BEHAVIORAL HEALTH BILLING: LESSONS LEARNED FROM COLORADO PRACTICES

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ENOS Medical Coding

Approved Instructor

Agenda

- Documentation Basics
- Psychotherapy Codes/Time
- Interactive Complexity
- Other types psychotherapy services
- Med Management Visits
- New Medicare Add-On
- Question & Answer

Documentation is CRITICAL!

- The primary function of the medical record is to convey important medical information in order to ***deliver optimal care to the patient***.
- A secondary function of the medical record is for ***medicolegal*** purposes.
- Lastly the medical record acts as a sort of ***invoice***.

Most Common Errors:

- Invalid or Missing Chief Complaint
- Time Missing
- Initial Psychiatric Evaluation Missing Complete History
- Psychotherapy Missing Required Elements
- Prolonged Services Not Billed
- Interactive Complexity Present – Not Billed
- Telehealth Services – Time or other Required Element Not Documented

Medical Necessity

- The chief complaint describes the reason for the encounter.
- It should be clearly stated or easily inferred from the HPI.
- Without a properly document chief complaint, the claim may be denied due to ***lack of medical necessity.***
- A well-documented chief complaint establishes the medical necessity for the frequency or extent of the services

Medical Necessity

- The chief complaint is often stated in the patient's own words. It should be stated in a way that describes the patient's ***problem or condition***, and/or the reason for the encounter:
  - "I can't sleep"
  - Follow-up: depression and substance use disorder
  - Patient seen for evaluation of outbursts at school and worsening grades

- Avoid complaints that are vague, and don't describe the patient's condition:
  - **Routine visit**
  - **Here for f/u**
  - **Patient here for scheduled visit**

Psychiatric Diagnostic Evaluation

- 90791 (no medical component)
  - 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.

Psychiatric Diagnostic Evaluation

- 90792 (medical component)
  - Psychiatric diagnostic evaluation with medical services is an integrated biopsychosocial assessment ***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.

Medical Thinking

Medical thinking is the main component that differentiates an evaluation by a psychiatrist, APN, or PA from one by a non medical provider:

Includes *consideration* of:

– Medical history and comorbidities

– Medications prescribed by others

– Further medical work up

– Medical treatments

– Integration of signs and symptoms from a medical standpoint

Psychiatric Diagnostic Evaluation (90791-90792)

- The psychiatric diagnostic procedure codes require the elicitation of a **complete** medical (including past, family, social) and psychiatric history, a mental status examination, establishment of an initial diagnosis, an evaluation of the patient's ability and capacity to respond to treatment, and an initial plan of treatment.
- In 90792, additional medical services such as physical examination and prescription of pharmaceuticals are provided in addition to the diagnostic evaluation.
- This service may be covered once, at the outset of an illness or suspected illness.

Psychotherapy

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

Psychotherapy Coverage

In order to qualify for coverage, the services must meet certain criteria:

- Individualized Treatment Plan
- Reasonable Expectation of Improvement
- Frequency and Duration of Services

Psychotherapy Documentation

- ❑ **Name** of beneficiary and date of service
- ❑ **Type** of service (individual, group, family, interactive, etc.)
- ❑ **Time** element, where time spent performing psychotherapy services is documented
- ❑ **Modalities** and frequency of treatment furnished
- ❑ A clinical note for each encounter including: **diagnosis, symptoms, functional status, focused mental status examination, treatment plan**, **prognosis**, and **progress to date**.
- ❑ **Identity and professional credentials** of the person performing service

Psychotherapy Documentation

- ❑ **Capacity to participate in psychotherapy** (where there is cognitive impairment)
- ❑ **Target symptoms**
- ❑ **Goals of therapy**
- ❑ **Methods of monitoring outcome**
- ❑ **Time** spent in therapeutic maneuvers
- ❑ **Periodic summary of goals, progress toward goals, and updated treatment plan**

Prolonged periods of psychotherapy must be well-supported in the medical record describing the necessity for ongoing treatment.

