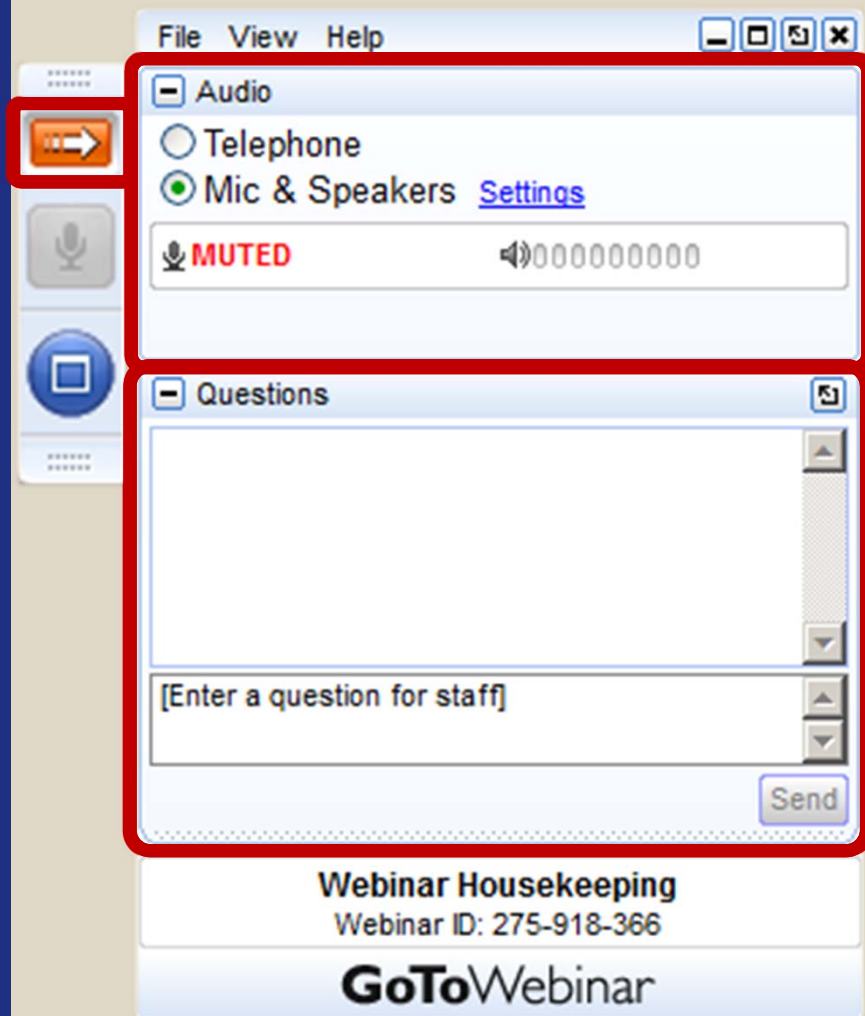




CPT Code Changes: E/M 102, Level Selection and Documentation Support

January 9, 2013

Slides available for download at:
www.TheNationalCouncil.org/CS/CPT_Codes



Open and close your control panel

Join audio:

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



Today's Agenda

- > Overarching CPT Code Changes for 2013
- > E/M Codes: Which Practitioners Can Use Them
- > New vs. Established Patients
- > E/M Level Selection
- > Pharmacologic Management
- > Interactive Complexity
- > Prolonged Psychotherapy Services
- > Additional Resources
- > Q&A



Today's Speakers

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CPT Codes are:

> **Procedure codes**

Diagnostic Codes
Rates
Policy Decisions

> **Established by the AMA, with CMS**

Individual
Payers

> **Reviewed annually**, although biggest changes to psychiatry section since 1998

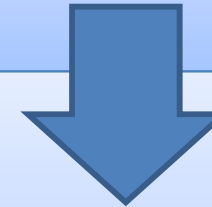
And tight timelines



Implementation of 2013 Changes

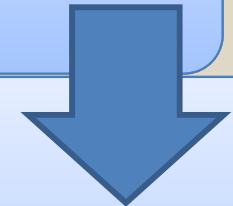
Code Changes

- Stakeholder input process
- Additions, deletions, modifications
- CMS approval and preliminary notification



Payer Valuation of Codes

- Independent decisions
- Often expressed in relation to Medicare rates
- For public agencies, may require regulatory changes



