

Coding and Documentation for Behavioral Health Providers (2016)

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Today's Agenda

- Introduction by Medicaid representative and a review of general documentation and coding in mental health by the presenter
- A review CPT coding for mental health (a.k.a. psychiatry codes) – instructions, definitions and process for coding
 - Assessment codes
 - Interactive Complexity
- Detailed review of E&M documentation and coding ...
 - E&M codes
 - Nurse visits
 - Medication management
- Psychotherapy documentation and coding
 - With and without E&M component
- Questions and Answers with Medicaid Representative

Disclaimer

The material presented on this program is educational in nature. The information presented in this program is based on CPT coding guidelines as well as relevant governmental and specialty association guidelines when pertinent. All CPT and ICD coding is time and specific policy sensitive. No part of this program can be reproduced or copied without written permission of the author. This content of this program is the responsibility of the presenter. This program is valid through 12/31/16

All payment policies must be verified with the covering entity, including but not limited to Medicare, Medicaid, and commercial insurers. For Ohio Medicaid, please refer to Ohio Revised Code, Ohio Administrative Code and Medicaid provider manuals. Manuals for community behavioral health providers are under development.

Acronyms

- CPT – Common procedural terminology
- E&M – evaluation and management
- FH – family history
- HPI – history of present illness/interval history
- ICD 10 - International classification of diseases, version 10
- MDM – medical decision making
- MLP – mid level provider (nurse practitioner, physician assistant) – non physician provider
- PE – physical exam
- PMH – past medical history
- ROS – review of systems
- SH – social history

2013 changes in behavioral health coding

- The changes in CPT code definitions in 2013...
 - Resulted in third party review of therapy and E&M service documentation and coding process
 - Modified logistics in terms of patient medical care and therapy services, provided alone or together
 - Importance of credentialing providers for care provided
 - Deletion of Medication Management code process with change E&M code
 - Clarified documentation and coding for interactive complexity
 - Revised how time is used in therapy services

Documentation of care provided

- All services coded and billed are based on the documentation within the medical record – whether paper or EMR
- The documentation of care for the updated coding process goes beyond clock time to the substance of care coded by E&M CPT codes; assessment coding with or without medical component; therapy coding; and interactive complexity;
- The notes must reflect “time” for some services, but E&M services are not time dependent

Basic review of EMR/EHR.....

- How the medical record is constructed for patient care as well as disease tracking (not just billing)
- How data is entered – timing and by whom is critical for E&M documentation
- How use of prior documentation for current care (carry forward, cloned notes) is imported or used
- How orders and secondary processes for nurses, therapists, case managers are identified
- How co-signing of notes by supervising providers is identified when required
- How note closure occurs as services cannot be coded and billed until the notes are closed/locked/complete

Concepts of the EMR/EHR

- Protected Health Information (“PHI”): PHI is individually identifiable health information that is transmitted or maintained in any medium, including oral statements.
- Authentication: The process that ensures that users are who they say they are. The aim is to prevent unauthorized people from accessing data or using another person's identity to sign documents or enter data/information beyond the accepted role for coding documentation
- Signature: A signature identifies the author or the responsible party who takes ownership of and attests to the information contained in a record entry or document. This may also include supervision process for certain levels of providers (adjunct therapists, nurses)

What is cloning and what is not..

- "Cloning" medical record documentation means cutting-and-pasting the information entered in the Electronic Medical Record (EMR) from one date of service to another. It can be a useful tool in providing elements of patient history on each page of the EMR, but can also cause problems.
- The concept of carryforward or cut and paste can be used correctly in some areas – continued diagnoses, ongoing plans and standard education as long as they are updated and pertinent to the care provided

Cloning and CMS (and everyone)

- Documentation is considered cloned when each entry in the medical record for a beneficiary is worded exactly like or similar to the previous entries. Cloning also occurs when medical documentation is exactly the same from beneficiary to beneficiary. It would not be expected that every patient had the exact same problem, symptoms, and required the exact same treatment. Cloned documentation does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, individual information. All documentation in the medical record must be specific to the patient and her/his situation at the time of the encounter. Cloning of documentation is considered a misrepresentation of the medical necessity requirement for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.

<https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-ehr-providerfactsheet.pdf>

Over documentation...

The Social Security Act, Section 1862 (a)(1)(A) states: "No payment will be made ... for items or services ...not reasonable and necessary for the diagnosis or treatment of an injury or illness or to improve the functioning of a malformed body member." This medical reasonableness and necessity standard is the overarching criterion for the payment for all services billed to Medicare. Providers frequently "over document" and consequently select and bill for a higher-level E&M code than medically reasonable and necessary. Word processing software, the electronic medical record, and formatted note systems facilitate the ...carry over... and repetitive "fill in" of stored information. Even if a "complete" note is generated, only the medically reasonable and necessary services for the condition of the particular patient at the time of the encounter as documented can be considered when selecting the appropriate level of an E&M service.

EMR/EHR Templates can be used:

- To assure the complete documentation occurs with standard format for assessments, exams, education process, treatment plans and specific services
- To make sure “requirements” are in place and accessible for tracking, disease management and state requirements
- When documentation within the template reflects the actual work provided and is edited to meet the specific patient needs
- To provide continuity for verified treatment plans, goals and patient care process

The structure of CPT codes...

- The structure of the CPT codes attempts to include the key component of care; identifies who can provide services in some cases; reflection of time required for certain services (therapy); and elements required within the encounter note (history, exam and plan)
- E&M codes are specific to location (office, outpatient, hospital, or other location) – for Medicaid behavioral health clinics the services are office/clinic place of service for E&M coding
- Procedures – such as therapy or psychiatric intervention may be time based and participant based such as individual, group or family therapy

CPT codes are broken down into “types”

CPT codes have “5” characters which have a unique order and type

- E&M services start with “99xxx”
- Codes starting with “0” may be anesthesia or temporary codes (that end in T),
- Surgical procedure codes start with 1, 2, 3, 4, 5, 6
- Radiology codes start with 7
- Lab codes start with 8 – drug screening
- Additional “medical services” start with 9xxx – therapy, injections, psychological testing
- Injections and supplies or HCPCs codes (case management, some nursing services)

