NORTH CAROLINA Psychiatric Association

UPDATE ON CPT CODING CHANGES

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OBJECTIVES

1. Billing
2. Documentation
3. How this relates to DSM 5

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Avoid Common Problems

1. Keep current
2. Stay familiar with codes
3. Codes do not equal reimbursement
4. Documentation is vital
5. Be proactive if you are experiencing problems
6. Know your resources

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BILLING

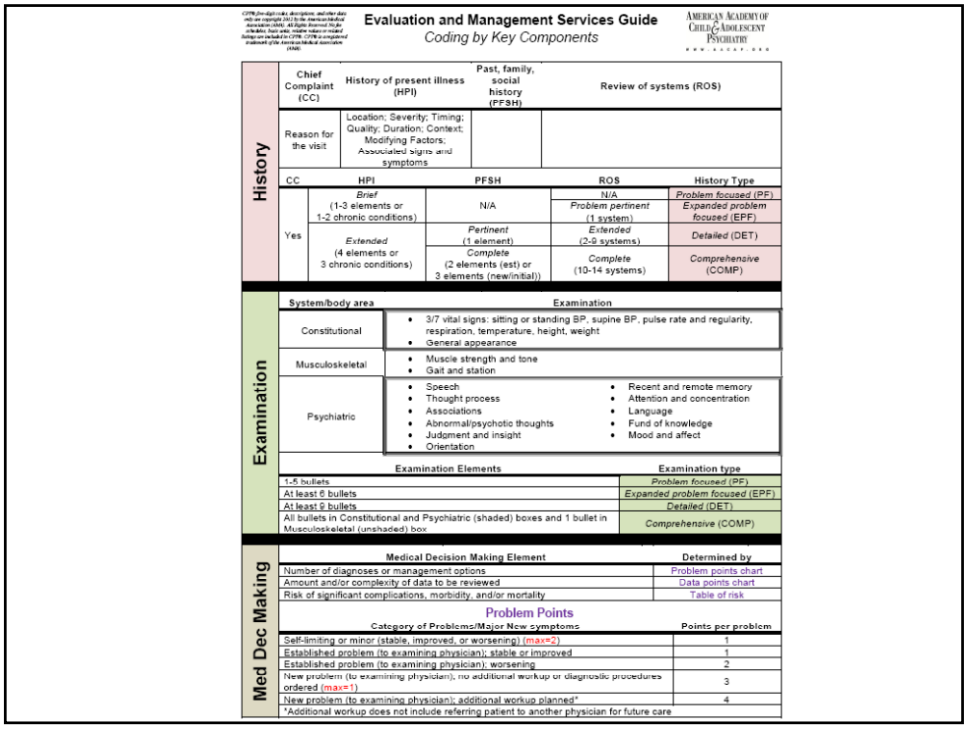
ALL STRESSED OUT
AND NO ONE TO CHOKE!

Office or Other Outpatient Services

New Patient	99201	99202	99203	99204	99205
HISTORY					
CC *	Required	Required	Required	Required	Required
HPI *	1-3 elements	1-3 elements	4 + elements	4 + elements	4 + elements
ROS *	N/A	Pertinent	2-9 systems	10-14 systems	10-14 systems
PFSH *	N/A	N/A	1 of 3 elements	3 of 3 elements	3 of 3 elements
PHYSICAL EXAMINATION					
1997	1-5 elements	6-8 elements	9 or more elements	Comprehensive	Comprehensive
1995	System of complaint	2-4 systems	5-7 systems	8 or > systems	8 or > systems
MEDICAL DECISION MAKING					
	SF	SF	Low	Moderate	High
TIME					
Face-to-face	10 min.	20 min.	30 min.	45 min.	60 min.

Office or Other Outpatient Services

Est. Patient	99211	99212	99213	99214	99215
HISTORY					
CC *	N/A	Required	Required	Required	Required
HPI *	N/A	1-3 elements	1-3 elements	4 + elements	4 + elements
ROS *	N/A	N/A	Pertinent	2-9 systems	10-14 systems
PFSH *	N/A	N/A	N/A	1 of 3 elements	2 of 3 elements
PHYSICAL EXAMINATION					
1997	N/A	1-5 elements	6-8 elements	9 or more elements	Comprehensive
1995	N/A	System of Complaint	2-4 systems	5-7 systems	8 or > systems
MEDICAL DECISION MAKING					
	N/A	SF	Low	Moderate	High
TIME					
Face-to-face	5 min. supervision	10 min.	15 min.	25 min.	40 min.



