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Frequently Asked Questions: 2013 CPT Coding Changes

The changes to the CPT Psychiatry codes were major. The entire coding framework has changed. The APA has based the answers to these FAQs on its general current understanding of the CPT codes and the information available to it. It is possible that as more information becomes available some the information could be outdated. THIS IS NOT LEGAL ADVICE. Members are advised to seek the advice of attorneys specializing in this area of law if for any legal questions.

Q: I understand there are now two codes to use for a standard initial psychiatric diagnostic evaluation, 90791 and 90792. Why was this done?

A: Previously all mental health clinicians use the same initial evaluation codes, 90801 and 90802, even though nonmedical providers could not provide the medical work that was described in those codes. In 2013, psychiatrists can use code 90792, which indicates medical services were provided, while nonmedical providers will use 90791, which does not include medical services. Medical services may consist of any medical activities such as performing elements of a physical exam or considering writing a prescription or modifying psychiatric treatment based on medical comorbidities.

Q: In looking at the 2013 Medicare Physician Fee Schedule, I noticed that Medicare is paying more for CPT code 90791, the code for the psychiatric diagnostic evaluation without medical services, than it is for 90792, the same code *with* medical services. How could this be?

A: These two codes were created to distinguish the work done by psychiatrists from that done by nonphysicians. They replace 90801, which was used by all mental health providers even though its descriptor included medical services that many of them were not qualified to perform. Unfortunately, and completely contrary to the usual procedure for newly created CPT codes, the Centers for Medicare and Medicaid service (CMS) chose to implement the new CPT coding structure for psychiatry without finalizing new values (RVUs) , as is normally the case. Instead, CMS created interim values for the new codes based on the 2012 code values and applied them to the 2013 coding structure. In order to maintain budget neutrality for 2013, CMS reduced the practice expense component for codes billed exclusively by medical professionals even though other changes to the code values were not made, while letting the practice expense value remain the same for nonphysician codes. The rationale given by CMS for this was that those providers now able to bill evaluation and management (E/M) services would benefit from higher practice expense payments any time they billed an E/M code. Oddly, CMS chose to apply this rationale not only to the values for the psychotherapy add-on codes that are used with E/M codes, but also to apply it to the initial diagnostic evaluation (90792) that includes medical services – a service that cannot be billed with an E/M code. As a result of this formula, the total payment for the 90792 is less (by about $25) than that for the 90791 even though the work is greater, the malpractice liability is greater, and the practice expense values are certainly no less than that for all mental health clinicians. Once the values are finalized and the practice expense is calculated equally, 90792 will pay more than 90791. Regardless of this, APA has made it clear to CMS that it is unacceptable for this current inequity to be in place even on an interim basis.

This anomaly incentivizes psychiatrists to code differently than they otherwise should. APA has asked CMS in multiple written communiqués and telephone conversations to correct this discrepancy but to date they have stood behind their decision despite the inequity and perverse incentives it has created in valuing a more complex service lower than the same service done without medical services .

Q: I understand that instead of using the previous psychotherapy codes with E/M services (90805, 90807), we now must bill using the appropriate E/M code from the 99xxx series of codes (i.e., 99211, 99212, etc) and a timed add-on code for the psychotherapy. What exactly is an add-on code?

A: An add-on code is a code that can only be used in conjunction with another, primary code and is indicated by the plus symbol (+) in the CPT manual. The add-on code concept was developed to eliminate the redundancy of work that occurs when you provide two services on the same day (i.e., reviewing a patient's medical record, greeting the patient). In the new Psychiatry codes there are three different types of add-on codes: 1.) Timed add-on codes to be used to indicate psychotherapy when it is done with medical evaluation and management; 2.) A code to be used when psychotherapy is done that involves interactive complexity; and 3.) A code to be used with the new crisis therapy code for each 30 minutes beyond the first hour. On the claim form, the add-on code is listed as a second code.

Q: What is an E/M code?

A: The evaluation and management (E/M) codes are found in the first section of the AMA CPT manual. The first two digits of this code set are 99. The E/M codes are generic in the sense that they can be used by all physicians. They describe general medical services. Code selection is based on whether the patient is new or established, the setting (outpatient, inpatient, nursing facility, etc.), and on the complexity of the service provided, which is based on the nature of the presenting problem. There are specific documentation requirements when using these codes. You can download a list of the most frequently used E/M codes as well as information on the documentation requirements on the APA's webpage for CPT Coding Changes (www.psychiatry.org/cptcodingchanges).

Q: I'd never used the CPT evaluation and management codes before, is there somewhere I can find out about how to use them?