Add on code definition

- An **add-on code** is a HCPCS/**CPT code** that describes a service always performed in conjunction with the primary service. An **add-on code** is eligible for payment only if it is reported with the appropriate primary procedure performed by the same physician.
- These codes have a “+” as part of the listing in CPT
- There is always a notation with these codes that identifies: (List separately in addition to the code for primary procedure)

The basics of E&M

- New patient – one that has not been seen in your entity or specific program by your providers in the past 3 years
- Established patient – one that is following up on care and services, or who returns within a three year time frame for a new episode of care
- The Psychiatric diagnostic evaluation codes – are not classified as “new” or “established” but are coded based on episode of care. To code a “second” evaluation the case would need to be closed, patient terminated or absent from the provider/agency for an identified length of time

The CPT codes for behavioral health services

- The E&M CPT codes are based on place of service. The identified “office/outpatient” CPT code description includes outpatient behavioral health settings, agencies and programs.
- The codes we will be discussing today are on the next three slides.
- Medicaid in the change will accept identified HCPCs codes that do not have an adequate CPT code for the services you provide. These will be identified in forthcoming Medicaid policies.

Initial Outpatient Office/Clinic Visit

New Patient: (has not received any professional service from any physician “in the exact same specialty and subspecialty who belongs to the same group practice” in the last three years)

- **99201 – 10 minutes**
 - Problem focused History
 - Problem focused Examination
 - Straightforward Medical Decision Making
- **99202 – 20 minutes**
 - Expanded problem focused History
 - Expanded problem focused Examination
 - Straightforward Medical Decision Making
- **99203 – 30 minutes**
 - Detailed History
 - Detailed Examination
 - Low complexity Medical Decision Making
- **99204 – 45 minutes**
 - Comprehensive History
 - Comprehensive Examination
 - Moderate Medical Decision Making
- **99205 – 60 minutes**
 - Comprehensive History
 - Comprehensive Examination
 - High Complexity Medical Decision Making

Nurse visit (RN, LPN)

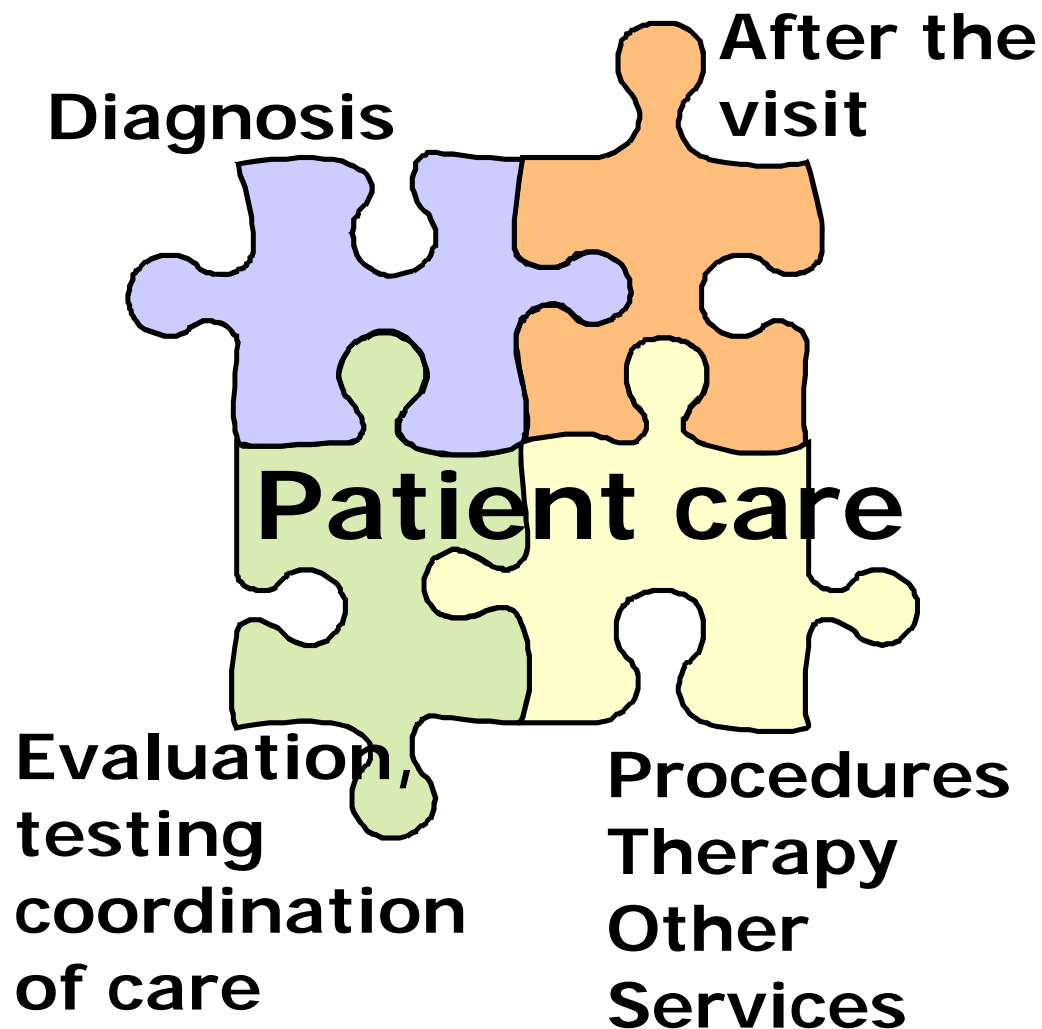
- 99211 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

Established Patient Outpatient Office/Clinic

Follow up services require 2 of the 3 parts of the note at the same level for correct code selection – and Medical Decision Making should be the key factor in coding

- **99212 – 10 minutes**
 - Problem Focused Interval History
 - Problem Focused Examination
 - Straightforward Medical Decision Making
- **99213 - 15 minutes**
 - Expanded Problem Focused Interval History
 - Expanded Problem Focused Examination
 - Low Complexity Medical Decision Making
- **99214 – 25 minutes**
 - Detailed Interval History
 - Detailed Examination
 - Moderate complexity Medical Decision Making
- **99215 – 40 minutes**
 - Comprehensive Interval History
 - Comprehensive Examination
 - High Complexity Medical Decision Making

The puzzle of patient care and coding



- The focus of all services is patient care
- The “other parts” relate to the care process and may impact the E&M level of care
- Coding and billing is the last piece but must match the documentation

All care must have a diagnosis...