Evaluation and Management Services Guide

Coding by Key Components

American Academy of Child & Adolescent Psychiatry

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		

CC	HPI	PFSH	ROS	History Type
Yes	*Brief* (1-3 elements or 1-2 chronic conditions)	N/A	N/A	*Problem focused* (PF)
			Problem pertinent (1 system)	*Expanded problem focused* (EPF)
	Extended (4 elements or 3 chronic conditions)	*Pertinent* (1 element)	*Extended* (2-9 systems)	*Detailed* (DET)
		Complete (2 elements (est) or 3 elements (new/initial))	*Complete* (10-14 systems)	*Comprehensive* (COMP)

Examination

System/body area	Examination
Constitutional	• 3/7 vital signs: sitting or standing BP, supine BP, pulse rate and regularity, respiration, temperature, height, weight • General appearance
Musculoskeletal	• Muscle strength and tone • Gait and station
Psychiatric	• Speech • Thought process • Associations • Abnormal/psychotic thoughts • Judgment and insight • Orientation • 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)

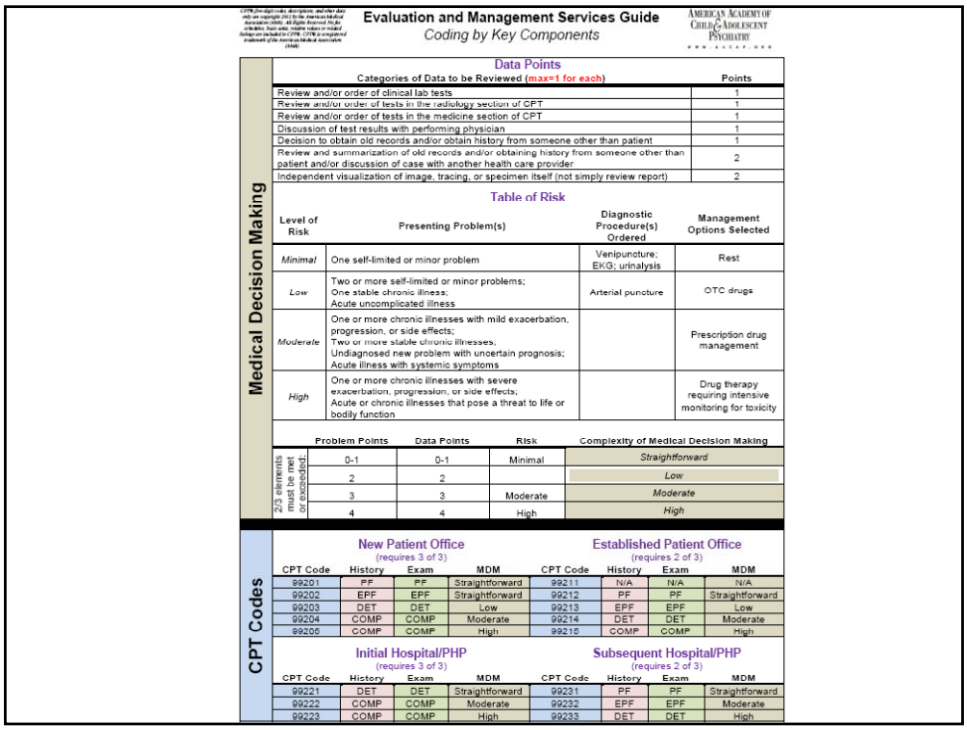
Med Dec Making

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



Evaluation and Management Services Guide

Coding by Key Components

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Medical Decision Making

Data Points

Categories of Data to be Reviewed (max=1 for each)	Points
Review and/or order of clinical lab tests	1
Review and/or order of tests in the radiology section of CPT	1
Review and/or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than patient	1
Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider	2
Independent visualization of image, tracing, or specimen itself (not simply review report)	2

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

2/3 elements must be met or exceeded: Problem Points	Data Points	Risk	Complexity of Medical Decision Making
0-1	0-1	Minimal	*Straightforward*
2	2		*Low*
3	3	Moderate	*Moderate*
4	4	High	*High*