Psychotherapeutic Maneuvers Employed

- Providers are encouraged to clearly document the psychotherapeutic maneuvers employed.
- Psychotherapy does not include teaching grooming skills, monitoring activities of daily living (ADL), recreational therapy (dance, art, play) or social interaction. Therefore time spent performing these services **should not** be included in psychotherapy time.

Psychotherapy Providers

- While a variety of psychotherapeutic techniques are recognized for coverage, services must be performed by persons authorized by their state to render psychotherapy services:
  - Physicians,
  - clinical psychologists,
  - registered nurses with special training, and
  - clinical social workers.

Psychotherapy Time

- When billing for psychotherapy, the codes are based on the amount of **time** spent in psychotherapy, and whether or not there was a **medical** evaluation and management service performed in conjunction with psychotherapy:

Psychotherapy Alone	
Time	**Report**
30 (16-37)	90832
45 (38-52)	90834
60 (53+)	90837

Psychotherapy Plus E/M	
Time	**Report**
30 (16-37)	E/M + 90833
45 (38-52)	E/M + 90836
60 (53+)	E/M + 90838

Psychotherapy Time

These codes are based on the amount of time spent in psychotherapy, therefore the documentation must include ***specifically*** how much time was spent ***in psychotherapy.***

Do:

- Psychotherapy time: 9:05am to 10am
- 40 minutes spent in psychotherapy today
- 50 minutes of this 60-minute session was spent in psychotherapy

Don't:

- Session time: 9am to 10am (if a service besides psychotherapy is billed)
- 1 hour spent with patient today reviewing medications, completing paperwork for his parole officer, and performing supportive therapy
- Very lengthy session today, I spent most of my morning with this patient.

Psychotherapy Tips

- When documenting time for an encounter with psychotherapy alone, simply document the estimated time spent in psychotherapy.
- Make a template with the required elements so you don’t forget any.
- Don’t forget, interactive complexity may still be reported for these visits!

Interactive Complexity

- 90785 is an add-on code, it is never reported alone. Instead, it is reported in conjunction with a 'parent' or 'primary' procedure, and results in increased reimbursement for the added complexity.
- 90785 describes 4 types of **communication factors**. It also describes 3 types of **patients and situations** most commonly associated with interactive complexity.

Typical Patients/Situations

Others legally responsible for patient's care

- **minors or adults with guardians**

Others involved in patient's care during the visit

- **adults accompanied by family members or interpreter**

Required involvement of other third parties

- **child welfare agencies, parole officers, schools**

Interactive Complexity

4 Specific Communication Factors are identified

1) Maladaptive Communication among visit participants
2) Interference from caregiver emotions or behavior
3) Disclosure and discussion of a sentinel event
4) Language difficulties

- These complicate the work of the primary psychiatric procedure
- Note that these are communication factors ***during*** the session.

Interactive Complexity

The Interactive Complexity add-on code **+90785** may be reported in conjunction with the following primary procedures:

- Psychiatric Diagnostic Evaluation (90791,90792)
- Psychotherapy (90832-90838)
- Group Psychotherapy (90853)

It **may not** be reported in conjunction with:

- An E/M procedure alone
- Family psychotherapy
- Psychotherapy for crisis

Other Psychotherapy

- Psychotherapy for crisis is an urgent assessment and history of a crisis state, a mental status exam, and a disposition. Treatment includes:
  - Psychotherapy,
  - Mobilization of resources to defuse the crisis and restore safety,
  - Implementation of psychotherapeutic interventions to minimize the potential for psychological trauma

- The presenting problem is typically ***life threatening*** or complex and ***requires immediate intervention***

Other Psychotherapy

- Psychotherapy time computed by total face-to-face time with the patient and/or family, even if the time is not continuous.
- Cannot provide services to any other patient during the same time period.
- **90839** is for the first 60 minutes (30-74 minutes)
- **+90840** is an add-on code for each additional 30 minutes (75-104, 105-134, etc.)

