CPT Primer for Psychiatrists

What is CPT?
Current Procedural Terminology (CPT) was first published by the American Medical Association (AMA) in 1966. The CPT coding system was created to provide a uniform language for describing medical and surgical procedures and diagnostic services that would facilitate more effective communication between clinicians, third-party payers, and patients. The 2010 CPT Manual is the most recent revision of the 4th edition of the book.

The AMA's CPT Editorial Panel has the sole authority to revise, update, or modify CPT. The panel has seventeen members, eleven nominated by the AMA, and one each from the Blue Cross and Blue Shield Association, the Health Insurance Association of American, the Centers for Medicare and Medicaid Services (formerly HCFA), the American Hospital Association, and the Health Care Professionals Advisory Committee, and one representative from the AMA/Specialty Society RVS Update Committee. In 1990, Tracy Gordy, M.D., became the first psychiatrist to be appointed to the panel. He retired as chair of the panel in November 2007.

The CPT Editorial Panel is supported by the CPT Advisory Committee, which has representatives from over 90 specialty societies. The committee's main role is to advise the editorial panel on procedural coding and nomenclature that is relevant to each committee member's specialty. The committee also serves as a conduit through which revision to CPT can be proposed by specialty societies, or by individual members of those specialty societies.

The AMA's CPT coding system is now used almost universally throughout the United States. The Transaction Rule of the Health Insurance Portability and Accountability Act (HIPAA), which went into effect on October 16, 2002, requires the use of CPT codes by all who are covered by HIPAA. The CPT codes comprise Level I of the HCPCS (Health Care Financing Administration Common Procedure Coding System) codes used by Medicare and Medicaid. Every healthcare provider who is paid by insurance companies should have a working knowledge of the CPT system.

How Is the CPT Manual Organized?
The CPT manual is organized to be as user friendly as possible. The following is a quick survey of its contents.

Introduction
The short introduction contains valuable information for the clinician on how to use the manual, including:

- A description and explanation of the format of the terminology (This section describes how some routine procedural terms are not repeated for subsequent related procedures to conserve entry space.);
- A description of how to request updates of CPT (It is vital that physicians keep the AMA aware of changes in practice that require coding changes.);
- A discussion of the specific guidelines that precede each of the manual's six sections (E/M and the five clinical sections);
- A discussion of "add-on codes" for additional or supplemental procedures;
- An explanation of code modifiers and how they are to be used;
- A brief discussion of how place of service relates to CPT;

- A discussion of the inclusion of codes for unlisted procedures or services in each section;
- A note that some CPT codes require interpretation and reporting if they are to be used;
- A note that special reports may be required to determine the medical appropriateness of rare or very new services;
- A discussion of how to identify code changes from year to year;
- A reference to the expanded alphabetical index now included in the Manual;
- A note on how to obtain electronic versions of CPT; and finally

- How references to AMA resources on the CPT codes are noted in the Manual.

Illustrated Anatomical and Procedural Review

This section provides a review of the basics of anatomy and medical vocabulary that are necessary for accurate coding. Lists of prefixes, suffixes, and roots are given, followed by 22 anatomical illustrations. There is also an index of all the procedural illustrations that appear throughout the manual, listed by their corresponding codes.

Evaluation and Management Codes
Although the rest of the CPT manual is organized according to the numerical order of the codes, the evaluation and management (E/M) codes, 99xxx, are provided in the first code section because they are used by physicians in *all* specialties to report a considerable number of their services. The E/M codes are preceded by fairly extensive guidelines that define the terms used in the code descriptors and provide instructions for selecting the correct level of E/M service.

Major Clinical Sections
Next come the major clinical sections: Anesthesia, Surgery, Radiology, Pathology and Laboratory, and Medicine. Each of these sections is preceded by guidelines. The psychiatry codes, 908xx, are found in the Medicine section. The codes in the Psychiatry subsection cover most of the services mental health professionals provide to patients in both inpatient and outpatient settings.