CPT Codes

New Patient Office (requires 3 of 3) / **Established Patient Office** (requires 2 of 3)

CPT Code	History	Exam	MDM	CPT Code	History	Exam	MDM
99201	PF	PF	Straightforward	99211	N/A	N/A	N/A
99202	EPF	EPF	Straightforward	99212	PF	PF	Straightforward
99203	DET	DET	Low	99213	EPF	EPF	Low
99204	COMP	COMP	Moderate	99214	DET	DET	Moderate
99205	COMP	COMP	High	99215	COMP	COMP	High

Initial Hospital/PHP (requires 3 of 3) / **Subsequent Hospital/PHP** (requires 2 of 3)

CPT Code	History	Exam	MDM	CPT Code	History	Exam	MDM
99221	DET	DET	Straightforward	99231	PF	PF	Straightforward
99222	COMP	COMP	Moderate	99232	EPF	EPF	Moderate
99223	COMP	COMP	High	99233	DET	DET	High

Psychiatric Single Organ System Exams

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 within a bold-type box and **at least one** element within a non-bold type box.

Psychiatric

System/Body Area	Elements of Examination
Constitutional	• **Measurement of *any three of the following seven* 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. preservation, 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*

Evaluation and Management Codes Most Likely to be Used by Psychiatrists

Category/Subcategory	Code Numbers
Office or outpatient services	
New patient	99201–99205
Established patient	99211–99215
Hospital observational services	
Observation care discharge services	99217
Initial observation care	99218–99220
Hospital inpatient services	
Initial hospital care	99221–99223
Subsequent hospital care	99231–99233
Hospital discharge services	99238–99239
Consultations	
Office consultations	99241–99245
Inpatient consultations	99251–99255
Emergency department services	
Emergency department services	99281–99288
Nursing facility services	
Initial Nursing Facility Care Subsequent nursing facility care	99304–99306 99307-99310
Nursing facility discharge services Annual Nursing Facility Assessment	99315–99316 99318
Domiciliary, rest home, or custodial care services	
New patient	99324–99328
Established patient	99334–99337
Home services	
New patient	99341–99345
Established patient	99347–99350

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Category/Subcategory	Code Numbers
Team conference services	
Team conferences with patient/family	99366*
Team conferences without patient/family	99367
Behavior Change Interventions	
Smoking and tobacco use cessation	99406-99407
Alcohol and/or Substance abuse structured screening and brief intervention	99408-99409
Non-Face-to-Face Physician Services*	
Telephone services	99441-99443
On-Line Medical Evaluation	99444
Basic Life and/or Disability Evaluation Services	99450
Work Related or Medical Disability Evaluation Services	99455-99456

*Medicare covers only face-to-face services

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Keep current; Stay familiar with codes

- The current *CPT* manual, which is the ultimate authority on procedure coding. You can buy a copy of the manual by calling the AMA at (800) 621-8335. Electronic versions are also available.
- As a physician, you are entitled to use *all* of the codes in the *CPT* manual, not just the psychiatry codes. *CPT* contains an entire section of neurology codes, as well as evaluation and management (E/M) codes that include outpatient visits, hospital visits, and consultations.

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Codes do not equal reimbursement

- If you are providing a unique service or want to bill with an unusual code, you should contact the payer directly before reporting such a service and reach an agreement about:
  1.) the payer's willingness to reimburse you for the service and
  2) the payer's preferred method for reporting the service.
- Taking a proactive approach increases the likelihood that your claim will be processed promptly and correctly. In addition, such an approach gives you the opportunity to establish

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DOCUMENTATION

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Tips

- Documentation should include at least the following information:

1. Length of encounter
2. Description of the patient's mental state
3. Description of the service provided
4. Treatments implemented
5. Response to treatment
6. Legible signature

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E/M

For documenting evaluation and management services (E/M), you also need to consult the *CPT* manual. It contains a section of E/M guidelines to assist you in selecting and documenting the proper code and level of service.