- It may be a symptom – agitation, violent behavior
- It may be an actual disease:
 - Alcohol dependency with mood disorder
 - Severe depression with hallucinations
 - Post traumatic stress disorder
- There is no “rule out”, possible or maybe
- The ICD 10 CM codes change and get updated every October 1st
- Must be documented by the physician or clinician
- If a diagnoses is identified for billing it must be part of the documentation for the care process and plan

Every note/encounter

- A reason for care – chief complaint
- Pertinent history for the care provided – history of present illness, PMH, SH and FH, review of systems
- Identified exam
- Identified time with the patient as pertinent to coding of care
- An identified assessment, plan, diagnoses status and author

The chief complaint..

- For nurse visits (RN, LPN) would be based on what the ordering clinician identified – medication check for schizophrenia, Suboxone follow up, depression follow up
- For a provider visit or therapy would be the diagnoses or condition being treated
- This reason can be from the scheduled reason for care/services
- This must be confirmed or clarified once the patient is in the agency or room by the provider of care
- Could be as direct as “group therapy for anger management” “individual therapy for...”

E&M documentation

- Patient/support staff can document the following that must be confirmed by the provider
 - Chief complaint (CC)
 - Past medical history (PMH)
 - Medications (PMH)
 - Allergies (and reactions)
 - Social history (SH)
 - Family history (FH)
 - Review of systems (ROS)
- Providers must document history of present illness (HPI), exam and medical decision making/plan

Who can provide what types of care...

E&M Services

- MD, DO
- Mid level providers
– APRN, CNS, and PA
- Nurses (RN/LPN)
for the 99211 level
alone

Psychiatry/Behavioral codes

- MD, DO and MLP's initial assessment with medical component, therapy with E&M
- Counselors, therapists – initial assessment without medical component
- Therapy alone codes
- Testing codes can be coded by any level or provider based on training

General Psychiatry/Behavioral Health Instructions..

- Psychiatry Services include (90785-90899)
 - Diagnostic services - assessment
 - Psychotherapy services with or without E&M
 - Other types of services to individuals, family and group
- Psychiatry Services are coded without regard to place of service, Medicaid however has restrictions
- E&M services are coded based on location can be used for treatment of psychiatric conditions as appropriate

What is part of “code” documentation...

- Whether one uses the psychiatry/behavioral health codes for initial assessment or therapy or E&M notes require
 - Reason for the visit (Diagnoses)
 - Pertinent history for the care provided
 - Rationale for interactive complexity when present
 - Identified care provided – E&M, therapy, or other intervention
 - Identified time if pertinent to service (therapy)
 - Identified plan of care: goals, objectives, plan and progress and return
 - Be signed, dated and reference supervision as pertinent to care

Review of psychiatry/behavioral health coding

- Psychiatry assessment codes with and without medical component – are not defined as “new” or “established” but status driven. E&M services are based on “new” versus “established” criteria
- Interactive complexity – based on patient status or a patient/family member “state of being”
- Therapy is based on face to face time, treatment plan, goals, objectives and summary of session

Diagnostic Assessment:

- 90791 Psychiatric Diagnostic evaluation

- Psychiatric diagnostic evaluation 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

- 90792 Psychiatric Diagnostic evaluation with medical services

- 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.

Diagnostic Interview Requirement

- The diagnostic interview differs from the E&M guidelines in terms of details of elements but in general they include pertinent
 - PMH, hospitalization, FH, SH and medications
 - Psychiatric examination of at least a mental status exam
 - Recommendations and identified plan of care and treatment

What is the difference for the “medical” 90792 and general evaluation 90791

The 90792 documentation needs to reflect

- Additional exam elements (pertinent to care)
- Prescription of medication or coordination of medications as part of medical care
- Order/review of medical diagnostic studies – lab, imaging, and other diagnostic studies
- Medical thought process must be clearly reflected in assessment and plan

What is medical “thought”

- Identified PMH, SH and/or FH that may reflect co-morbid issues (medical conditions)
- Medications and treatment prescribed by others and the impact on the psychiatric care
- Additional medical work up to identify the psychiatric issue with the medical issues (hypertension, diabetes, dementia, etc.)
- Integration of symptoms and issues for the medical component of the patient for appropriate coordination of care

The diagnostic assessment note must include....

- Reason for the assessment (or re-assessment after absence from the setting)
- History of present issue/condition
- PMH – psychiatry and general pertinent to care
- Family history (FH), Social history (SH)
- Review of systems (pertinent to care plan)
- Examination – at minimum mental status exam
- Interactive complexity if pertinent to care
- Assessment (for diagnoses coding)
- Identified plan with goals, objectives, follow up
- Signed and dated

As part of the assessment...

- A treatment plan must be initiated or identified
- Specific goals and objectives for the patient with services, therapy and care
- Specific types of services – therapy (individual, group, family), follow up E&M, medication
- Method of therapy, duration of sessions, projected length of time in session; provider of therapy
- Medical involvement – physician, testing
- Patient responsibilities
- Target dates for goals and objectives
- Signed, dated and reviewed regularly

Interactive complexity coding

- This concept was a component of the old evaluation and therapy codes but was not a separate CPT code as it is now. This CPT code is an “add on code”
- +90785 Interactive complexity (List separately in addition to the code for primary procedure)
 - Is always second to a primary code/service
 - Cannot be coded with E&M services alone
 - Per CMS interactive complexity is not coded for the sole purpose of translation or interpretation services (deaf) as that may be a violation of federal laws that prohibit discrimination on the basis of disability or ethnicity

The coding of interactive complexity - 90875

- Can be added to diagnostic evaluation codes (90791, 90792)
- Can be added to psychotherapy codes (90832, 90834, 90837)
- Can be added to psychotherapy when performed with an E&M service (90833, 90836, 90838, 99201-99245)
- Can be added to group psychotherapy (90853)
- Cannot be used on E&M services alone (9920x or 9921x without therapy add on codes)
- Cannot be coded with crisis coding (90839/90840)
- Cannot be added to family therapy codes (90846, 90847, 90849)