Technology Considerations

- Psychotherapy services do meet the criteria for telehealth billing. The following services may be billed to Medicare *even if they are audio-only.*
  - Psychiatric Diagnostic Evaluation
  - Psychotherapy
  - Family Psychotherapy
  - Group Psychotherapy
  - Psychotherapy For Crisis

CPT Code	Description	Telehealth Eligible	Permanent or Temporary Allowance
90791	Psychiatric diagnostic evaluation	Yes	Permanent
90792	Psychiatric diagnostic evaluation with medical services	Yes	Permanent
90832	Psychotherapy, 30 minutes	Yes	Permanent
90834	Psychotherapy, 45 minutes	Yes	Permanent
90837	Psychotherapy, 60 minutes	Yes	Permanent
90839	Psychotherapy for crisis, first 60 minutes	Yes	Permanent
90840	Psychotherapy for crisis, each additional 30 minutes	Yes	Permanent
90785	Interactive complexity (add-on code)	Yes	Permanent

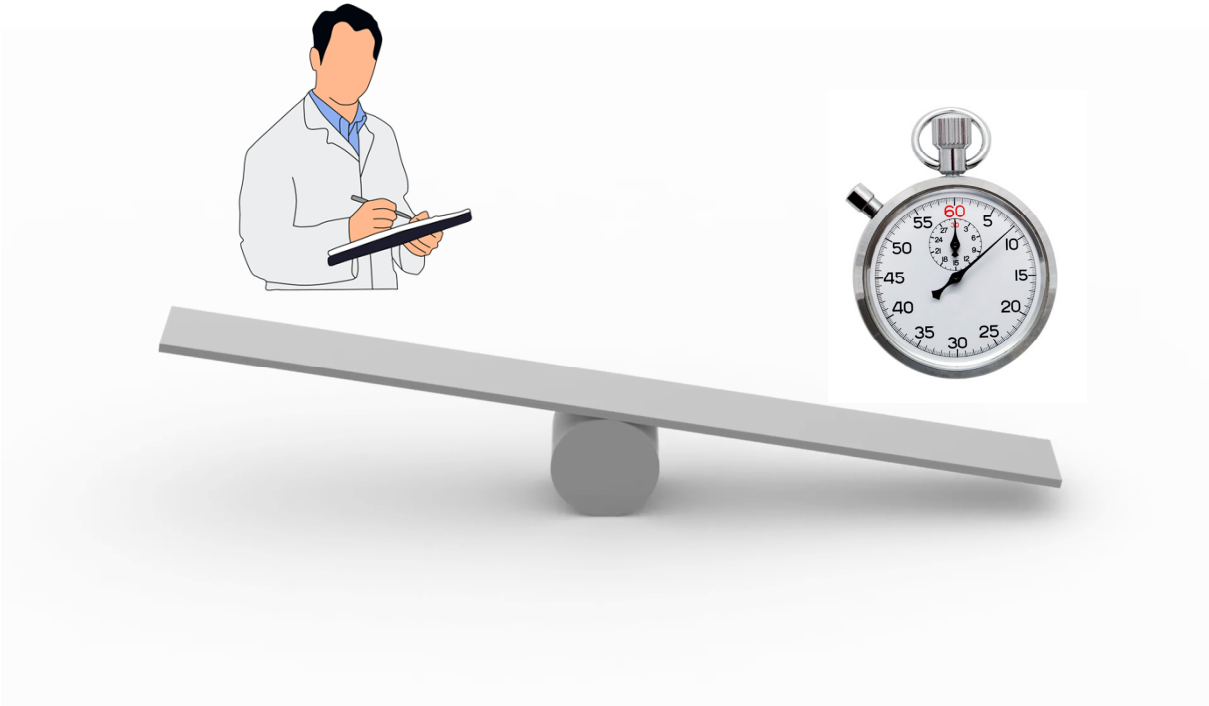
CPT Code	Description	Telehealth Eligible	Permanent or Temporary Allowance
99202	E/M services, new patient, 15-29 minutes	Yes	Permanent
99202	E/M services, new patient, 15-29 minutes	Yes	Permanent
99204	E/M services, new patient, 45-59 minutes	Yes	Permanent
99204	E/M services, new patient, 45-59 minutes	Yes	Permanent
99212	E/M services, established patient, 10-19 minutes	Yes	Permanent
99212	E/M services, established patient, 10-19 minutes	Yes	Permanent
99212	E/M services, established patient, 10-19 minutes	Yes	Permanent
99212	E/M services, established patient, 10-19 minutes	Yes	Permanent