A: You can download the chapter on E/M coding from the book *Procedure Coding for Psychiatrists* (the information on the psychiatry codes in this 2011 book is now obsolete, but the information about the E/M codes is current.) The chapter is available on the APA website at www.psychiatry.org/cptcodingchanges as are a number of webinars dealing with E/M coding. APA also has an online CME course on the CPT code changes available free to members at www.apaeducation.org .

Q: What E/M code would I be most likely to use to replace the basic E/M services I've been providing to my patients with whom I do psychotherapy and evaluation and management (for which I used to code 90807)?

A: The most basic E/M service provided by a physician for outpatient work with an established patient is 99212. This would most likely be the appropriate code to use when you see a stable patient. There are specific guidelines for selecting E/M codes published by the Centers for Medicare and Medicaid Services, and a link can be found to these guidelines at http://psychiatry.org/cptcodingchanges. The guidelines mandate elements of history, examination, and medical decision making that must be covered to satisfy the various levels of E/M coding, and you will have to be sure that your documentation fulfills the requirements for 99212 or any other E/M code that you use. The APA has templates on its website to assist with this documentation.

Q: Can I choose the E/M code on the basis of time spent providing counseling and coordination of care and also bill for psychotherapy using the psychotherapy add-on?

A: No, if you are doing psychotherapy in conjunction with an E/M service, you must choose the E/M code on the basis of the work performed, NOT on the basis of time spent providing counseling and coordination of care.

Q: In my outpatient practice I often see patients for medication management and previously used CPT code 90862, which was deleted for 2013. What code will I use in place of 90862?

A: The typical outpatient 90862 is most similar to E/M code 99213. If the patient you are seeing is stable, and really just needs a prescription refill, code 99212 might be a more appropriate crosswalk. If you have a patient with a very complex situation, you might need to use 99214, a higher level E/M code. The E/M codes have documentation guidelines published by the Centers for Medicare and Medicaid Services (CMS) that explain how to determine which level code to choose. There is a link to this information at http://psychiatry.org/cptcodingchanges.

Q: Are the times listed for the add-on psychotherapy codes in addition to the time spent doing the E&M or is the time spent doing the E&M included in the time listed for the psychotherapy?

A: The time listed for psychotherapy add-on code accounts ONLY for the time spent providing psychotherapy. Any time spent providing E/M services should not be included in the psychotherapy add-on time.

Q: I am a solo practitioner and generally see my patients for both E/M and psychotherapy on a weekly basis. Does the E/M code I bill limit the psychotherapy code I can bill?

A: No. The two services are separate. You code and document for whatever level of E/M is warranted by the patient's presenting problem that day and select the add-on psychotherapy code based on the length of time of the psychotherapy provided. The add-on psychotherapy codes are 90833 for 30 minutes, 90836 for 45 minutes, and 90838 for 60 minutes. Since the new psychotherapy codes are not for a range of time, like the old ones, but for a specific time, the CPT "time rule" applies. If the time is more than half the time of the code (i.e., for 90832 this would be 16 minutes) then that code can be used. For up to 37 minutes you would use the 30 minute code; for 38 to 52 minutes, you would use the 45-minute code, 90834; and for 53 minutes and beyond, you would use 90837, the 60-minute code.

Q: **I take no insurance in my practice, but give my patients invoices for my services, which they submit to their insurance company for reimbursement. I see my patient regularly for psychotherapy along with medical evaluation, and in the past have always coded for the visit with 90807. Under the new coding format, the patient is required to submit a bill with the new codes. I will code using 99212 (since almost all my patients are stable and just require minimal E/M) and 90836, the add-on psychotherapy code for 45 minutes of psychotherapy. My question is, with the new CPT codes, am I required to apportion my fee between these two codes? If so, is there a reasonable way to do this?**

A: It has become clear that most insurers are requiring that you apportion your fee between the two codes. The most reasonable way to do this may be to base how you apportion the fee on the relative value units that Medicare assigns to each of the codes. You can find these RVUs on the APA's website www.psychiatry.org/cptcodingchanges under the heading "RVUs." If you take the total of the RVUs for the two codes you bill and divide that into your total fee, that will give you your practice's fee for 1 RVU. Multiplying this by the RVUs assigned to each code will give you a fee for each code. Many payers base their fee schedules on the RVUs Medicare assigns so the provider may accept this approach.

If the patient's insurer does not use the Medicare RVUs, you could get a copy of the fee schedule used by the patient's insurer for its in-network providers. You can apply the ratio they use for the two codes to your total fee and come up with the ratio that insurer deems is appropriate for the two codes. If the insurer will not provide you with the fee schedule, ask them to provide the ratio between the relevant codes and use that information in your calculation.