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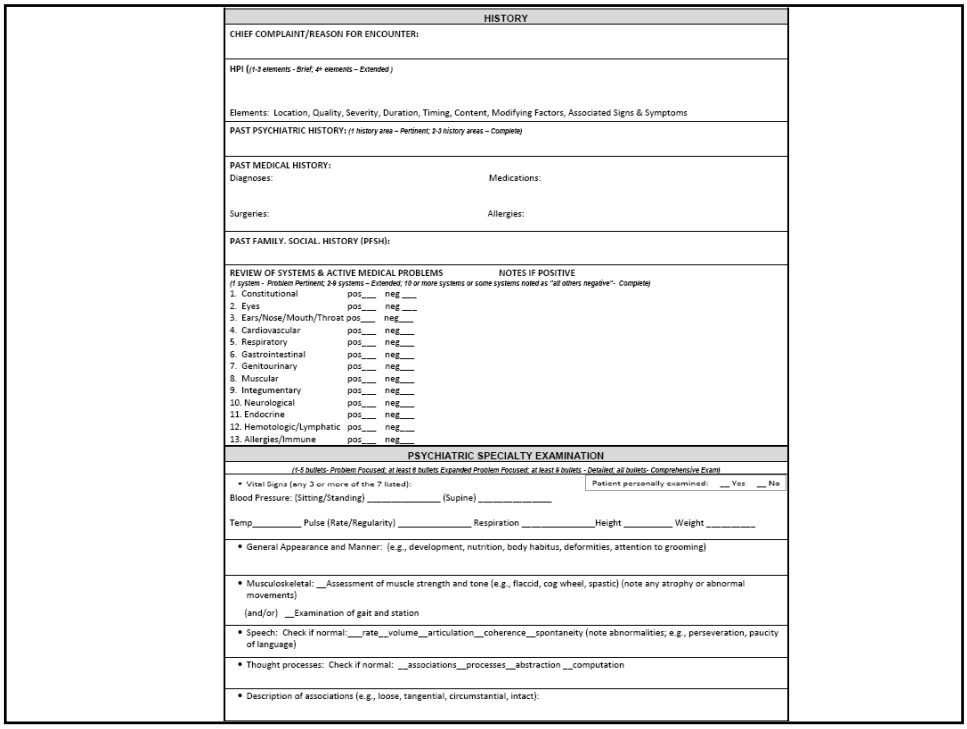


HISTORY

CHIEF COMPLAINT/REASON FOR ENCOUNTER:

HPI (*1-3 elements - Brief; 4+ elements – Extended*)

Elements: Location, Quality, Severity, Duration, Timing, Content, Modifying Factors, Associated Signs & Symptoms

PAST PSYCHIATRIC HISTORY: (*1 history area – Pertinent; 2-3 history areas – Complete*)

PAST MEDICAL HISTORY:

Diagnoses: Medications:

Surgeries: Allergies:

PAST FAMILY. SOCIAL. HISTORY (PFSH):

REVIEW OF SYSTEMS & ACTIVE MEDICAL PROBLEMS **NOTES IF POSITIVE**

(*1 system - Problem Pertinent; 2-9 systems – Extended; 10 or more systems or some systems noted as "all others negative"- Complete*)

1. Constitutional pos___ neg ___
2. Eyes pos___ neg ___
3. Ears/Nose/Mouth/Throat pos___ neg___
4. Cardiovascular pos___ neg___
5. Respiratory pos___ neg___
6. Gastrointestinal pos___ neg___
7. Genitourinary pos___ neg___
8. Muscular pos___ neg___
9. Integumentary pos___ neg___
10. Neurological pos___ neg___
11. Endocrine pos___ neg___
12. Hemotologic/Lymphatic pos___ neg___
13. Allergies/Immune pos___ neg___

PSYCHIATRIC SPECIALTY EXAMINATION

(*1-5 bullets- Problem Focused; at least 6 bullets Expanded Problem Focused; at least 9 bullets - Detailed; all bullets- Comprehensive Exam*)

- Vital Signs (any 3 or more of the 7 listed):

Patient personally examined: __Yes __No

Blood Pressure: (Sitting/Standing) _____ (Supine) _____

Temp_____ Pulse (Rate/Regularity) _____ Respiration _____Height _____ Weight _____

- General Appearance and Manner: (e.g., development, nutrition, body habitus, deformities, attention to grooming)
- Musculoskeletal: __Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) (note any atrophy or abnormal movements)