Evaluation & Management
Medical Decision Making or Total Time

New Pt Office Visit		
E/M Code	MDM	Time
99202	S.F.	15 - 29
99203	Low	30 - 44
99204	Moderate	45 - 59
99205	High	60 - 74

Established Pt Office Visit		
E/M Code	MDM	Time
99212	S.F.	10 - 19
99213	Low	20 - 29
99214	Moderate	30 - 39
99215	High	40 - 54

MDM or Total Time



Time

- **Time alone may be used** to select the appropriate code level for E/M services
- For coding purposes, time for these services is the **total time on the date of the encounter**.
- It includes both the *face-to-face* and *non-face-to-face time personally spent* by the provider on the day of the encounter

Time

Physician/other qualified health care professional time includes the following activities, when performed:

- preparing to see the patient (eg, review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures

Time

Physician/other qualified health care professional time includes the following activities, when performed:

- referring and communicating with other health care professionals**
- documenting clinical information in the electronic or other health record
- independently interpreting results** and communicating results to the patient/family/caregiver
- care coordination**

***(when not separately reported)*

Time

When billing an E/M visit based on time, 2 things must be documented:

1) The **total time** spent on that date
2) What **activities** were done

30 minutes were spent reviewing prior records, meeting and examining the patient, counseling them regarding their condition, placing orders and referrals, and documenting in the health record.

Prolonged Services Code 99417

- The CPT Editorial Panel created a code for Prolonged Services. This new code captures shorter prolonged services (15-minute increments).
- **99417** has been updated and now may be used to report a prolonged office visit, office consultation, or other outpatient evaluation including home visits.

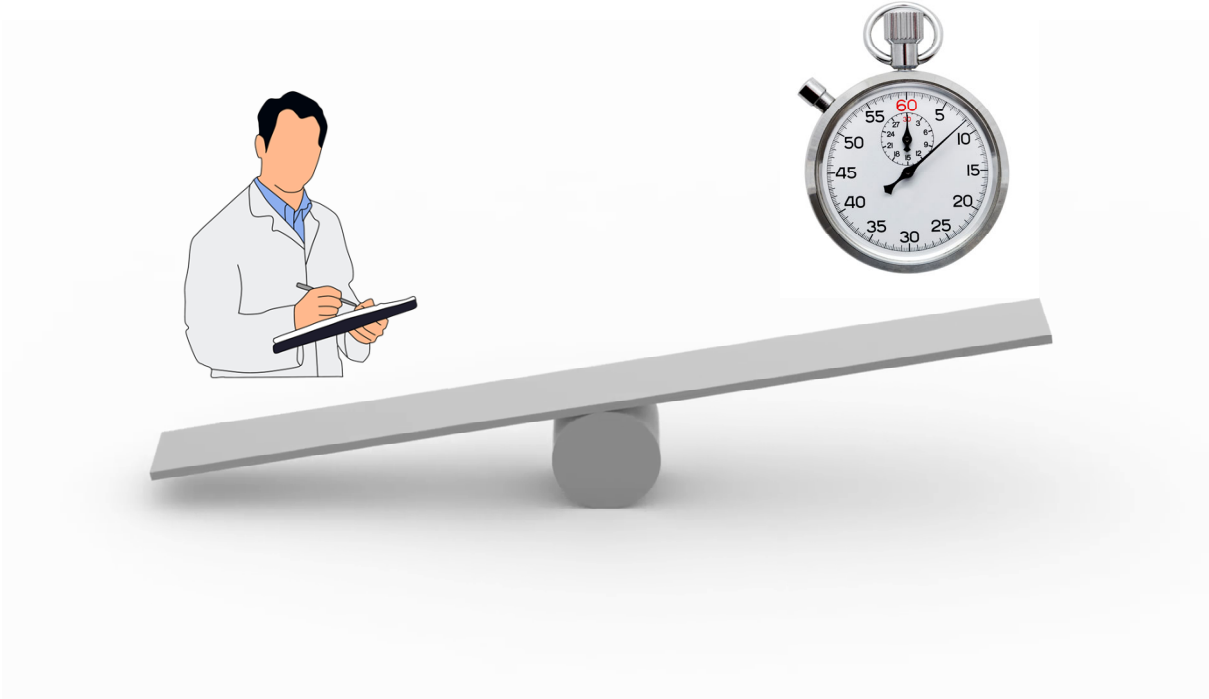
99417 Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time