Category II and III Codes
The Medicine section is followed by a listing of the supplemental Category II and Category III codes. These codes are generally optional codes used to facilitate data collection and are never used as substitutes for the standard Category I CPT codes.

Category II codes are used for performance measurement. According to the CPT Manual, Category II codes are "intended to facilitate data collection about the quality of care rendered by coding certain services and test results that support nationally established performance measures and that have an evidence base as contributing to quality patient care." These codes will be used more and more as Medicare attempts to shift from volume-based payment to quality-based payment.

Category III codes are temporary codes that are used to allow data tracking for emerging services and procedures.

Appendixes and Index
The last section of the manual includes appendixes and an extensive alphabetical index. There are 13 appendixes:

1. Appendix A: Modifiers—modifiers are two-digit suffixes that are added to CPT codes to indicate that the service or procedure has been provided under unusual circumstances (e.g., –21, which indicates a prolonged E/M service) (See Appendix B of this book for a list of modifiers.)

2. Appendix B: Summary of Additions, Deletions, and Revisions (of codes in the current manual)

3. Appendix C: Clinical Examples—provides clinical examples to clarify the use of E/M codes in various situations

4. Appendix D: Summary of CPT Add-On Codes—codes used to denote procedures commonly carried out in addition to a primary procedure

5. Appendix E: Summary of CPT Codes Exempt From Modifier –51 (multiple procedures)

6. Appendix F: Summary of CPT Codes Exempt From Modifier –63 (which denotes a procedure perfomed on infants)

7. Appendix G: Summary of CPT Codes That Include Moderate (Conscious) Sedation

8. Appendix H: Alphabetic Index of Performance Measures by Clinical Condition or Topic (a listing of the diseases, clinical conditions, and topics with which the Category II codes are associated.)

9. Appendix I: Genetic Testing Code Modifiers (used "to provide diagnostic granularity of service to enable providers to submit complete and precise genetic testing information wihout altering test descriptors.")

10. Appendix J: Electrodiagnostic Medicine Listing of Sensory, Motor, and Mixed Nerves

11. Appendix K: Products pending FDA Approval (vaccine products that have been assigned a Category I codes in anticipation of their approval)

12. Appendix L: Vascular Families

13. Appendix M: Crosswalk to Deleted CPT Codes (indicating which current codes are to be used in place of the deleted ones)

The index is preceded by instructions explaining that there are four primary classes of index entries:

1. Procedure or Service
2. Organ or Other Anatomic Site
3. Condition
4. Synonyms, Eponyms, and Abbreviations

The instructions also explain the index's use of modifying terms, code ranges, and space-saving conventions.

Psychiatry Codes

The codes most frequently used by psychiatrists can be found in the Psychiatry subsection of the Medicine section of the CPT Manual (codes 90785-90899). For 2013 and beyond there have been major changes to the Psychiatry codes. A distinction has been made between an initial evaluation with medical services done by a physician (90792) and an initial evaluation done by a non-physician (90791). The psychotherapy codes have been simplified: There are now three timed codes to be used in all settings (90832- 30 minutes; 90834-45 minutes; 90837-60 minutes) and accompanying add-on codes for psychotherapy (indicated in CPT by the + symbol) that are to be used by psychiatrists when the psychotherapy is provided in the same encounter as medical evaluation and management (+90833 -30 minutes, +90836 - 45 minutes, +90838 – 60 minutes). In lieu of the codes for interactive psychotherapy, there is now also an add-on code for interactive complexity (+90785) that may be used with any code in the Psychiatry section for which it is appropriate. Another change is that a new code has been added for psychotherapy for a patient in crisis (90839). When a crisis encounter goes beyond 60 minutes there is an add-on code for each additional 30 minutes (+90840). Code 90862 has been eliminated, and psychiatrists will now use the appropriate evaluation and management (E/M) code when they do pharmacologic management for a patient. (A new code, add-on code +90863, has been created for medication management when done with psychotherapy by the psychologists in New Mexico and Louisiana who are permitted to prescribe, but this code is **not** to be used by psychiatrists or other medical mental health providers). All of these changes are discussed in detail below.