Provider and Other Stakeholder Preparation

- Alignment of HIT systems and charge sheets
- Amendments to contracts and provider agreements
- Documentation trainings for direct service providers and compliance staff



2013 and Behavioral Health Shift to Evaluation/Management

- > Removal of “combination codes” for psychotherapy and evaluation/management (90805, 90807)
- > Elimination of Medication Management codes in Psychotherapy section for providers who can use E/M codes for pharmacologic management

Additional changes:

- > New psychotherapy codes: time, place, number
- > Addition of codes for crisis services
- > Add-on codes for interactive complexity



Implementation on January 1, 2013

- > Effective date required under HIPAA
- > Implementation has not been delayed
- > Individual carriers transitioning into new codes (interactive complexity, crisis codes, rates for add-on psychotherapy codes) at different time frames



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).



Initial Psychiatric Diagnostic Procedure: 90791

> Initial Evaluation 90791 includes the following:

- Biopsychosocial assessment including history, mental status and recommendations
- May include communication with family, others, and review and ordering of diagnostic studies



Initial Psychiatric Diagnostic Evaluation with Medical Services: 90792

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



Reporting 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.



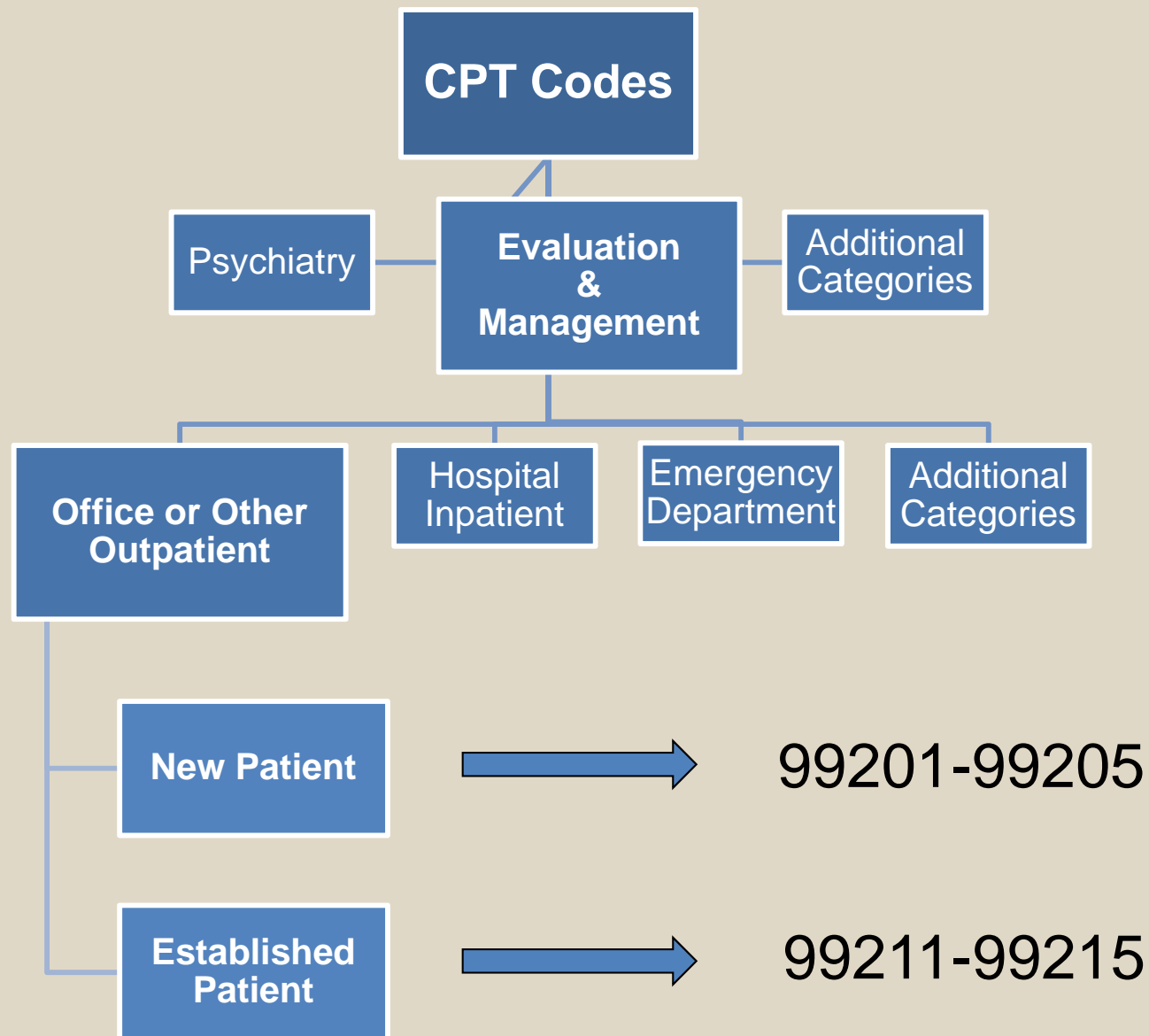
Reporting Psychiatric Diagnostic Procedures, cont.