Prolonged Services Example

A new patient is seen for evaluation of a rash. The provider spends a combined **80 minutes** preparing to see the patient (reviewing prior notes) obtaining the patient's extensive personal and family history, performing a full skin exam, counseling the patient and her spouse regarding diagnostic and treatment options, ordering medications and tests, and documenting information in the EHR.

Total Time	Billing
15 – 29	99202
30 – 44	99203
45 – 59	99204
60 – 74	99205
75 – 89	99205 **and** 99417
90 – 104	99205 **and** 99417 x 2

MDM or Total Time



Medical Decision Making (MDM)

Problems	Minimal	Low	Moderate	High
Data	Minimal	Limited	Moderate	Extensive
Risk	Minimal	Low	Moderate	High
MDM	**Straightforward**	**Low**	**Moderate**	**High**
Code	**Level 2**	**Level 3**	**Level 4**	**Level 5**

Number/Complexity of Problems Addressed

Problems	Minimal	Low	Moderate	High
	❑ **1** self-limited or minor problem	❑ **2** or more self-limited or minor problems; ❑ **1** stable chronic illness; ❑ **1** acute, uncomplicated illness or injury	❑ **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment; ❑ **2** or more stable chronic illnesses; ❑ **1** undiagnosed new problem with uncertain prognosis; ❑ **1** acute illness with systemic symptoms; ❑ **1** acute complicated injury	❑ **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; ❑ **1** acute or chronic illness or injury that poses a threat to life or bodily function

Number/Complexity of Problems Addressed

- ***Problem addressed:*** A problem is addressed or managed when it is evaluated or treated at the encounter. This includes consideration of further testing or treatment that may not be elected.
- Notation in the patient's medical record that another professional is managing the problem does not qualify as being 'addressed.'
- '**Stable**' is defined by the specific treatment goals for an individual patient

Number/Complexity of Problems Addressed

- Comorbidities, in and of themselves, are not considered in selecting a level of E/M services *unless* they are addressed, and their presence increases the complexity of data to be reviewed and analyzed or the risk of complications.
- The final diagnosis for a condition does not in itself determine the complexity or risk.
- Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.