<u>**Interactive Complexity Add-On**</u>

 + 90785 ⬧ Interactive Complexity -- This add-on code may be used with any of the codes in the Psychiatry section when the encounter is made more complex by the need to involve others than the patient. It will most frequently be used in the treatment of children. When this add-on is used, documentation must explain what exactly the interactive complexity was (i.e., the need for play equipment with a younger child; the need to manage parents' anxiety; the involvement of parents with discordant points of view).

What is an add-on code? An add-on code is a code that can only be used in conjunction with another code and is indicated by the plus symbol (**+**) in the CPT manual. While basic CPT codes are valued to account for pre- and post-time, add-on codes are only valued based on intra-service time since the pre- and post-time is accounted for in the basic code. 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 along with medical evaluation and management; 2.) A code to be used when psychotherapy is done that involves interactive complexity (e.g., psychotherapy provided to children or geriatric patients who have difficulty communicating without assistance); and 3.) A code to be used with the crisis therapy code for each 30 minutes beyond the first hour.

<u>**Psychiatric Diagnostic Evaluation Codes**</u>[*]

90791 ⬥ Psychiatric Diagnostic Evaluation – This code is used for an initial diagnostic interview exam for an adult or adolescent patient that does not include any medical services. In all likelihood this code will not be used by psychiatrists . It includes a chief complaint, history of

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[*] +90785, the system complexity add-on code, may be used with these codes

present illness, review of systems, family and psychosocial history, and complete mental status examination, as well as the order and medical interpretation of laboratory or other diagnostic studies. Most insurers will reimburse for one 90791 per episode of illness. Medicare will pay for only one 90791 per year for institutionalized patients unless medical necessity can be established for others.

90792♦ Psychiatric Diagnostic Evaluation with Medical Services– This code is used for an initial diagnostic interview exam for an adult or adolescent patient that includes medical services. It includes a chief complaint, history of present illness, review of systems, family and psychosocial history, and complete mental status examination, as well as the order and medical interpretation of laboratory or other diagnostic studies. Most insurers will reimburse for one 90792 per episode of illness. Medicare will pay for only one 90792 per year for institutionalized patients unless medical necessity can be established for others. Medicare permits the use of this code or the appropriate level of the E/M codes (see below) to denote the initial evaluation or first-day services for hospitalized patients. Medicare also allows for the use of 90792 if there has been an absence of service for a three-year period.

For 2013, it is important to note that both codes 90791 and 90802 are not subject to the outpatient mental health services limitation under Medicare that will be eliminated in 2014. They have always been reimbursed at 80% like all other medical codes.

Psychiatric Therapeutic Procedure Codes*
There are now three basic timed individual psychotherapy codes, which are to be used in all settings and add-on codes to be used when psychotherapy is done along with medical evaluation and management and/or when psychotherapy is provided for a patient when there is interactive complexity. Note that the descriptors for the psychotherapy codes now list the time as the time spent "with patient and/or family member," rather than "face-to-face with the patient" as for the previous psychotherapy codes.

Another difference is the way time is now defined by CPT. The CPT manual has standards in place that are to be used when selecting codes that have a time attached to them, except when rules are stipulated within the codes themselves. The bullets below will provide you with the basics for coding for psychiatric services.
- Time is only the time spent face-to-face with the patient and/or family member.
- When codes have sequential typical times attached to them, as with the basic psychotherapy codes, the code that is closest to the typical time should be selected.
- A unit of time is attained when the mid-point is passed. (For example, if you see a patient for more than 15 minutes you may code using 90832, the 30-minute code; and if you see a patient for 35 minutes, you would also use 90832. However, if you see the patient for 40 minutes, you would use 90834, the 45-minute code).