- > 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.



E/M, 90791 and 90792: Which to Use?

- > Rates for 90791 are higher than 90792, even though 90792 includes medical services
- > Carrier limits on 90791 and 90792
- > Risk of using 90791 as a physician just because rate is higher than 90792





Evaluation/Management Codes

- > Psychiatrists, Physician Extenders, Nurse Practitioners and others who are licensed to perform medical activities must use E/M codes for services such as medication management
- > These codes are the same ones all physicians use for similar services, and use the numbers 99XXX
- > Documentation requirements are much more specific for these codes and require addressing various degrees of medical complexity
- > APA has a training program online for members in the use of these codes
- > Other mental health professionals do not use these codes



Evaluation/Management Codes, cont.

- > E/M codes, since they are a category of CPT codes, are comprised of five digits
- > 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)



Recovery Audit Finding: Not a New Patient – Incorrect Coding

- > Recovery Auditor Contractors (RACs) determined that providers are incorrectly billing new patient services for reimbursement under Medicare Part B.
- > New patient Evaluation and Management (E/M) services for the same beneficiary within a 3-year period should not be billed to Medicare.
- > A problem exists when multiple new patient E/M services are reimbursed under Medicare Part B inside of this time frame.
 - *CMS, Medicare Quarterly Provider Compliance Newsletter, (February 2011).*



CPT E/M New Patient Definition

- > 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.”
- > 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).



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 and subspecialty 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.



New or Established Patient?

- > 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?

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.



New or Established Patient?

- > 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.



New or Established Patient?

- > 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.



New or Established Patient?

- > 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.



New or Established Patient?

- > 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.



New or Established Patient?

- > 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.



Non-Physician Practitioners

- > A new patient is defined as an individual who has not received any professional services from the physician/non-physician practitioner (NPP) or another physician of the same specialty who belongs to the same group practice within the previous three years.
- > An established patient is an individual who has received professional services from the physician/NPP or another physician of the same specialty who belongs to the same group practice within the previous three years.
- > *CMS, Evaluation and Management Services Guide (December 2010).*



Medicare – New Patient Definition

- > Medicare's definition of a new patient, taken from the Chapter 12 of the Medicare Claims Processing Manual, instructs:
- > “Interpret the phrase ‘new patient’ to mean a patient who has not received any professional services, i.e., E/M 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” [emphasis added.]



New or Established Patient?

- > Tom has been receiving psychotherapy from Nurse Jones, a N.P.
 - The following week he sees a psychiatrist for an office visit.
 - Is Tom a new patient?

Yes. Although Tom was seen by a N.P., he did not received an E/M or other “medical service.” Because he has not received a medical service from the organization in the last three years, he is considered a new patient.



New or Established Patient?

- > Dr. Smith, a General Psychiatrist, practices for ABC Behavioral Health Services in one of their 6 behavioral health offices within the state of Ohio.
- > Dr. Smith sees John, a depressed patient on October 1, 2011. John relocates to Mayberry, Ohio, where there is another ABC Behavioral Health Services, and is seen by Dr. Jones, who is also employed by ABC Behavioral Health Services.
- > Each office of ABC Behavioral Health Services maintains their own medical records and one office doesn't have access to another's medical records.
- > Is John a New patient?

It depends on how group practice is defined. For example, WPS (a Medicare Part B carrier) defines group practice by Federal Tax Identification Number (TIN). If ABC bills under a single TIN, then John is not a new patient.



Important Caveats on Proper Coding

- > Medicare does not always speak with one voice.
 - Local Medicare policies can dictate coding rules.

- > Medicare is not the only payor.
 - Payor policies make a difference.