Medical Decision Making (MDM)

Problems	Minimal	Low	Moderate	High
Data	Minimal	Limited	Moderate	Extensive
Risk	Minimal	Low	Moderate	High
MDM	**Straightforward**	**Low**	**Moderate**	**High**

Amount/Complexity of Data Analyzed

	Min	Limited	Moderate	Extensive (must meet 2/3)
Data	none	❑ **Any combination of 2 from the following:** ➢ Review of prior ***external note***(s) from each unique source ➢ review of the result(s) of each unique test ➢ ordering of each unique test ❑ **Assessment requiring an *independent historian*(s)**	❑ **Any combination of 3 from the following**: ➢ Review of prior external note(s) from each unique source ➢ Review of the result(s) of each unique test ➢ Ordering of each unique test ➢ Assessment requiring an independent historian(s) ❑ **Independent interpretation of a test performed by another physician/ qualified health care professional** ❑ **Discussion of management or test interpretation with external physician/other qualified health care professional**	❑ **Any combination of 3 from the following**: ➢ Review of prior external note(s) from each unique source ➢ Review of the result(s) of each unique test ➢ Ordering of each unique test ➢ Assessment requiring an independent historian(s) ❑ **Independent interpretation of a test performed by another physician/ qualified health care professional** ❑ **Discussion of management or test interpretation with external physician/other qualified health care professional**

Amount/Complexity of Data Analyzed

- An **external physician** is an individual who is not in the same group practice or is a different specialty or subspecialty.
- An **independent historian** is an individual who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history or because a confirmatory history is judged to be necessary.

Amount/Complexity of Data Analyzed

- ***Test:*** A clinical laboratory panel is a single test.
- ***Independent Interpretation:*** The interpretation of a test for which there is a CPT code and an interpretation or report is customary. This does ***not*** apply when the physician is reporting the service or has previously reported the service for the patient.

Amount/Complexity of Data Analyzed

Data is divided into three categories:

1. Tests, documents, orders, or independent historian(s).
2. Independent interpretation of tests.
3. Discussion of management or test interpretation with external physician.

Limited – category 1

2 tests

Moderate – Any **1** category

3 tests if using category 1

Extensive – Any **2** categories

3 tests if using category 1

Risk of Complications and/or Morbidity or Mortality

Risk: The assessment of the level of risk is affected by the nature of the event under consideration.

- Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty.
- For the purposes of medical decision making, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated.
- Risk also includes medical decision making related to the need to initiate or forego further testing, treatment and/or hospitalization.

Risk of Complications and/or Morbidity or Mortality

Risk	Minimal	Low	Moderate	High
	Minimal risk of morbidity from additional diagnostic testing or treatment	Low risk of morbidity from additional diagnostic testing or treatment	Moderate risk of morbidity from additional diagnostic testing or Treatment *Examples only:* • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by **social determinants of health**	High risk of morbidity from additional diagnostic testing or treatment *Examples only:* • Drug therapy requiring **intensive monitoring for toxicity** • Decision regarding elective major surgery w/ identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital-level care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Parenteral controlled substances

Risk of Complications and/or Morbidity or Mortality

- ***Social determinants of health:*** Economic and social conditions that influence the health of people and communities. (e.g. food or housing insecurity)
- ***Drug therapy requiring intensive monitoring for toxicity:*** A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. The monitoring may be by a lab test, a physiologic test or imaging. (e.g. monitoring for a cytopenia in the use of an antineoplastic agent between dose cycles or the short-term intensive monitoring of electrolytes and renal function in a patient who is undergoing diuresis.)

Medical Decision Making (MDM)

To qualify for a particular level of medical decision making, ***two of the three*** elements for that level of medical decision making must be met or exceeded.

Problems	Minimal	Low	Moderate	High
Data	Minimal	Limited	Moderate	Extensive
Risk	Minimal	Low	Moderate	High
MDM	**Straightforward**	**Low**	**Moderate**	**High**
Code	**Level 2**	**Level 3**	**Level 4**	**Level 5**

MDM Tips

MDM Complexity	Example
Straightforward	One self-limited or resolved problem
Low	Stable, uncomplicated, single problem
Moderate	Unstable, complicated, or multiple problems
High	Significant risk, requiring hospitalization

Evaluation & Management
Medical Decision Making or Total Time

New Pt Office Visit		
E/M Code	MDM	Time
99202	S.F.	15 - 29
99203	Low	30 - 44
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Established Pt Office Visit		
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99214	Moderate	30 - 39
99215	High	40 - 54