  (and/or) __Examination of gait and station
- Speech: Check if normal:___rate__volume__articulation__coherence__spontaneity (note abnormalities; e.g., perseveration, paucity of language)
- Thought processes: Check if normal: __associations__processes__abstraction __computation
- Description of associations (e.g., loose, tangential, circumstantial, intact):

- Description of abnormal or psychotic thoughts (e.g., hallucinations, delusions, preoccupation with violence, homicidal or suicidal ideation, obsessions):

Suicidal ideation: __ Present__ Absent Homicidal ideation: __Present __ Absent Violent ideation: __Present __ Absent

- Description of patient's judgment and insight:
- Orientation:
- Memory (Recent/Remote):
- Attention/Concentration:
- Language:
- Fund of knowledge: __intact __inadequate
- Mood and affect:

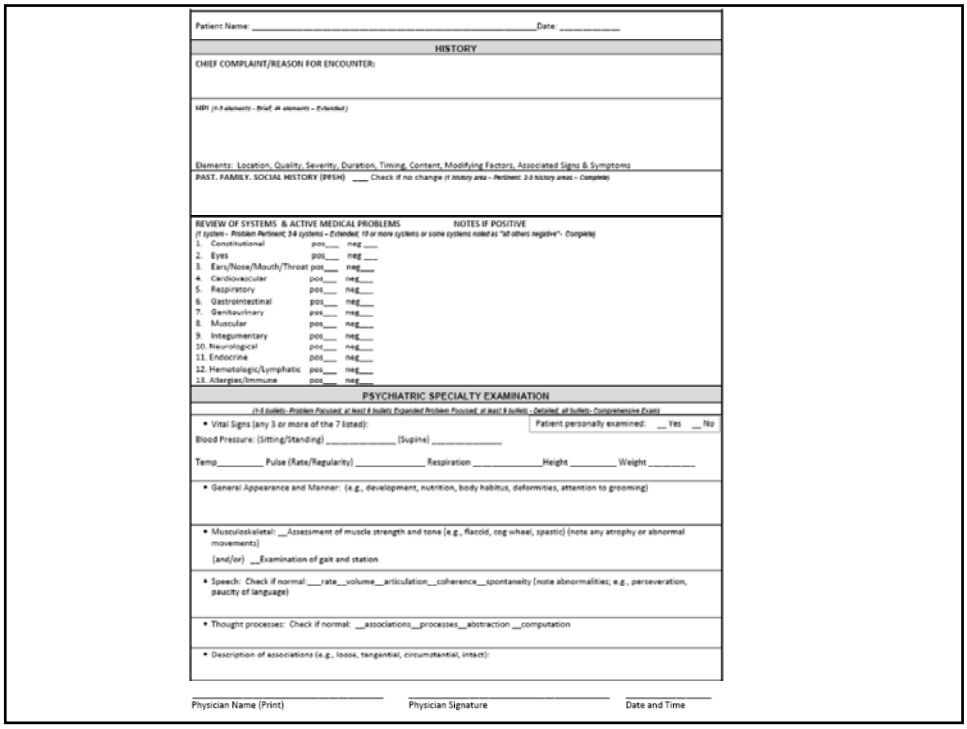
Other Findings (e.g. cognitive screens, etc.):

MEDICAL DECISION MAKING

Need for admission/evaluation:	Data Medical Records/Labs/Diagnostic Tests Reviewed:
Diagnoses	**Treatment Plan**
Axis I-V: Rule outs:	Intervention/Psychotherapy Medication
Formulation:	Labs/Radiology/Tests/Consultation Other

__Greater than 50% of time spent in counseling/coordination of care (document)

Physician Name (Print) Physician Signature Date and Time



Patient Name: _____ Date: _____

HISTORY

CHIEF COMPLAINT/REASON FOR ENCOUNTER:

HPI *(1-3 elements - Brief; 4+ elements – Extended)*

Elements: Location, Quality, Severity, Duration, Timing, Context, Modifying Factors, Associated Signs & Symptoms

PAST, FAMILY, SOCIAL HISTORY (PFSH) ___ Check if no change *(1 history area – Pertinent; 2-3 history areas – Complete)*