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Services Should Always Be Medically Necessary



Two Paths to E/M Selection

Path One

- Based on the **Elements** (History, Exam, and Medical Decision Making)

Path Two

- Basing the code on **Time** (when Counseling and/or Coordination of Care > 50% time)
- If you are using an add on psychotherapy code, you cannot use time as the basis of selecting the code for the E/M portion of the work.



SELECTING E/M CODES

Path One 

Based on the Elements
History, Exam, and MDM



E/M Level Selection

History

Chief Complaint

History of Present Illness (HPI)

Past, Family and/or Social History (PFSH)

Review of Systems (ROS)

Exam

Number of system/body areas examined

“Bullets” or elements completed within specific systems

Medical Decision Making

Number of Diagnoses or Management Options

Amount and/or Complexity of Data to be Reviewed

Risk of Significant Complications, Morbidity, and/or Mortality

* Each line impacts kind of History, Exam, and MDM



“Bullets?”

Reference:
***CMS 1997 Documentation
Guidelines for Evaluation &
Management Services***

**Includes guidelines for
single-organ examinations,
like Psychiatry**

***Link available on
National Council's
CPT Resource Page***

1997 DOCUMENTATION GUIDELINES FOR EVALUATION AND MANAGEMENT SERVICES

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“Bullets?”

Excerpt from Psychiatry section of 1997 *Documentation Guidelines for Evaluation & Management Services*

Link available on
National Council's
[CPT Resource
Page](#)

System/Body Area	Elements of Examination
Psychiatric	<ul style="list-style-type: none"> • Description of speech including: rate; volume; articulation; coherence; and spontaneity with notation of abnormalities (eg, perseveration, paucity of language) • Description of thought processes including: rate of thoughts; content of thoughts (eg, logical vs. illogical, tangential); abstract reasoning; and computation • Description of associations (eg, loose, tangential, circumstantial, intact) • Description of abnormal or psychotic thoughts including: hallucinations; delusions; preoccupation with violence; homicidal or suicidal ideation; and obsessions • Description of the patient's judgment (eg, concerning everyday activities and social situations) and insight (eg, concerning psychiatric condition) <p>Complete mental status examination including</p> <ul style="list-style-type: none"> • Orientation to time, place and person • Recent and remote memory • Attention span and concentration • Language (eg, naming objects, repeating phrases) • Fund of knowledge (eg, awareness of current events, past history, vocabulary) • Mood and affect (eg, depression, anxiety, agitation, hypomania, lability)

Content and Documentation Requirements

Level of Exam

Perform and Document:

Problem Focused

One to five elements identified by a bullet.

Expanded Problem Focused

At least six elements identified by a bullet.

Detailed

At least nine elements identified by a bullet.

Comprehensive

Perform **all** elements identified 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.



E/M New Patient Visit

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

Requires 3 out of 3 components for History, Exam, MDM



E/M Established Patient Visit

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

Requires 2 out of 3 components for History, Exam, MDM



Example: 99212 vs. 99213

Level	E/M Code	History	Exam	Medical Decision Making	Time
2	99212	Problem Focused	Problem Focused	Straightforward	10
3	99213	Expanded Problem Focused	Expanded Problem Focused	Low	15
Distinction between 99212 vs. -213		Number of Systems Reviewed (N/A vs. 1 system)	Number of bullets reviewed (1-5 bullets vs. at least 6 bullets)	Problem Points, Data Pts, or Risk levels (0-1 vs. 2; 0-1 vs. 2; minimal vs. low)	n/a for this ex.

Requires **2 out of 3 components** for History, Exam, MDM; in this example, **not** selecting based on time



Outpatient E/M for Established Patients

	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
PHYSICAL 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



Example: 99212 or 99213?

A 42-year-old male established patient with a history of bipolar II disorder, last seen 2 months prior, is seen for an office visit. Interval history taking focuses on the presence/absence of symptoms, the patient's level of social/vocational function, and the patient's adherence to the medication regimen. A mental status examination focuses on the patient's affective state. The patient's lithium blood level is reviewed. The side effects of the medication are reviewed, and prescriptions for the same medications are provided.



Example, cont.

> History:

- Chief complaint: yes → *Always Required*
- HPI: 1-2 chronic conditions reviewed → *Brief*
- PFSH: No additional review → *N/A*
- ROS: Reviewed one system (psychiatric) → *Problem Pertinent = Expanded Problem Focused*

> **Exam:** Mood and Affect = 1 bullet = **Problem Focused**

> **Medical Decision Making:** Estab. Prob/Stable = 1 pt.

