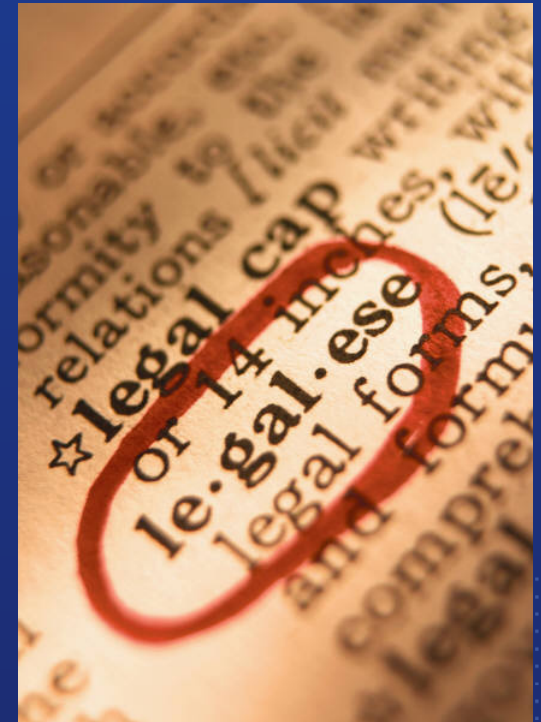




Definition of Overpayments

> In plain language, overpayments would include:

- Improperly submitted claims and
- Interim payments improperly retained after date cost report is due.

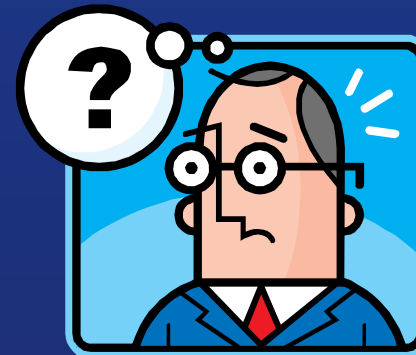




Identification of Overpayments

> The statute defines “knowing” and “knowingly” by referencing the definition contained in the False Claims Act:

- Actual knowledge
- Deliberate ignorance
- Reckless disregard



> However, the words “knowing” and “knowingly” never appear elsewhere in the statute after being defined.



Identification of Overpayments

> Proposed rule links “identification” to the “knowingly” standard.

- When information of a potential overpayment is received, the rule would create an obligation to make a reasonable inquiry .
- Failure to make inquiry “with all deliberate speed” would constitute knowing retention of overpayment.





Returning Overpayments

> To whom must providers return overpayments?

- Statute and proposed rule allow for reporting and notification to:
 - CMS
 - OIG
 - Medicaid agency
 - State enforcement agency
 - Medicare intermediary/carrier





Returning Overpayments

- > What options do providers have for returning overpayments?
 - Reverse payment with a reason code
 - Repayment using voluntary refund form
 - Self-disclosure to enforcement agency
 - Remit check for repayment, along with a written description of the reason for the overpayment
- > Proposed rule would require reporting and notification by using existing voluntary refund process adopted by many Medicare contractors.
 - CMS would standardize the form
- > Medicaid agencies may have their own processes in place.





Potential Penalties

> False Claims Act liability (31 U.S.C. § 3729, *et seq.*)

- Failure to return overpayments within time limits constitutes an “obligation” to the government.
- Knowingly and improperly avoiding or decreasing an obligation to pay money to the government constitutes a “reverse false claim”
- \$5,500-11,000 per reverse false claim
- Up to treble damages

True

☐

False





Potential Penalties

> Civil Monetary Penalties (42 U.S.C. § 1320a–7a(a)(10))



- The OIG may impose civil monetary penalties if a provider knows of an overpayment and does not report and return the overpayment.
 - \$10,000 per claim
 - Treble damages
- Additionally, the OIG may also exclude the provider from participation in Federal health care programs.