REVIEW OF SYSTEMS & ACTIVE MEDICAL PROBLEMS NOTES IF POSITIVE

(1 system – Problem Pertinent; 2-9 systems – Extended; 10 or more systems or some systems noted as "all others negative"- Complete)

1. Constitutional pos___ neg ___
2. Eyes pos___ neg ___
3. Ears/Nose/Mouth/Throat pos___ neg___
4. Cardiovascular pos___ neg___
5. Respiratory pos___ neg___
6. Gastrointestinal pos___ neg___
7. Genitourinary pos___ neg___
8. Muscular pos___ neg___
9. Integumentary pos___ neg___
10. Neurological pos___ neg___
11. Endocrine pos___ neg___
12. Hematologic/Lymphatic pos___ neg___
13. Allergies/Immune pos___ neg___

PSYCHIATRIC SPECIALTY EXAMINATION

(1-5 bullets- Problem Focused; at least 6 bullets Expanded Problem Focused; at least 9 bullets - Detailed; all bullets- Comprehensive Exam)

- Vital Signs (any 3 or more of the 7 listed): Patient personally examined: __ Yes __ No

Blood Pressure: (Sitting/Standing) _____ (Supine) _____

Temp_____ Pulse (Rate/Regularity) _____ Respiration _____Height _____ Weight _____

- General Appearance and Manner: (e.g., development, nutrition, body habitus, deformities, attention to grooming)

- Musculoskeletal: __Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) (note any atrophy or abnormal movements)

  (and/or) __Examination of gait and station

- Speech: Check if normal: ___rate__volume__articulation__coherence__spontaneity (note abnormalities; e.g., perseveration, paucity of language)

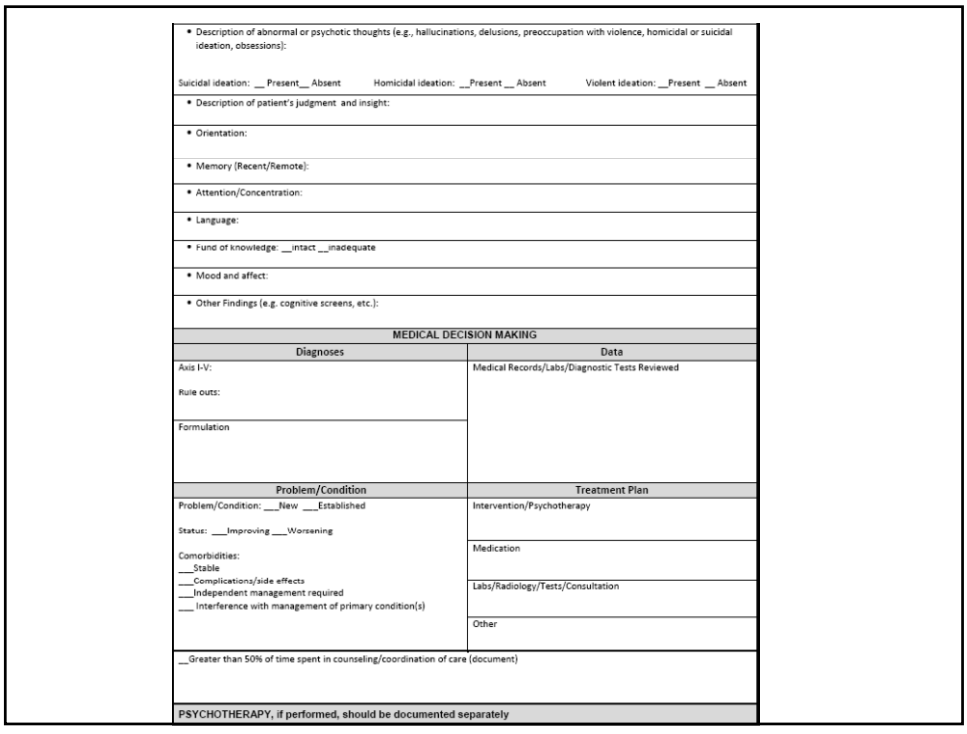
- Thought processes: Check if normal: __associations__processes__abstraction __computation

- Description of associations (e.g., loose, tangential, circumstantial, intact):