> Li Level is reviewed = 1 pt., Moderate risk with Rx mgt,
= **Straightforward Complexity of MDM**



Answer: 99213

A 42-year-old male established patient with a history of bipolar II disorder, last seen 2 months prior, is seen for an office visit. Interval history taking focuses on the presence/absence of symptoms, the patient's level of social/vocational function, and the patient's adherence to the medication regimen. A mental status examination focuses on the patient's affective state. The patient's lithium blood level is reviewed. The side effects of the medication are reviewed, and prescriptions for the same medications are provided.

Explanation for code choice: In order to make a decision about medications, the psychiatrist must do an **expanded problem-focused history and examination**. An expanded problem-focused history includes one to three elements of a review of systems. The actual medical decision to continue the medication regimen is of **low complexity**. Requires 2 of the 3 to match.



Outpatient E/M for Established Patients

Established	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
PHYSICAL 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



Outpatient E/M for New Patients

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
PHYSICAL 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



Additional Resource for Level Selection

Coding by Key
Components created by
the *American Academy
of Child & Adolescent
Psychiatry*

*Link available on
National Council's
[CPT Resource Page](#)*

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Evaluation and Management Services Guide Coding by Key Components

AMERICAN ACADEMY OF
CHILD & ADOLESCENT
PSYCHIATRY
WWW.AACAP.ORG

History	Chief Complaint (CC)		History of present illness (HPI)		Past, family, social history (PFSH)		Review of systems (ROS)				
	Reason for the visit		Location; Severity; Timing; Quality; Duration; Context; Modifying Factors; Associated signs and symptoms		Past medical; Family medical; Social		Constitutional; Eyes; Ears, Nose, Mouth, and Throat; Cardiovascular; Respiratory; Genitourinary; Musculoskeletal; Gastrointestinal; Skin/Breast; Neurological; Psychiatric; Endocrine; Hematologic/Lymphatic; Allergic/Immunologic				
	CC		HPI		PFSH		ROS		History Type		
	Yes	Brief (1-3 elements or 1-2 chronic conditions)		N/A		N/A		Problem pertinent (1 system)		Problem focused (PF)	
		Extended (4 elements or 3 chronic conditions)		Pertinent (1 element)		Extended (2-9 systems)		Expanded problem focused (EPF)			
Complete (2 elements (est) or 3 elements (new/initial))				Complete (10-14 systems)		Detailed (DET)					
								Comprehensive (COMP)			
Examination	System/body area				Examination						
	Constitutional		<ul style="list-style-type: none">3/7 vital signs: sitting or standing BP, supine BP, pulse rate and regularity, respiration, temperature, height, weightGeneral appearance								
	Musculoskeletal		<ul style="list-style-type: none">Muscle strength and toneGait and station								
	Psychiatric		<ul style="list-style-type: none">SpeechThought processAssociationsAbnormal/psychotic thoughtsJudgment and insightOrientationRecent and remote memoryAttention and concentrationLanguageFund of knowledgeMood and affect								
	Examination Elements				Examination type						
	1-5 bullets				Problem focused (PF)						
	At least 6 bullets				Expanded problem focused (EPF)						
	At least 9 bullets				Detailed (DET)						
	All bullets in Constitutional and Psychiatric (shaded) boxes and 1 bullet in Musculoskeletal (unshaded) box				Comprehensive (COMP)						
	Med Dec Making	Medical Decision Making Element				Determined by					
Number of diagnoses or management options				Problem points chart							
Amount and/or complexity of data to be reviewed				Data points chart							
Risk of significant complications, morbidity, and/or mortality				Table of risk							
Problem Points											
Category of Problems/Major New symptoms				Points per problem							
Self-limiting or minor (stable, improved, or worsening) (max=2)				1							
Established problem (to examining physician); stable or improved				1							
Established problem (to examining physician); worsening				2							
New problem (to examining physician); no additional workup or diagnostic procedures ordered (max=1)				3							
New problem (to examining physician); additional workup planned*				4							
*Additional workup does not include referring patient to another physician for future care											



Example #2

99203: Office Visit, New Patient

A 27-year-old woman with a history of depression who is visiting the area is seen in an initial office visit. She is currently under treatment in her hometown. History taking focuses on a review of her past psychiatric history, present illness, and interval history since her last visit to her treating psychiatrist. Her medication history is reviewed, as is her side-effect history. A mental status examination focuses on her current affective state, ability to attend and concentrate, and insight. A prescription for an antidepressant is provided, along with education on its use and side effects.