Identification of Overpayments

Recommendations for Compliance with the 60-Day Rule:

- 1) Ensure you have a mechanism for receiving reports of potential overpayments.
- 2) Promptly investigate any report of potential overpayment to document that “reasonable inquiry” occurred.
- 3) Document investigation to demonstrate that inquiry occurred with “all deliberate speed”.
- 4) Conduct coding, billing, and documentation audits on a regular basis to show that there has been no deliberate ignorance or reckless disregard of information about a potential overpayment.





Returning Overpayments

> Watch the Clock!

- Be diligent about timely reporting and returning overpayments.

> Do not draw too much attention!

- Minimize risk of triggering a government investigation.

> Get the help you need!

- Engage qualified legal counsel and financial consultants, as appropriate.





2013 CPT Code Changes in Detail

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MTM Services

www.mtmservices.org



CPT Codes Enhanced

- > “The new codes will enhance reporting of innovative diagnostic tools that will promote medicine's overarching goals of reducing disease burdens, improving health outcomes and reducing long-term care costs. Additional updates to the 2013 CPT code set reflect practice changes and technology improvements in neurologic testing and psychiatry.”

AMA Press Release September 17, 2012



Major Changes – Initial Psychiatric Diagnostic Procedures

- > Two new codes distinguish between
 - an initial evaluation with medical services provided by a physician (90792) and
 - an initial evaluation provided by a non-physician (90791).



Major Changes – Psychiatric Diagnostic Procedures - 90791

- > Initial Evaluation 90791 includes the following:
 - Assessment including history, mental status and recommendations
 - May include communication with family, others, and review and ordering of diagnostic studies



Major Changes – Psychiatric Diagnostic Procedures - 90792

- > Initial Evaluation 90792 with medical services and provided by a physician includes those services in (90791) AND:
- > Medical assessment beyond mental status as appropriate
- > May include communication with family, others, *prescription medications*, and review and ordering of *laboratory* or other diagnostic studies



Major Changes – Psychiatric Diagnostic Procedures

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



Major Changes – Psychiatric Diagnostic Procedures

- > May be reported more than once for a patient when *separate diagnostic evaluations* are conducted with the patient and other collaterals such as family members, guardians, and significant others.
- > Providers must use the patient's name for services reported under these codes.



Psychotherapy Overview

- > Psychotherapy codes are no longer site specific
- > Psychotherapy time includes face-to-face time spent with the patient and/or family member
- > Time is chosen according to the CPT time rule
- > Interactive psychotherapy is reported using the appropriate psychotherapy code along with the interactive complexity add-on code



Major Changes – Psychotherapy Procedures

- > Simplified and expanded to include both time with patient and/or family member.
- > Three codes using time for psychotherapy in all settings:
 1. 90832 – 30 minutes
 2. 90834 – 45 minutes
 3. 90837 – 60 minutes



Major Changes – Psychotherapy Procedures

- > All mental health professionals including psychologists, counselors, psychiatrists, nurses and social workers delivering psychotherapy services will use the same new codes for psychotherapy, though psychiatry will change how they bill for medical services.



Psychotherapy Procedures: Time Rule Applies

- > When time with patient and/or family crosses half of the time for the code, that code can be used.
 - When codes are in sequential times, choose the code with closest time
- > Example: *For up to 37 minutes you would use the 30 minute code; for 38 to 52 minutes, you would use the 45-minute code, 90834; and for 53 minutes and beyond, you would use 90837, the 60-minute code.*
- > Psychotherapy of less than 16 minutes is not reported
- > Patient must be present for all or some of the service



Pharmacological Management

- > Pharmacologic Management Code 90862 has been eliminated.
- > Psychiatrists must now use the appropriate E/M code for pharmacologic management when both psychotherapy and E/M is provided.
- > If reporting psychotherapy and E/M, pharmacologic management is considered part of E/M service
- > Do not count time of pharmacologic management in psychotherapy codes.
- > If providing only pharmacologic management, report only E/M service codes.
- > These changes will result in an increase use of E/M codes by psychiatrists.