Q: I'm a solo practitioner and still file paper claims, how do I fill out the 1500 form to show I've done an E/M service with psychotherapy?

A: The first service reported will be the E/M code, on line 1, and underneath that, on line 2, you will put the add-on code (just the five digits, no plus sign) as a second service. You fill out each line completely, including the fee for each service.

Q: I am a child psychiatrist and, in the past, generally billed using one of the interactive psychotherapy codes. What do I use now?

A: There is now an add-on code, 90785, that can be used with diagnostic evaluation or psychotherapy codes to indicate what is now referred to as "interactive complexity." The concept of interactive complexity has been expanded. See the interactive complexity guide developed by the American Academy of Child and Adolescent Psychiatry at http://psychiatry.org/cptcodingchanges .

Q: I practice at a community mental health center where the billing department has told me that I cannot use E/M codes because "it's not allowed" and because no insurance company, including Medicare, will reimburse for them. I have never understood this and am now wondering whether we will suddenly be able to use E/M codes in 2013 or whether we're going to have trouble getting paid for anything.

A: The CMHC where you work may, for whatever reasons, choose not to bill using E/M codes, and they may have contracts with some insurers that limit them to the codes in the Psychiatry section of CPT. However, Medicare has no stricture against reimbursing psychiatrists for providing E/M services, and under Parity no insurance company should refuse to reimburse psychiatrists when they provide E/M services. Under the new coding framework psychiatrists will have to use E/M codes for the evaluation and management services they provide. Any CMHC that previously excluded them from its billing should have changed its policy by now.

Q: What CPT code would be appropriate for a psychiatrist to bill for the evaluation of a patient in the emergency room setting? Would the ER evaluation and management CPT codes (99281-99291) be appropriate if the patient was already seen by a clinical social worker and the clinical social worker is billing for the psychiatric evaluation by using CPT 90791? Or, would the psychiatrist be allowed to bill for CPT code 90792 on the same day the clinical social worker used CPT 90791?

A: Usually the ER codes would be billed by the ER physician who sees the patient in the ER. The psychiatrist who sees the patient in the ER is doing so as an outpatient consultation. He/she could use the E/M outpatient consult codes (99241-99245) or 90792. (If the patient has Medicare, you can't bill the consult codes, but can use the outpatient E/M new patient visit codes , 99201-99205, instead, or 90792). If both a social worker and a psychiatrist each did a complete evaluation on a patient, the social worker could bill a 90791 and the psychiatrist a 90792. That said. Although you could code this way, it is likely that many payers would question why it was necessary for both clinicians to do an initial evaluation and they may not be willing to reimburse for both. If the patient is admitted to the inpatient psychiatry service, the psychiatrist would use the initial hospital care E/M codes (99221-99225), which would cover both the consult and initial psychiatric evaluation.

Q: What are the RVUs (including malpractice, practice expense, and work components) associated with the new codes? Without that information it is hard to decide what to charge for them.

A: Although RVUs for the codes were recommended to the Centers for Medicare and Medicaid Services by the AMA RUC based on surveys that were done for the new codes. CMS chose to give interim values to the new and revised CPT codes that had been reviewed. In the Final Rule for the 2013 Medicare Physician Fee Schedule, CMS said it would l finalize the values once all of the codes had been surveyed and valued by the RUC. This has occurred and final RVUs should be listed in the 2014 Medicare Fee Schedule. A table with the 2013 RVUs (the interim values) can be found at www.psychiatry.org/cptcodingchanges.

Q: Is the 90863 code for RNs to use?

A: 90863 is *only* for use by those few psychologists licensed to prescribe in Louisiana and New Mexico but who, as nonmedical clinicians, are not qualified to bill evaluation and management codes. 90863 is not recognized by Medicare.

Q: Can prescribing psychologists use E/M codes?

A: No, that is why code 90863 was created.

Q: Where in the CPT code manual does it state that 90863 is for prescribing psychologists only? (I don't find this reading the information provided on page 486.)

A: CPT is not provider specific, so this is not specifically stated. However, the rationale behind the development of that code was to accommodate those few psychologists who could prescribe, but by law cannot bill an E/M service.

Q: If during an evaluation or a follow-up session, meds are NOT prescribed, but the patient is assessed as to whether meds would be appropriate, can we still consider that an E/M?

A: Yes, E/M codes describe any manner of medical work and not just the prescription of medication.

Q: If the psychiatrist sees the patient and does 30 minutes of combined psychotherapy and medication management, and then the patient sees a social worker for 30 minutes of psychotherapy alone, what should they bill?

A: You would bill the work performed (E/M and the appropriate psychotherapy code for the psychiatrist; 30 minute psychotherapy code for the social worker). However, it's important to understand that the payer determines whether or not those codes can be billed on the same day for the same patient.