Definition of interactive complexity

90785

- This refers to specific communication factors that complicate or impact the delivery of a psychiatric procedure or care
 - Difficult communication with a discordant patient or emotional family members
 - Patients maladaptive communication issues (anger, anxiety, reaction) with verbal impairment or underdeveloped in communication skills
 - Third party active involvement in the care process – parents, guardians, other significant others, agencies, court involved persons, schools

Outside participants that would support an interactively complex patient

- May involve third parties who are legally responsible for care (institutions, guardians of minors and adults)
- May be individuals involved in care at the request of the patient or significant party for active participation in the care plan and treatment process
- May be required third parties for protection, monitoring or active support (child or adult welfare, parole, probation, school system)

Per CMS when coding interactive complexity requires:

At least one of the following must be identified in the documentation

- The need to manage maladaptive communication
- Caregiver emotions or behavior interferes with the caregiver's understanding of the treatment plan and process
- Evidence or disclosure of a sentinel event that requires mandated reporting with discussion with patient/others participating in care
- Coordination of care with third party actively involved
- Use of play, adaptive equipment, physical devices, interpreter, translator

Maladaptive communication includes:

- High anxiety – fear, worry, angst, apprehension
- High reactivity – response, anger
- Repeated questions
- Inability to comprehend and understand
- Disagreement – denial, argumentative, conflict,

The use of “supports” in communications for Interactive Complexity

- The patient is not fluent in the language requiring support beyond an interpreter
- The patient not developed the communication ability (by age or status) requiring adapted care
- Has lost the ability to express, explain or simply comprehend the normal communication process

Examples of when 90785 would be correctly appended

- During court ordered therapy the patient is angry and explosive throughout the 45 minute session and refuses to engage or participate in the treatment plan
- During initial assessment for bipolar with manic tendencies the patient is unable to verbally communicate without supports because of a tracheostomy
- During therapy the participating spouse was in denial about the severity of the drug addiction and suicidal ideations the patient presented

Disclosure of a sentinel event when coding Interactive Complexity

- During therapy and identified event or process is disclosed or identified that requires involvement of an outside party
 - Child Abuse
 - Elder Abuse
 - Self Harm or harm to others
- This would include the discussion with the patient and other participants in the session

The time involved with the “interactive complexity”

- The time this portion of the encounter takes with the patient and other participants is..
 - Is counted by psychotherapy session time
 - Is added on to the psychotherapy codes (90832, 90834, 90837 and the 90833, 90836 and 90838)
- Interactive complexity is not coded with the E&M services coded without therapy. The interactive complexity status for E&M service be a component of medical decision making

Template for Interactive complexity...

- This case was complicated and supported interactive complexity because of the following:







Support interactive complexity...

- 5 year old assessment with coordination parents, school for treatment plan • Yes/No
- Elderly gentleman who requires an interpreter alone • Yes/No
- A woman involved in therapy and coordination of services through court system and is very anxious, scared • Yes/No
- A patient with an outside caseworker involved who is coordinating care and services • Yes/No

E&M Coding and Documentation

- E&M services are the basis for all other care
- All testing and services must come from the hub of the E&M – lab, x-ray, therapy, medications, referrals.
- E&M is condition based (not prevention)
- The rules are the same for all E&M codes no matter the location- this program focuses on office/clinic location



E&M services

- Can to be coded for the medical issues – by physicians, APRN, CNS and PA's
- Cannot be used by psychologists, social workers or other behavioral health providers
- Office services have 5 levels of care and are either new or established
- Only one E&M service per day can be coded
- Terms like “comprehensive” or “detailed” “moderate medical decision making” within the CPT code description refer to history, exam and medical decision making and drive the level of care

Parts of an E&M

E&M Componets

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graph TD; A[E&M Componets] --- B[History]; A --- C[Exam]; A --- D[Medical Decision]; B --- B1[PMH, SH, FH,]; B --- B2[Prior Treatment]; B --- B3[Review of Systems]; C --- C1[Vitals]; C --- C2[Observations]; C --- C3["Touched"]; D --- D1[Diagnosis, Testing]; D --- D2[Risk issues]; D --- D3[Treatment Options];
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History

PMH, SH, FH,
Prior Treatment
Review of Systems

Exam

Vitals
Observations
"Touched"

Medical Decision

Diagnosis, Testing
Risk issues
Treatment Options

History... Required for E&M

- Chief complaint – reason for visit
- History of Present Illness – must always be documented by the provider of care – not the nurse or clinical support person and includes: Context, Timing; Duration; Quality; Location; Severity; Associated Signs & Symptoms; Modifying factors
- Past Medical History (PMH)
- Family History (FH)
- Social History (SH)
- Review of systems (ROS) – requirements
 - “10” for a comprehensive E&M level
 - 2-9 for a detailed E&M level

The HPI/Interval History requires 1-4 of:

- The history or present illness or interval history is documented using terms that describe:
 - Context – withdrawal from opioids, after traumatic brain injury
 - Timing – within the past 24 hours, yesterday, since hospital discharge
 - Duration – 20 years, lasted for 2 hours
 - Quality – throbbing, aching, intermittent
 - Location – arm, eyes, back
 - Severity – degree of issue, 0-10 rating scale
 - Associated Signs & Symptoms – symptoms that may be related or possibly related to a condition
 - Modifying factors – what makes it better, worse, use of medication, attending therapy

Review of Systems are by symptom not disease...

- Psychiatric - mental health concerns
- Integumentary
- Musculoskeletal
- Allergy/Immunology
- Gastroenterology
- Genitourinary
- Cardiovascular
- Respiratory
- Ears, Nose, Throat
- Eyes (vision)
- Neurologic
- Hematologic
- Endocrine
- Constitutional