New Add-on Code G2211

CMS will cover this add-on code when it is billed with an office visit to better account for the additional resources of visits associated with:

- Serving as the **continuing focal point** for all of the patients' health care services needs
- Ongoing medical care related to a patient's **single, serious** condition, or **complex** condition

New Add-on Code G2211

- G2211 captures the inherent complexity of the visit that's derived from the **longitudinal nature** of the practitioner and patient relationship.
- The complexity that code G2211 captures isn't in the clinical condition, the complexity is in the **cognitive load** of the continued responsibility of being the focal point for all needed services for the patient.

New Add-on Code G2211

- There is no additional documentation required to bill G2211. The documentation only needs to show a **medically reasonable and necessary** office/outpatient E/M visit.
- G2211 reimburses approximately $16.05
- G2211 may not be reported without reporting an **associated O/O E/M visit**.
- G2211 isn't payable when the associated O/O E/M visit is reported with **modifier 25**

New Add-on Code G2211

Example:

A patient sees their primary care provider for sinus congestion. The PCP weighs conservative treatment or antibiotics. The PCP decides on a course of treatment and communicates recommendations to the patient.

99213

G2211

New Add-on Code G2211

Example:

During an office visit, Ms. H, diagnosed with anxiety, expresses worsening symptoms and admits to medication non-adherence. Trusting her psychiatrist, she shares this due to their established relationship. The psychiatrist adjusts dosages and emphasizes medication adherence, highlighting the importance of their ongoing care. This illustrates the complexity of managing conditions like anxiety, where trust is vital.

99214

G2211

Most Common Errors:

- Invalid or Missing Chief Complaint
- Time Missing or Unclear for Psychotherapy
- Initial Psychiatric Evaluation Missing Complete History
- Psychotherapy Progress Notes Missing Diagnosis or Plan
- Psychotherapy Missing or Unclear Modality
- Med Management Visits Missing Time (when it would have helped)
- Prolonged Services Not Billed
- Interactive Complexity Present – Not Billed
- Telehealth Services – Time or other Required Element Not Documented

Questions?

ENOS Medical Coding

Approved Instructor

About the Speaker

Mike Enos, CPC,CPMA,CEMC has over 15 years of experience in medical coding, billing compliance and revenue cycle management . After earning his B.A. from Rhode Island College, Mike pursued three professional medical coding certifications, including Certified Professional Coder (**CPC**), Certified Professional Medical Auditor (**CPMA**) and Certified Evaluation and Management Coder (**CEMC**). Mike became a certified CPC instructor (**CPC-I**) in 2016.

Mike has contributed articles to *Medical Economics* and *MGMA Connection* Magazine, and *AAPC Coder's Edge* magazine, and collaborated with *Physicians Practice*, *Contemporary OB/GYN*, and *Contemporary Pediatrics* magazines. He has presented at Regional and National MGMA Conferences, AAPC Chapter Meetings, the Rhode Island Medical Society, and the New England Quality Care Alliance (**NEQCA**) Fall Forum. He has joined the MGMA Health Care Consultant Group, and is a partner in Enos Medical Coding. He has joined several nationally accredited professional organizations, including the American Academy of Professional Coders (**AAPC**), National Alliance of Medical Auditing Specialists (**NAMAS**), Medical Group Management Association (**MGMA**), and American College of Medical Practice Executives (**ACMPE**.)

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Reference Material:

Contractor Name: Novitas Solutions, Inc.
MAC Jurisdiction: H
States: Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, and Texas
Article ID: L35101
Title: Psychiatric Codes
Link to article

Contractor Name: Novitas Solutions, Inc.
MAC Jurisdiction: H
States: Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, and Texas
Article: Checklist: Psychotherapy services documentation
Link to article

Publisher: Medicare Learning Network
Article: Evaluation and Management Services Guide
ICN: 006764 January 2020
Link to article

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