Pharmacological Management – HCPCS Code

- > Healthcare Common Procedure Coding System Used by Medicare – HCPCS
- > **M0064** – Brief Office Visit for Monitoring or Changing Drug Prescriptions for the Treatment of Mental, Psychoneurotic, and Personality Disorders



Pharmacological Management for Non-Physicians (e.g. Prescribing Psychologists)

- > +90863 Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services
- > Add-on code reported only with psychotherapy codes 90832, 90834, 90837 (stand-alone psychotherapy codes)



Sample Use of Add On Codes

24.	A						B	C	D			E
	DATE(S) OF SERVICE						Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			DIAGNOSIS CODE
	From	To							CPT/HCPCS	MODIFIER		
	MM	DD	YY	MM	DD	YY						
1	02	05	2013	02	05	2013	11	1	90832			296.23
2	02	05	2013	02	05	2013	11	1	90863			296.23
3												
4												
5												
6												

Add On code for
Pharmacologic Management
(only to be used when
performed with
psychotherapy services)



E/M Codes

- > E/M codes are a category of CPT codes
- > E/M codes specifically begin with 99.
- > E/M subsequent numbers depend on the type of E&M.
- > A level 1 (last digit a 1) is the least complex
- > A level 2 (last digit a 2) is greater complexity
- > The highest code level will end in a 3 (an inpatient hospital admission), or a 5 (Outpatient or consultations).



E/M Coding

- > Each individual code listed has three components that qualify physicians to work for the specific code:
 - 1) History
 - 2) Examination
 - 3) Medical Decision Making (MDM)



How To Select E/M Service Codes

- > Selecting code from proper category
- > Selecting appropriate level of service
- > Supporting selection with documentation
- > Meets CPT definitions
- > Meets CMS Documentation Guidelines



How To Select E/M Service Codes

- > Includes services medically necessary to evaluate/tx the patient
- > Code selection must be supported by “work” and “medical necessity”
- > *Medical necessity* of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code



Medical Decision Making

- > There are three components:
 1. Risk to patient,
 2. Amount and complexity of data,
 3. Diagnosis.

- > The complexity of MDM is the lowest of the two highest components.



Major Changes – Psychotherapy and E/M Procedures

- > If patient receives medical E/M service and psychotherapy service on the same day by the same provider, report:
 - E/M code at the appropriate level AND
 - Psychotherapy add-on code (90833, 90836, 90838)
- > The two services must be significant and separately identifiable
- > A separate diagnosis is not required



Major Changes – Psychotherapy and E/M Procedures

- > Reporting both E/M and psychotherapy codes
 - Type and level of E/M is selected first based on the key components (history, exam, MDM)
 - Time may not be used as basis of E/M code selection
 - Psychotherapy service code based on time providing psychotherapy
 - Time providing E/M activities is not considered in selection of time-based psychotherapy code



Major Changes – Psychotherapy Procedures: Add On Codes with E/M

- > When psychotherapy is done in the same encounter as an E/M service and by the same provider, there are timed add-on codes for psychotherapy (indicated in CPT by the + symbol) that are to be used by psychiatrists to indicate both services were provided (+90833 -30 minutes, +90836 - 45 minutes, +90838 – 60 minutes). Each procedure can be with the patient and/or family member.
- > Both services must be separately identifiable.



E/M Levels

Level Of Exam

Problem Focused

Expanded Problem Focused

Detailed

Comprehensive



E/M and Time – Level

- > Time may be the factor used for the selection of the Level of the E/M Service when counseling or coordination of care dominates the encounter more than 50 percent EXCEPT when done in conjunction with a psychotherapy visit.