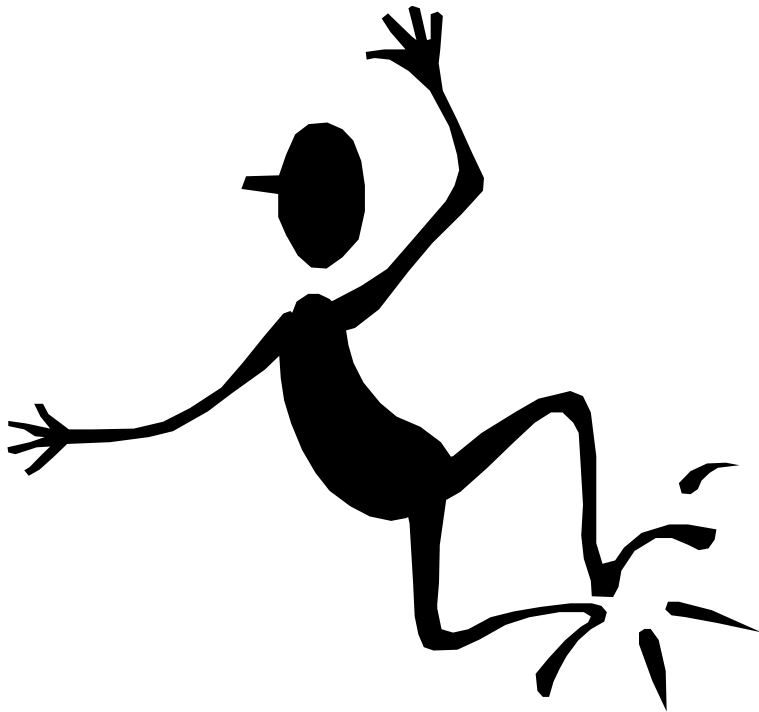
Levels of history per CMS

Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
99201(new) 99212 (est.)	99202 (new) 99213(est.)	99203 (new) 99214 (est.)	99204, 99205 (new) 99215 (est.)
Chief complaint	Chief complaint	Chief complaint	Chief complaint
Brief HPI (1-2)	Brief HPI (1-2)	Complete HPI (4)	Complete HPI (4)
No required PMH, SH FH	No required PMH, SH FH	<u>Pertinent</u> PMH, SH, FH to problem(s)	Complete PMH, SH and FH
No ROS	Pertinent ROS 1-2 systems	Pertinent ROS of 2-9 systems	Complete 10 system review

How do positive elements of history impact MDM

- Identification of change
- Identification of stability or instability
- Support for additional work up
- Support for additional monitoring
- Support for referrals
- Support for education and identified issues of compliance
- Compliance

The exam...



- Vitals (3) required for high level visit E&M services (99204, 99205)
- Include observations of physical fact (Examples: tearful, tremor, shuffle, facial droop)
- Touch, palpate, rotate, and examine – mini mental status exam

1995 Exam criteria – by AMA

Guidelines

- 1995 Body region
 - Head
 - Abdomen
 - Neck
 - Back
 - Chest
 - Genitalia
 - Extremity (each)
 - Vitals (3)
- 1995 Organ System
 - Eyes
 - ENT/Mouth
 - Cardio
 - Respiratory
 - Gastrointestinal
 - Genitourinary
 - Musculoskeletal
 - Skin
 - Neurologic
 - Psychiatric
 - Hematologic
 - Constitutional/Vitals

Single Organ Psych Exam 1997 by CMS

Constitutional: ALL elements must be documented.

- Measurement of any 3 of the following 7 vital signs:
 1. sitting or standing blood pressure, 2. supine blood pressure, 3. pulse rate and regularity, 4. respiration, 5. temperature, 6. height, 7 . weight (May be measured and recorded by ancillary staff)
- General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)

Musculoskeletal

- Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements
- Examination of gait and station

Psychiatric

- Description of speech including: rate; volume; articulation; coherence; and spontaneity with notation of abnormalities (e.g., perseveration, paucity of language)
- Description of thought processes including: rate of thoughts; content of thoughts (e.g., logical vs. illogical, tangential); abstract reasoning; and computation
- Description of associations (e.g., 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 (e.g., concerning everyday activities and social situations) and insight (e.g., concerning psychiatric condition)

- Complete mental status examination including:
 - Orientation to time, place and person
 - Recent and remote memory
 - Attention span and concentration
 - Language (e.g., naming objects, repeating phrases)
 - Fund of knowledge (e.g., awareness of current events, past history, vocabulary)
 - Mood and affect (e.g., depression, anxiety, agitation, hypomania, lability)
- In children the details of the exam may be limited by age and cognitive development and this should be clearly identified within the exam process

Levels of Exam per CMS

Problem Focused 99201 (new) 99212 (est.)	Expanded Problem Focused 99202 (new) 99213 (est.)	Detailed 99203 (new) 99214 (est.)	Comprehensive 99204, 99205 (new) 99215 (est.)
Limited exam of affected body area or organ system 1-2 system exam or 1-5	A limited exam of the affected body area or organ system and other related system 1-3 system exam or 6	An extended exam of the affected body area or organ system and other related systems 2-7 system exam or 9	A general multi system exam (8 systems) or a complete single organ exam (by 1997 guidelines) 8 system exam or complete single system

Identified Examination...

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, weight • General appearance 		
	Musculoskeletal	<ul style="list-style-type: none"> • Muscle strength and tone • Gait and station 		
	Psychiatric	<ul style="list-style-type: none"> • Speech • Thought process • Associations • Abnormal/psychotic thoughts • Judgment and insight • Orientation 	<ul style="list-style-type: none"> • Recent and remote memory • Attention and concentration • Language • Fund of knowledge • Mood 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)	

For the single organ exam

- All elements of this exam must be documented in positive or negative terms – no “unremarkable” or “same”
- The exam documentation, except for the vitals, must be based on the physician, APRN, CNS or PA exam or observation not that of other support staff

Medical Decision Making per CMS is a combination of

- Clinical judgment involved in care
- Presenting problem – problem points
- Amount and complexity of data – data points
- Number of possible diagnoses/management options identified in the plan
- Risk issues – identified by treatment, diagnostic work up, underlying conditions that impact the care and treatment

Problem Points Per CMS

Problem Category	Number	Points	Score
Self limited or minor problem (stable, improving or worsening)	MAX =2	1	
Established diagnoses/ problem, stable, improved	(unlimited number)	1	
Established diagnoses / problem worsening	(unlimited number)	2	
New problem, No additional work up planned	MAX =1	3	
New problem, additional work up planned/ consultation	(unlimited number)	4	
Scoring: 1= Minimal 2= Low 3 = Moderate 4= High		Total	

Examples of problem points

Examples	
Self limited or minor problem (stable, improving or worsening)	Rash follow up reaction to a medication; healing self inflicted wound
Established diagnoses/ problem, stable, improved	Stable depression, stable ADHD,
Established diagnoses / problem worsening	PTSD with increased anxiety, Drug dependency with worsening mood
New problem, No additional work up planned	Transfer patient with current completed work up
New problem, additional work up planned/ consultation	New headaches requiring referral to ... Disclosure of sentinel event with testing ordered

In Medical Decision Making...