_____ Physician Name (Print)

_____ Physician Signature

_____ Date and Time



- Description of abnormal or psychotic thoughts (e.g., hallucinations, delusions, preoccupation with violence, homicidal or suicidal ideation, obsessions):

Suicidal ideation: __ Present__ Absent Homicidal ideation: __Present __ Absent Violent ideation: __Present __ Absent

- Description of patient's judgment and insight:
- Orientation:
- Memory (Recent/Remote):
- Attention/Concentration:
- Language:
- Fund of knowledge: __intact __inadequate
- Mood and affect:
- Other Findings (e.g. cognitive screens, etc.):

MEDICAL DECISION MAKING

Diagnoses	Data
Axis I-V: Rule outs:	Medical Records/Labs/Diagnostic Tests Reviewed
Formulation	
Problem/Condition	**Treatment Plan**
Problem/Condition: ___New ___Established Status: ___Improving ___Worsening Comorbidities: ___Stable ___Complications/side effects ___Independent management required ___ Interference with management of primary condition(s)	Intervention/Psychotherapy Medication Labs/Radiology/Tests/Consultation Other

__Greater than 50% of time spent in counseling/coordination of care (document)

PSYCHOTHERAPY, if performed, should be documented separately

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Counseling and Coordination of Care IS NOT Therapy

- Counseling is defined as a discussion with the patient and/or family or other care giver concerning one or more of the following: diagnostic results, prognosis, risks and benefits of treatment, instructions for management, compliance issues, risk factor reduction, patient and family education.
- Coordination of care is defined as discussions about the patient's care with other providers or agencies.

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Sample Therapy Documentation

Today we continued a session of _____ therapy.
Education was provided on _____ diagnosis.
We processed _____ issue/event related to this diagnosis.
_____ homework was provided to the patient to complete prior to the next session.
Time spent in session:

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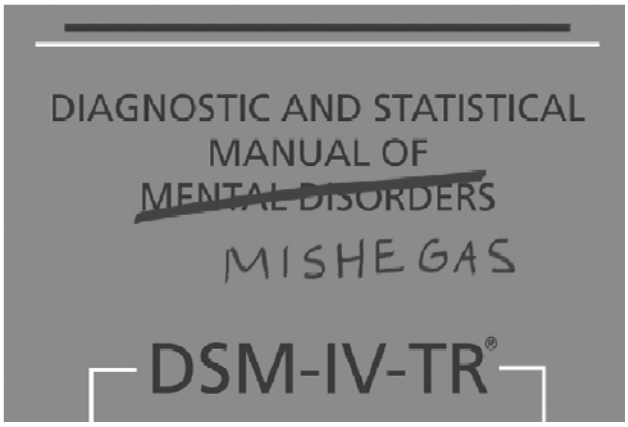
How This Relates to DSM 5



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Current information

- Dual coding is provided to account for the lag between DSM 5's publication and official implementation of ICD -10-CM codes (October 11, 2014).
- The APA is working with CDC-NCHS, CMS, and private insurance agencies to hopefully transition to DSM 5 by the insurance industry by December 31, 2013.

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If you experience reimbursement problems despite coding and documenting correctly, there are a number of steps you can take.

1. Fill out all forms completely and legibly. Stamp or write on any attachments: **PLEASE DO NOT SEPARATE ATTACHMENTS.**
2. Call the payer's provider relations department for feedback and information on policies.
3. Contact the chair of the Insurance or Managed Care Committee of your local psychiatric society. He or she may be able put you in touch with colleagues with similar problems, assist you in accessing APA resources, sponsor legislation, and/or organize and sponsor legal actions.
4. Call the APA's Practice Management Help Line, (800) 343-4671, to find out how to access the CPT Coding Network that is available to APA members.

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APA members with CPT coding questions should:

1. Create an e-mail or memo with their name, APA member number, city, state, phone number, fax number, and e-mail address.
2. State the question or describe the problem thoroughly, but succinctly— a short paragraph is usually all that is necessary.
3. Include any relevant correspondence from Medicare carriers, insurance companies, or third-party payers.
4. Cite any actions that have been taken relating to the problem, i.e., calls made or letters written.
5. Send the question to the attention of Rebecca Yowell by e-mail (hsf@psych.org), fax (703–907–1089), or regular mail (Office of Healthcare Systems and Financing, APA, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209).

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Questions?