Counseling and E/M

- > When Discussing with the Patient or Family any of the following:
 - Prognosis
 - Test Results
 - Instructions
 - Risk Reduction
 - Education
 - Compliance/Adherence



E/M Outpatient Services, Codes and 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



E/M New Patient Visit

Level	E/M Code	History	Physical Exam	MDM	Time
1	99201	Problem Focused	Problem Focused	Straightforward	10
2	99202	EPF	EPF	Straightforward	20
3	99203	Detailed	Detailed	Low	30
4	99204	Comprehensive	Comprehensive	Moderate	45
5	99205	Comprehensive	Comprehensive	High	60



CPT E/M New Patient Definition

Solely for the purposes of distinguishing between new and established patients, professional services are those face to face services rendered by a physician and reported by a specific CPT code(s).

A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.



E/M Established Patient Visit

Level	E/M Code	History	Physical Exam	MDM	Time
1	99211	None	None	None	5
2	99212	Problem Focused	Problem Focused	Straightforward	10
3	99213	EPF	EPF	Low	15
4	99214	Detailed	Detailed	Moderate	25
5	99215	Comprehensive	Comprehensive	High	40



CPT E/M Established Patient Definition

An established patient is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past 3 years.

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



E/M Office Consultation Visit

Level	E/M Code	History	Physical Exam	MDM	Time
1	99241	Problem Focused	Problem Focused	Straightforward	15
2	99242	EPF	EPF	Straightforward	30
3	99243	Detailed	Detailed	Low	40
4	99244	Comprehensive	Comprehensive	Moderate	60
5	99245	Comprehensive	Comprehensive	High	80



CPT E/M Consultation Definition

- > A service provided by a physician at the request of another physician or other appropriate source:
 - To recommend care for a specific condition, or problem OR
 - To determine whether to accept responsibility for the ongoing management of the patient's entire care or care of a specific condition or problem.



Major Changes – CPT Behavioral Health

- > Allows all codes to be reported in all settings without regard to site
- > Hospital care for psychiatric inpatient or partial hospitalization may be reported using E/M codes (99221-99233)
- > If services such as ECT or psychotherapy are provided in addition to hospital E/M services, both E/M and other service can be reported



Major Changes – Psychotherapy Procedures

- > A new code has been added for psychotherapy for a patient in crisis (90839).
- > When a crisis encounter goes beyond 60 minutes there is an add-on code for each additional 30 minutes (+90840).



Psychotherapy For Crisis Services Defined

- > “An urgent assessment and history of a crisis state, a mental status exam, and a disposition. The treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma. The presenting problem is typically life threatening or complex and requires immediate attention to a patient in high distress.”



Psychotherapy for Crisis Services

- > 90839 Psychotherapy for crisis; first 60 minutes
- > +90840 Each additional 30 minutes
- > Used to report total duration of face-to-face time with the patient and/or family providing psychotherapy for crisis
- > Time does not have to be continuous
- > Provider must devote full attention to patient and cannot provide services to other patients during time period.



Psychotherapy for Crisis Services

- > 90839 (60 min) used for first 30-74 minutes
- > Reported only once per day
- > 90840 (each additional 30 min) report for up to 30 minutes each beyond 74 minutes
- > Example: 120 min of crisis therapy reported:
 - 90839 X 1
 - 90840 X 2
- > Less than 30 minutes reported with codes 90832 or 90833 (psychotherapy 30 min)



Psychotherapy for Crisis Services

- > Presenting problem typically life-threatening or complex and requires immediate attention to a patient in high distress

Codes include:

- Urgent assessment and history of crisis state
- Mental status exam
- Disposition



Psychotherapy for Crisis Services

> Treatment includes:

- Psychotherapy
- Mobilization of resources to diffuse crisis and restore safety
- Implementation of psychotherapeutic interventions to minimize potential for psychological trauma



Psychotherapy for Crisis Services

> Codes for crisis services cannot be reported in combination with:

- 90791, 90792 (diagnostic services)
- 90832-90838 (psychotherapy)
- 90785 (interactive complexity)



Interactive Complexity

- > +90785 Interactive complexity
- > Add-on code to be reported with:
 - Diagnostic Evaluations (90791-90992)
 - Psychotherapy (90833-90838)
 - E/M codes (99201-99255; 99304-99377; 99341-99350)
 - Group Psychotherapy (90853)