Explanation for code choice: Although a new patient to the examining psychiatrist, this patient has an existing treatment source. The psychiatrist obtains a detailed history and performs a detailed mental status examination (Requires at least 9 bulleted elements). (A detailed history requires a detailed [two to nine elements] review of symptoms.) The provision of a prescription requires medical decision making of low complexity. Requires 3 of 3



Example #3

99205: Office Visit, New Patient

A 38-year-old man brought by his parents for evaluation of paranoid delusions and alcohol abuse is seen in an initial office visit. History taking focuses on the family history of mental illness. The past medical and psychiatric history, history of present illness, and social history of the patient are taken. The results of a mental status examination reveal a poorly groomed individual, poor eye contact, no spontaneity to speech, flat affect, no hallucinations, paranoid delusions about the police, no suicidal/homicidal ideation, and intact cognitive status. The patient has no history of current medical problems. The patient denies alcohol use. The parents are interviewed and provide a history of the patient that includes at least 5 years of binge drinking. Routine blood studies are ordered. The patient's vital signs are taken. A prescription for a neuroleptic is given, and education about medication is provided to the patient and the parents. Referrals to a dual-diagnosis treatment program and Alcoholics Anonymous are made.



Example #3

99205: Office Visit, New Patient (continued)

Explanation for code choice: This initial evaluation requires complex (high) medical decision making because of the psychotic symptoms in the context of alcohol

abuse. The psychiatrist must complete a comprehensive history and examination. The comprehensive history includes a complete review of systems. HPI extended; PFSH 3 elements; ROS complete = Comprehensive Hx.

Exam = all bullets in shaded box and 1 bullet in unshaded (musculoskeletal)

MDM= High risk; Problem pt. (4); Data pt. 1+1; = High Complexity



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



Alternative Pharmacological Management Code – 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



Example #4: “Pharmacologic Management”

- > 9 yo male seen for follow up visit for ADHD. Visit attended by patient and mother, history obtained from both. Grades are good, but patient distracted in class. Lunch appetite poor but eats well at other meals. No problems with depression, anxiety, sleep.
- > He appears dressed appropriately, interacts well, has normal rate and tone of speech, there is no HI/SI or psychosis, associations intact, he is oriented x3, he is euthymic and affect is appropriate.



Example #4 Pharmacologic Management

- > Problem 1: ADHD
- > Comment: Relatively stable, mild sx.s.
- > Plan: Renew Ritalin, increase dose
 - Recheck in 2 months



Example #4 Pharmacologic Management – Code 99213

- > **HX:** Expanded Problem Focused: Brief (1-3): associated signs and sxs, quality, context
 ROS: Problem pertinent: 1 system (psychiatric)
- > **EXAM:** Expanded problem focused: **at least 6**
- > **MDM(LOW):** Problem: **1 pt.** Established, Minimal
 Data: Obtain info from someone else besides the patient= 2, limited
 Risk: Chronic illness with mild exacerbation=moderate, manage with prescription



Interactive Complexity: +90785

- > Refers to specific communication factors **during** a visit that complicates delivery of the primary psychiatric procedure
- > Typical patients:
 - Have others legally responsible for their care, such as minors or adults with guardians
 - Request others to be involved in their care during the visit
 - Require the involvement of other third parties, such as child welfare agencies, parole or probation officers, or schools



Interactive Complexity: Factors

1. The need to manage maladaptive communication (related to, e.g., high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicates delivery of care.
2. Caregiver emotions or behaviors that interfere with implementation of the treatment plan.
3. Evidence or disclosure of a sentinel event and mandated report to a third party (e.g., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.



Interactive Complexity: Factors, cont.

4. Use of play equipment, physical devices, interpreter or translator to overcome barriers to diagnostic or therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language.

NOTE: Per the Center for Medicare and Medicaid Services (CMS), “**90785 generally should not be billed solely for the purpose of translation or interpretation services**” as that may be a violation of federal statute.