Q: Do you recommend using the E/M new patient codes or 90792?

A: You could use either. There may be times, based and the presenting problem and the complexity of the work performed, when a higher level E/M code may be more appropriate.

Q: What is the difference between Psychotherapy with E/M versus E/M with Psychotherapy?

A: Nothing, they both describe work that includes E/M and psychotherapy services, which is reported using a different coding schema in 2013. The new coding is meant to allow more accurate accounting of the E/M services provided.

Q: I am in-network for several insurance companies and they don't seem to be dealing correctly with the new coding. One of them is paying me less than it did last year even though I am providing the same service, albeit using different coding, and another is saying I should collect two copays from my patients even though I know this is wrong. What can I do?

A: Many insurers were handling claims inappropriately at the beginning of 2013, but have since adjusted their systems to comply with the new coding. If you are still having problems, please contact the APA's Practice Management HelpLine at 800-343-4671 or email us at hsf@psych.org .

Q: What are the times for the various E/M codes for established patients, and is there any reason you couldn't use the 50% counseling and coordination of care for every follow up visit if it applies?

A: Correct coding requires that you choose the code that most closely represents the work performed. If more than 50% of your E/M service involves counseling and coordination of care, you can choose the code on the basis of time. You cannot choose the E/M code on the basis of counseling and coordination of care if you also bill a psychotherapy service for the same visit. We must also warn you that consistently billing using high level E/M codes on the basis of counseling and coordination of care may often elicit an audit from Medicare or commercial insurers. In fact, Medicare announced that in 2013 it will be auditing claims for 99215 on the basis of frequency.

Q: What constitutes "counseling and coordination of care"?

A: Counseling, as defined by CPT, is a discussion with a patient and/or family concerning one or more of the following areas:

- Diagnostic results, impressions, and/or recommended diagnostic studies
- Prognosis
- Risks and benefits of management (treatment) options
- Instructions for management (treatment) and/or follow-up
- Importance of compliance with chosen management (treatment) options
- Risk factor reduction
- Patient and family education

Q: Is 30 minutes now the minimum face to face time for psychotherapy with a patient?

A: 30 minutes is the lowest timed psychotherapy code. Under the CPT time rule, the 30-minute code can be billed for sessions between 16 and 37 minutes.

Q: What has happened to the family therapy codes, 90846, 90847?

A: They are still there, nothing has changed.

Q: Family members of a man with serious mental illness who is not a patient of mine have asked to see me for assistance with navigating the mental health system on behalf of the patient and for help in dealing with

the patient at home. I was thinking of using 90846 and calling it Family Therapy without the patient present, but since the patient is not part of my practice this seems questionable.

A: You are not required to use CPT codes any time you provide medical services, although they are required for billing purposes. Since this is not a service that would be covered by health insurance, there is really no reason to code for this encounter. What is important is that you set the fee with the family in advance, and then provide them with a simple bill for counseling and assistance regarding the family member with mental illness.

Q: What is the difference between a new outpatient E/M visit versus an established outpatient visit; 99201 vs 99211?

A: You only use the new outpatient visit code when this is the first time you've ever treated the patient or it has been more than three years since you or anyone in your practice of the same specialty or subspecialty has seen the patient.

Q: If you are a small psychiatric office and purchasing CPT books, would it be best to purchase AMA CPT or ICD-9-CM VOL 1-3? Bundles are cheaper.

A: We would suggest purchasing the AMA CPT book so you have reference to the complete set of coding guidelines developed for the new codes psychiatrists will be using. The DSM uses ICD diagnostic codes, and the DSM-5 provides both the ICD-9-CM codes, which are in use now, and the ICD-10-CM codes, which will go into effect for use in the U.S. in October, 2014.

Q: Are there visit note templates that have been developed for psychiatrists to easily check off the bullets necessary for E/M coding?

A: Templates are available on the APA website at www.psychiatry.org/cptcodingchanges.

Q: Does 90792 cover deciding and prescribing medications in the session?

A: Yes, that could be one component of the medical service that differentiates 90792 from 90791.

Q: Are there specific requirements for 90792, and are there other codes for new patients beyond 90791 and 90792?

A: The documentation requirements for the 90792 are really the same as the documentation for 90801. The only difference is you will want to be sure to list any of the medical work when billing the 90792. Psychiatrists and others who can bill E/M codes may also choose to bill an initial evaluation with the appropriate E/M code.

Looking for more information on the CPT changes?

Go to http://www.psychiatry.org/cptcodingchanges.

Questions? APA Members may call 800-343-4671 or send an email to hsf@psych.org.

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