Interactive Complexity

- > Add on code for interactive complexity which may be used when the patient encounter is made more complex by the need to involve people other than the patient (+90785).
- > Can be used with initial evaluation codes (90791 and 90792)
- > Can be used with the psychotherapy codes
- > Can be used with the non-family group psychotherapy code (90853)
- > Can be used with E/M codes when they're used in conjunction with psychotherapy services



Interactive Complexity - conditions

- > Refers to specific communication factors complicating delivery of psychiatric service
- > Common factors include:
 - Discordant or emotional family members
 - Young and verbally undeveloped
 - Impaired patients



Interactive Complexity - conditions

- > Factors typically present with patients who:
- > Have others legally responsible for their care
- > Request others to be involved in care during visit
- > Require the involvement of other third parties



Interactive Complexity - Requirements

- > Code can be reported when at least one of the following is present:
 - Need to manage maladaptive communication that complicates care delivery
 - Caregiver's emotions or behaviors interferes with ability to assist in treatment plan
 - Evidence or disclosure of sentinel event and mandated report to state agency with initiation of discussion of event and/or report



Interactive Complexity - Requirements

- > Use of play equipment, or other physical devices, interpreter, or translator for communication with patient who:
 - Is not fluent in same language as provider
 - Has not developed, or has lost, expressive or receptive communication skills necessary for treatment



Interactive Complexity

- > Time spent on Interactive Complexity service is to be reflected in time of psychotherapy code reported
- > Interactive Complexity service is not a factor for selecting E/M code except as it affects key components



CPT Documentation Guidelines – Getting it Right

Two sets of guidelines in place:

- > AMA's CPT Documentation Guidelines
- > CMS Documentation Guidelines



Documentation Guidelines

- > Use the guidelines that are designated by the payer.
- > The CMS Documentation Guidelines are used for most Medicaid (depending on the State) and all Medicare.



Documentation Guidelines

1997 Content & Documentation Requirements for Psychiatric Examination is recommended because of single organ systems.



Content and Documentation Requirements for Psychiatric Evaluation*

LEVEL OF EXAM	PERFORM AND DOCUMENT
Problem Focused	1-5 Elements Identified by a Bullet
Expanded Problem Focused	At least 6 Elements Identified by a Bullet
Detailed	At least 9 Elements Identified by a Bullet
Comprehensive	Perform all Elements by a Bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.
*Reference: CMS Documentation Guidelines for E/M Services - 1997	



Outpatient E/M for New Patient

New Patient	99201	99202	99203	99204	99205
HISTORY					
Chief Complaint	Required	Required	Required	Required	Required
History of Present Illness	1-3 Elements	1-3 Elements	4 + Elements	4+ Elements	4+ Elements
ROS*	NA	Pertinent	2-9 Systems	10-14 Systems	10-14 Systems
PFSH**	NA	NA	1 of 3 Elements	3 of 3 Elements	3 of 3 Elements
EXAMINATION					
1997 CMS Doc. Guidelines	1-5 Bulleted Elements	6-8 Bulleted Elements	9 or More Bulleted Elements	Comprehensive	Comprehensive
MEDICAL DECISION MAKING					
	Straight Forward	Straight Forward	Low	Moderate	High
TIME					
Face-to- Face	10 min	20 min	30 min	45 min	60 min



Outpatient E/M for Established Patients

Estab. Patient	99211	99212	99213	99214	99215
HISTORY					
Chief Complaint	NA	Required	Required	Required	Required
History of Present Illness	NA	1-3 Elements	1-3 Elements	4+ Elements	4+ Elements
ROS*	NA	NA	Pertinent	2-9 Systems	10-14 Systems
PFSH**	NA	NA	NA	1 of 3 Elements	2 of 3 Elements
EXAMINATION					
1997 CMS Doc. Guidelines	NA	1-5 Bulleted Elements	6-8 Bulleted Elements	9 or more Elements	Comprehensive
MEDICAL DECISION MAKING					
	NA	Straight Forward	Low	Moderate	High
TIME					
Face-to- Face	5 min	10 min	15 min	25 min	40 min