- The number of problems counted would be the ones specific to the provider's care – not just the ones the patient “has” or that are historic in nature
- The data includes lab, imaging, other testing (psychological testing), other physician reports
- The problem points must be reflected within the medical record – new, chronic, worse, stable, exacerbated by – are terms one looks for in this documentation

Data type and points per CMS

Points	Type of data
1	Review and/or order clinical lab tests (CPT 8xxxx)
1	Review and/or order radiology tests (CPT 7xxxx some 3xxxx)
1	Review and order medical tests (CPT 9xxxx some 5xxxx)
1	Discuss test results with performing/ interpreting physician
2	Independent review of image, tracing or specimen
1	Decision to obtain old records and/or decision to obtain history from others
2	Review <u>and</u> summarize old records and/or history obtained from others
	Total
	Scoring for data: ≤ 1 = minimal 2= limited 3=moderate 4= high

Example of data points

Data points	
Lab	Drug screen, HIV testing,
Radiology	Chest x-ray, CAT scan
Other Medical	EKG, psychological testing, neuro testing
Discussion	Call to psychologist on testing
Independent review	Interpretation of psychological testing, interpretation of EKG
Old Records information from others	Call (with permission) to family, record request from prior treatment ER review
Summary	Formal process for treatment plans with coordinated care team

Point counting...

- Current and pertinent testing counts only when it is being actively used for the care and treatment
- Re-review of prior testing is only counted if there is a change, a need to compare or some process involved (trending of labs) that brings this into the current visit

Table of risk...

Table of Risk

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	One self-limited or minor problem	Venipuncture; EKG; urinalysis	Rest
Low	Two or more self-limited or minor problems; One stable chronic illness; Acute uncomplicated illness	Arterial puncture	OTC drugs
Moderate	One or more chronic illnesses with mild exacerbation, progression, or side effects; Two or more stable chronic illnesses; Undiagnosed new problem with uncertain prognosis; Acute illness with systemic symptoms		Prescription drug management
High	One or more chronic illnesses with severe exacerbation, progression, or side effects; Acute or chronic illnesses that pose a threat to life or bodily function		Drug therapy requiring intensive monitoring for toxicity

The table of risk..

- The table of risk is a guide point and the documentation needs to clearly identify the risk.
 - High risk medication
 - Black box warning with medication
 - Risk of self harm or harm to others
 - Co-morbid risks of medical conditions or diseases
 - Psycho social risks
 - Compliance/non compliance

Components that identify MDM

- Current and pertinent testing counts only when it is being actively used for the care and treatment
- Re-review of prior testing is only counted if there is a change, a need to compare or some process involved (trending of labs) that brings this into the current visit
- Status of a condition – better, worsening, in denial, improving, deteriorating supported by active symptoms, test results or collateral information (therapy notes)
- Active exam elements that identify an abnormality in either the exam system or other medical issues

Medical Decision Making and Table of Risk

The following table shows the progression of the elements required for each level of medical decision-making. To qualify for a given type of decision-making, two of the three elements in the table must either meet or exceed the requirements for that type of decision-making (from APA)

Type of Decision Making	Number of Dx or Treatment Options	Amount and/or complexity of Data to review	Risk of complications and/or morbidity or mortality
Straight forward	Minimal 0-1	Minimal or None 0	Minimal
Low Complexity	Limited 0-1	Limited 0-1	Low
Moderate Complexity	Multiple 3	Multiple 3	Moderate
High Complexity	Extensive 4	Extensive 4	High

E&M: PUTTING IT ALL TOGETHER

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

BY THE ELEMENTS:

- Number of elements in HPI + ROS + PFSH
- Number of Examination elements
- Level of Medical Decision Making

OR

BY TIME:

- Time spent in Counseling and Coordination of Care (if greater than 50% of the time)
- Therapy codes are not coded in addition to E&M

Add on codes for E&M services

- When patient care takes a prolonged amount of time the add on codes (99354, 99355) are used in addition to the primary E&M code
- In these cases “clock time” must be documented to support the use of the E&M and the prolonged care code. An exam would be:
 - Total time with patient from 1:00 to 2:45 providing education, coordination of care with primary care and group home setting for exacerbation of severe depression with psychotic features

Prolonged care codes for office/clinic

- +99354 Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient Evaluation and Management service)
- +99355 Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (List separately in addition to code for prolonged service)

When to code E&M not therapy

- In patients that cannot benefit from therapy or is not a candidate for therapy because of dementia, behavior, or capacity and the service is beyond medication management
- In patients where the mental health issues are complicated by medical issues that are monitored, assessed and coordinated as part of the mental health concern.

Medication management...

- The Pharmacology management code no longer exists as an identified CPT code for the provider (MD,DO., APRN, CNS PA level)
- This service is coded as an E&M service based on the combined history, exam and plan with medical decision making
- Therapy would only be coded with this based on documentation of the identified issues, goals, objectives and plan

Nurses providing medication education (RN and LPN)

- 99211 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

Reason for visit – diagnoses

Summary of visit

Signed and dated – co-signed by supervising provider

Injection only service...

For a patient who presents for an injection service the diagnoses and ordering provider must be noted

- 96372 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
- And the J code for the specific drug or biologic with the specific NDC number
- A nurse visit (99211) would not be coded with this unless the services went beyond the injection

Historic issues in documentation and coding in behavioral medicine services

- Incomplete documentation of therapy services specific to time, goals, treatment plan and status
- Initial assessments not including treatment plan
- Incomplete E&M services missing pertinent history, mental status exam and/or medical decision making
- Incomplete Medication Management documentation missing the mental status exam, response to medication and education

A word about “shared visits” between a physician and mid level provider

- When working with an APRN or PA some visits can be “shared” when both providers see the patient and document their role in care
- This means both providers see, examine and document care with the patient
- Coded “under the physician”
- “Sharing” can occur with residents – but not medical students or PA or APRN students
- This is not “incident to” as incident to is when the mid level provider care for a patient but bills under the supervising physician

Psychotherapy – CPT guidelines

- Psychotherapy is the treatment of mental illness and behavioral disturbance in which the physician or other qualified health care professional , through definitive therapeutic communication, attempts to alleviate emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage growth and development.
- All therapy services are time based and time must be documented within the record. Therapy for less than 16 minutes cannot be coded as therapy

Therapy....