Additional Resource for Interactive Complexity

Guide created by the
**American Academy of
Child & Adolescent
Psychiatry**

Link available on
National Council's
[CPT Resource Page](#)



www.psychiatry.org

**Interactive
Complexity**
Revised 11/3/12

AMERICAN ACADEMY OF
CHILD & ADOLESCENT
PSYCHIATRY
www.aacap.org

Definition	A new concept in 2013, interactive complexity refers to 4 specific communication factors <i>during</i> a visit that complicate delivery of the primary psychiatric procedure. Report with CPT add-on code 90785 .	Typical Patients	Interactive complexity is often present with patients who: <ul style="list-style-type: none">• Have other individuals legally responsible for their care, such as minors or adults with guardians, or• Request others to be involved in their care during the visit, such as adults accompanied by one or more participating family members or interpreter or language translator, or• Require the involvement of other third parties, such as child welfare agencies, parole or probation officers, or schools.
Code Type	Add-on codes may be reported in conjunction with specified "primary procedure" codes. Add-on codes may never be reported alone.		Interactive complexity is commonly present during visits by children and adolescents, but may apply to visits by adults, as well.
Replaces	Codes for interactive diagnostic interview examination, interactive individual psychotherapy, and interactive group psychotherapy are deleted.		
Use in Conjunction With	The following psychiatric "primary procedures": <ul style="list-style-type: none">• Psychiatric diagnostic evaluation, 90791, 90792• Psychotherapy, 90832, 90834, 90837• Psychotherapy add-on codes, 90833, 90836, 90838, when reported with E/M• Group psychotherapy, 90853 When performed with psychotherapy, the interactive complexity component (90785) relates only to the increased work <i>intensity</i> of the psychotherapy service, and does not change the <i>time</i> for the psychotherapy service.	Report 90785	When at least one of the following communication factors is present during the visit: <ol style="list-style-type: none">1. The need to manage maladaptive communication (related to, e.g., high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicates delivery of care.2. Caregiver emotions or behaviors that interfere with implementation of the treatment plan.3. Evidence or disclosure of a sentinel event and mandated report to a third party (e.g., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.4. Use of play equipment, physical devices, interpreter or translator to overcome barriers to diagnostic or therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language.
May Not Report With	<ul style="list-style-type: none">• Psychotherapy for crisis (90839, 90840)• E/M <i>alone</i>, i.e., E/M service <i>not</i> reported in conjunction with a psychotherapy add-on service• Family psychotherapy (90846, 990847, 90849)		Per the Center for Medicare and Medicaid Services (CMS), "90785 generally should not be billed solely for the purpose of translation or interpretation services" as that may be a violation of federal statute.
Complicating Communication Factor Must Be Present During the Visit	The following examples are <i>NOT</i> interactive complexity: <ul style="list-style-type: none">• Multiple participants in the visit with straightforward communication• Patient attends visit individually with no sentinel event or language barriers		<ul style="list-style-type: none">• Treatment plan explained during the visit and understood without significant interference by caretaker emotions or behaviors



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
90-134 minutes	90837 90834	60 minutes Prolonged Services
135-154 minutes	90837 90834 90835	60 minutes Prolonged Services Prolonged Services, each additional 30 minutes



Risk Management: How Are You Selecting Codes?

- > “We’re going to instruct our people to only use 99202 for new patient visits.”
- > “Our back office staff will select the codes after reviewing the documentation.”



Remember:

- > If you know one Medicaid program, you know one Medicaid program
 - Individual payers have individual policies and individually-determined rates
- > Medical necessity must drive your services



Resources

- > AMA Code Book www.amabookstore.com or 1-800-621-8335
- > [National Council webpage](#) dedicated to the CPT changes with resources such as:
 - 2012-2013 Crosswalk
 - Frequently Asked Questions
 - Free training resources
- > *Compliance Watch*, new CPT series
 - www.TheNationalCouncil.org/CS/Compliance_Watch_Newsletter



Resources

- > American Psychiatric Association:
<http://www.psych.org>
- > American Academy of Child & Adolescent Psychiatrists:
www.aacap.org
- > 1997 Documentation Guidelines for Evaluation and Management Services
<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf>
- > Center for Medicare and Medicaid Services (CMS)
<http://www.cms.gov/Medicare/Medicare.html?redirect=/home/medicare.asp>



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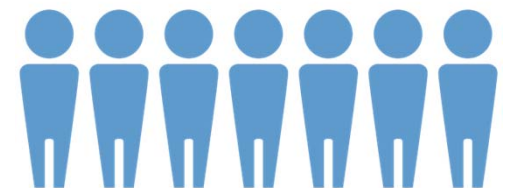
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ATTENDEES



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National Council

CPT Resource Page: www.TheNationalCouncil.org/CS/CPT_Codes

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