Impact of CPT Code Revisions on Practices

- > Procedure code simplification
- > Decisions about rates and limitations are still to be decided by payers
- > The greater usage of E/M codes by psychiatrists will demand that the work and documentation support the E/M code
- > Errors in coding may result in reduced reimbursement



Impact of CPT Code Revisions on Practices

- > Knowledge of E/M coding will be necessary to ensure that psychiatrists and other qualified professionals receive appropriate reimbursement
- > Contracts with payers will need to be revised to include the coding changes



Impact of CPT Code Revisions on Practices

- > Medicaid limits E/M procedures in certain states and may be more rapidly exhausted if Psychiatrists use E/M codes to a greater extent.
- > Research with payers between now and January 1, 2013!



AccuMed

Already equipped to handle the upcoming changes.

A product update is NOT required for these changes.

Recommend downloading [“2013 CPT Coding Changes,”](#) which includes screen shots to assist in entering the codes for 2013.

Preparing Your HIT Systems



Preparing Your HIT, cont.

CoCentrix

Has developed a [document](#) designed to provide suggested Service Item and/or PCR set-up changes based on each of the major categories of mandated 2013 CPT coding changes.

Core Solutions, Inc.

CORE's Cx360 platform is designed to accommodate these changes with appropriate updates to configuration. Will be conducting a webinar in December to help customers understand how to update the system with the new codes.



Preparing Your HIT, cont.

Credible

Have been in touch with partners about the changes.

Providing best practices and training.

Are programming inside the November release cycle.

DeFran

Changes are easily accommodated in Evolv-CS

Will provide specific guidance in the coming weeks to our customers through our [support site](#).



Preparing Your HIT, cont.

ECHO Group

Software already has the ability to handle the CPT changes.

Can put start/end date ranges on codes and other billing configurations to allow transition payer by payer

eHana

eHana EHR fully supports the transition to the 2013 codes, including supporting the legacy codes for payers not yet ready to switch over on January 1st. More information can be found on our [website](#).



Preparing Your HIT, cont.

Netsmart

Changes focus heavily on user experience, take into account interactive complexity and add-on codes, length of the visit and other areas to provide guidance.

Questions? [Reference document](#) or contact Client Alignment Executive.

Qualifacts

CareLogic Enterprise already supports the CPT code changes where only the five-digit CPT code has changed, through its [cloud-based software](#). Evaluating changes necessary for E/M, interactive complexity and add-on codes.



Resources

- > AMA Code Book www.amabookstore.com or 1-800-621-8335
- > [National Council webpage](#) dedicated to the CPT changes with resources such as:
 - [The National Council for Community Behavioral Healthcare Crosswalk: 2012-2013 CPT Code Sets](#)
- > *Compliance Watch*, new CPT series



Resources

- > Center for Medicare and Medicaid Services (CMS)

<http://www.cms.gov/Medicare/Medicare.html?redirect=/home/medicare.asp>

- > American Psychiatric Association

<http://www.psych.org/practice/managing-a-practice/cpt-changes-2013>

- > 1997 Documentation Guidelines for Evaluation and Management Services

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf>



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ATTENDEES



Q&A

1. Will implementation of these changes be postponed by CMS and other payers?
2. Where can we find rates for these codes?
3. By using E/M codes, will psychiatrists have to take blood pressure and other physical health care measurements?



Presenter Contact Information

Q&A

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Coming Up

National Council Webinar:

E/M 101: Preparing Your Organization for 2013 CPT Code Changes

- December 3, 2012
- 1:00-3:00pm EST
- Online registration open now at
www.thenationalcouncil.org

Stay informed at:

http://www.thenationalcouncil.org/cs/cpt_codes