- The therapist provides individual psychotherapy in an office or outpatient facility using supportive interactions, suggestion, persuasion, reality discussions, re-education, behavior modification techniques, reassurance, and the occasional aid of medication. These interactions are done with the goal of gaining further insight and affecting behavior change or support through understanding. Individual psychotherapy is performed face to face with the patient for the identified time. If medical evaluation and management services were also furnished the documentation of these medical issues with history, exam and plan also needs to be documented and coded with the E&M codes

Therapy criteria

- Psychotherapy services must comprise clinically recognized therapies pertinent to the patient's illness or condition.
- The type, frequency and duration of services must be medically necessary for the patient's condition under accepted practice standards.
- There must be a reasonable expectation of improvement in the patient's disorder or condition, demonstrated by an improved level of functioning or maintenance of level of functioning where decline would otherwise be expected in the case of a disabling mental illness or condition or chronic mental disorders

Therapy criteria, continued

- The patient must have the capacity to actively participate in all therapies prescribed (mental capacity and motivation)
- To benefit from psychotherapy, an individual must be cognitively intact to the degree that he can engage in a meaningful verbal interaction with the therapist.
- Psychotherapy services are not covered when documentation indicates that dementia or brain injury has produced a severe enough cognitive defect to prevent establishment of a relationship with the therapist, which allows insight-oriented, behavior-modifying or supportive therapy to be effective.

Family therapy...

- 90846 Family psychotherapy (without the patient present)
- 90847 Family psychotherapy (conjoint psychotherapy) (with patient present)
- The therapist provides family psychotherapy in a setting where the care provider meets with the patient's family without the patient present. The family is part of the patient evaluation and treatment process. Family dynamics as they relate to the patient's mental status and behavior are a main focus of the sessions. Attention is also given to the impact the patient's condition has on the family, with therapy aimed at improving the interaction between the patient and family members.

90849 Multiple-family group psychotherapy

- The therapist provides multiple family group psychotherapy by meeting with several patients' families together. This is usually done in cases involving similar issues. The session may focus on the issues of the patient's care needs and problems. Attention is also given to the impact the patient's condition has on the family. This code is reported once for each family group present.

90853 Group psychotherapy (other than of a multiple family group)

- The psychiatric treatment provider conducts psychotherapy for a group of several patients in one session. Group dynamics are explored. Emotional and rational cognitive interactions between individual persons in the group are facilitated and observed. Personal dynamics of any individual patient may be discussed within the group setting. Processes that help patients move toward emotional healing and modification of thought and behavior are used, such as facilitating improved interpersonal exchanges, group support, and reminiscing. The group may be composed of patients with separate and distinct maladaptive disorders or persons sharing some facet of a disorder. This code should be used for group psychotherapy involving patients other than the patients' families.

The group and interactive complexity

- The interactive complexity code can be added to this service for the specific patient for whom this issue applies
- The +90785 is the add on code for this and the documentation in the specific patient record would need to reflect this component of care

Documentation for therapy requires

- Diagnoses for therapy – reason
- Time of therapy (in minutes) that is face to face for 16 minutes or longer
- Method of therapy
- Focused exam as pertinent to care
- Summary of therapy
- Identified goals and objectives for the therapy and the patient status with these
- Identified plan for return, homework and follow up
- Signed and dated
- Supervision as required by licensure level

Therapy services include:

- The psychotherapy services coded with CPT codes 90832 through 90838 include ongoing assessment and adjustment of the psychotherapeutic interventions and may include involvement of family members or others in the treatment process

Individual therapy codes...

- 90832 Psychotherapy, 30 minutes with patient and/or family member
- +90833 Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (List in addition to the code for the primary procedure)
- 90834 Psychotherapy, 45 minutes with patient and/or family member
- +90836 Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (List in addition to the code for the primary procedure)

Individual therapy codes continued

- 90837 Psychotherapy, 60 minutes with patient and/or family member
- +90838 Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service (List in addition to the code for the primary procedure)
- (Use appropriate prolonged service code – 99354- 99357 for psychotherapy services 68 minutes or longer) is permitted per CPT and CMS in 2016 (Medicaid policy question)

Time ranges per CPT

- In the introduction to CPT it identifies that time based codes are to be selected based on time, and one must achieve at least 50% of the CPT code definition time to code the service. With this in mind the coding for therapy would be based on...
 - For psychotherapy under 16 minutes there is no CPT code for this service

Summary of time ranges for CPT codes

Code	“Exact” Time (minutes)	Time Range (minutes)
90832, +90833	30 minutes	16-37 minutes
90834, +90836	45 minutes	38-52 minutes
90837, +90838	60 minutes	53 + minutes

Interactive code with therapy

- The interactive complexity code 90785 can be coded with the therapy and therapy with E&M services
- Interactive complexity is a state of being – that requires documentation of this state.
- The time spent on the interactive complexity is considered part of the therapy time process
- Interactive complexity cannot be coded with crisis codes

Therapy and E&M services

- When behavioral health patients receive medical evaluation and management services on the same day as psychotherapy by the same provider.
- To report both CPT codes the documentation must clearly identify that the E&M was separate from the psychotherapy
- The psychotherapy with E&M services are add on codes (+)

E&M and therapy coding process

- The type of E&M service is selected as the primary code based on history, exam and medical decision making not time
- The time associated with therapy is documented in addition to the E&M with the components supporting therapy and the specific time for this service. This support includes time, method of therapy, summary of therapy, status with goals, objectives and treatment plan

What might count as “separate” E&M from therapy

- The medical issues identified by medications, symptoms, co-morbid conditions, additional testing coordination of care that impacts the behavioral health care plan. This medical component is used to support the treatment plan and process (change in medication, referral for testing)
- The documentation would support both services independently
- The encounter does not need to have two diagnoses to qualify

A few thoughts on E&M and therapy

- The time with the patient **not devoted to meeting criteria for psychotherapy** is a component E&M level of care. This may include gathering history, review of testing, review of outside reports, performing the exam, writing orders and prescriptions
- Documentation of E&M must be clearly separate from the therapy portion or easy to identify both services

Examples of “E&M” and therapy add on codes

- Medication monitoring and education – that is more than just a statement of “meds reviewed”
- Order and review of labs, imaging and other outside testing and discussion of results with respect to co-morbid issues, not psychotherapy
- Review and discussion of medical issues – not just listing the medical diagnoses but identifying the role in the care plan
- Writing of orders – and explaining these to the patient/parent/significant other
- Additional examination components (vitals, ambulation, respiratory status)

Examples...

- A 19 year old being seen for ongoing therapy for adjustment reaction to an amputation. The session was for 47 minutes and covered coping mechanisms and review of medical issues of pain medication and psych medications; a review of what phantom limb pain is
- A 62 year old with multiple medical concerns with therapy for depression related to a recent loss of a daughter. She has multiple medications, symptoms related to medication as well as therapy around grief and loss with a change in medication with review of side effects and monitoring needs

Treatment plan process

- When therapy is a part of care, whether alone or with an E&M a treatment plan needs to be part of this process
 - Identified diagnoses for the treatment plan
 - Goals
 - Objectives
 - Timing and methods of achieving the identified plan process
- A few examples on the following slides...

Diagnosis: Anxiety Disorder

Goal: Alleviation of anxiety symptoms and improvement in ability to function independently

Objectives:

- Patient will identify at least three new coping skills that she can utilize
- Patient will report at least six hours of sleep per night
- Patient will participate in group.....
- Patient will identify anxiety/fear situations and.... (diary, log,)

Diagnosis: Obsessive-Compulsive Disorder

Goal: Reduction in the amount of time spent focused on obsessive thoughts and performing compulsive behaviors

Objectives:

- Patient will identify the relationship between obsessions and compulsions
- Patient will perform at least one new activity previously prevented by her OCD
- Patient will practice daily relaxation exercises
- Patient will identify at least three behaviors with response prevention
- Patient will attend

Diagnoses Alcohol/Drugs and Other Addictions

Goal: Be free of drug/alcohol use/abuse

Objectives:

- Avoid people, places and situations where temptation might be overwhelming
- Explore dynamics relating to being the [child/husband/wife] of an [alcoholic/addict] and discuss them each week at support group meetings
- Learn five triggers for alcohol & drug use
- Reach _____ days/months/years of clean/sober living
- Attend.....

Creation of “templates”

- Templates can be used to create goals and objectives as long as they are customized to meet the specific patient need/process
- These elements may be carried over from visit to visit as long as the current status or progress is identified as part of this process
- No blanket goals and objects for all patients – this is cloning and may be considered medically unnecessary documentation

Psychotherapy in crisis

- These new codes are time based and status based
- 90839 Psychotherapy in crisis, first 60 minutes
- +90840 each additional 30 minutes (List separately in addition to code for primary service)

(Use 90840 in conjunction with 90839 based on total time)

(Do not report 90839, 90840 in conjunction with 90791, 90792, psychotherapy codes 90832-90838 or other psychiatric services 90785-90899)

The crisis code...

- Is used for an urgent assessment and history of crisis state, a mental status exam and disposition.
- This includes psychotherapy, mobilization of resources to diffuse crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma
- Typically life threatening, complex and requires immediate attention to a patient in high distress
- Can be coded by DO, MD, APRN, or PA or other qualified health care providers (LSW, LISW, psychology, counselors)

The time

- The time counted towards this service must be face to face with the patient and/or family
- The time does not need to be continuous
- The full attention of the provider (physician or other qualified health care provider) must be devoted to this patient/family
- The patient must be present for some or all of the service
- 90839 is for the first 30-74 minutes and can only be coded once per date
- 90840 is coded for each additional block of 30 minutes (not less than 15 minutes)
- For services under 30 minutes, code 90832/90833 for time over 16 minutes

Summary Therapy services...

CPT code	Service	Add on code
90839	Psychotherapy for crisis; first 60 minutes +90840 Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)	None – no interactive complexity, no assessment or E&M by the same provider
90846	Family psychotherapy (without the patient present)	None
90847	Family psychotherapy (conjoint psychotherapy) (with patient present)	None
90849	Multiple-family group psychotherapy	None
90853	Group psychotherapy (other than of a multiple-family group)	Interactive complexity

Individual Therapy coding...

CPT Code	Service	Add on code(s)
90832	Psychotherapy, 30 minutes with patient and/or family member	Interactive complexity(90785)
+90833	Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	E&M primary Interactive complexity
90834	Psychotherapy, 45 minutes with patient and/or family member	Interactive complexity
+90836	Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	E&M primary Interactive complexity

CPT Code	Service	Add on Code(s)
990837	Psychotherapy, 60 minutes with patient and/or family member	Interactive complexity (90785)
+90838	Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	E&M primary Interactive complexity

Additional Resources

- Ohio Department of Medicaid

<http://bh.medicaid.ohio.gov/>

- CGS – Ohio Medicare for links to E&M documentation and coding guidelines

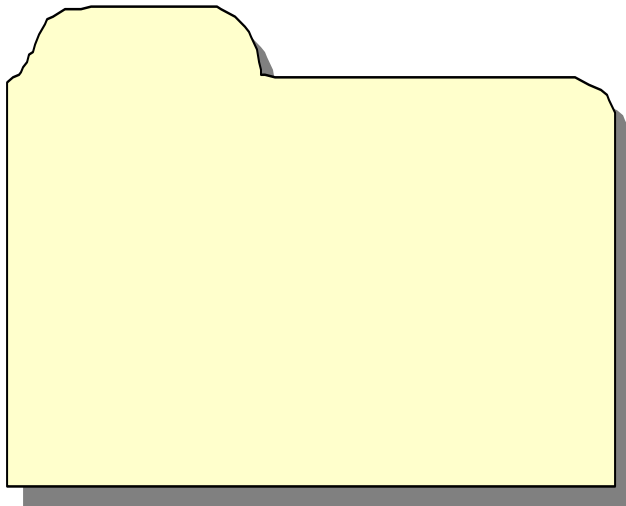
<http://www.cgsmedicare.com/partb/index.html>

Under “Browse by Topic”

Evaluation and Management

Mental Health Services

Questions and answers..



- If the care and services are not documented they are considered not performed
- Timely
- Complete within EMR/EHR or handwritten document
- Signed
- HIPAA compliant!