90832 ♦ Individual Psychotherapy, 30 minutes with patient and/or family member
+90833 ♦ Individual 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 the primary procedure.)

90834 ♦ Individual Psychotherapy, 45 minutes with patient and/or family member

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* +90785, the system complexity add-on code, may be used with all of these codes

+90836 ⬦ **Individual 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 the primary procedure.)

90837 ⬦ **Individual Psychotherapy, 60 minutes with patient and/or family member**
+90838 ⬦ **Individual 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 the primary procedure.)

Other Psychotherapy Codes[*]
90845 ⬦ **Psychoanalysis** – Psychoanalysis is performed by therapists who are trained and credentialed to practice it. Psychoanalysis is reported on a per-session basis and is reimbursed by most insurance programs. The issue of medical necessity has resulted in challenges to reimbursement for psychoanalysis by managed care companies. Note that 90845 is not a time-based code.

90846 ⬦ **Family Psychotherapy (Without the Patient Present)** – This code is used when the psychiatrist provides therapy for the family of a patient without the patient being present. Under Medicare rules, 90846 is only covered if the therapy is clearly directed toward the treatment of the patient, rather than to treating family members who may have issues because of the patient's illness.   While most insurance companies will reimburse for this code, problems may occur because the service is not face-to-face with the patient.

90847 ⬦ **Family Psychotherapy (Conjoint Psychotherapy) (With Patient Present)** – This code is used when the therapy includes the patient and family members. It is covered by most insurance plans, and is challenged less often than 90846 because the patient is present. It should also be used for couples therapy.

90849 ⬦ **Multiple-Family Group Psychotherapy** – This code is used when the psychiatrist provides psychotherapy to a group of adult or adolescent patients and their family members. The usual treatment strategy is to modify family behavior and attitudes. The service is covered by most insurance plans.

90853 ⬦ **Group Psychotherapy (Other Than of a Multiple-Family Group)** – This code relies on the use of interactions of group members to examine the pathology of each individual within the group. In addition, the dynamics of the entire group are noted and used to modify behaviors and attitudes of the patient members. The size of the group may vary depending on the therapeutic goals of the group and/or the type of therapeutic interactions used by the therapist. The code is used to report per-session services for each group member. Most insurance plans cover this procedure.

Codes for Other Psychiatric Services or Procedures ∗
90865 ⬦ **Narcosynthesis for Psychiatric Diagnostic and Therapeutic Purposes** (e.g. sodium amobarbital (Amytal) interview) – This procedure involves the administration, usually through slow intravenous infusion, of a barbiturate or a benzodiazepine in order to suppress inhibitions, allowing the patient to reveal and discuss material that cannot be verbalized without the disinhibiting effect of the medication. This code is reimbursed by most insurers.

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[*] +90785, the system complexity add-on code, may be used with all of these codes

90867♦ Therapeutic Repetitive Transcranial Magnetic Stimulation (TMS) initial treatment, including cortical mapping, motor threshold determination, delivery and management

90868♦Subsequent TMS Delivery and Management, per session

90869♦ Subsequent TMS Motor Threshold Re-Determination with Delivery and Management

90870♦Electroconvulsive Therapy (Includes Necessary Monitoring); Single seizure – This code is for electroconvulsive therapy (ECT), which involves the application of electric current to the patient's brain for the purposes of producing a seizure or series of seizures to alleviate mental symptoms. ECT is used primarily for the treatment of depression that does not respond to medication. The code includes the time the physician takes to monitor the patient during the convulsive phase and during the recovery phase. When the psychiatrist also administers the anesthesia for ECT, the anesthesia service should be reported separately, using an anesthesia code. ECT is covered by most insurance plans.

90875♦Individual Psychophysiological Therapy Incorporating Biofeedback Training by any Modality (face-to-face with the patient), With Psychotherapy (e.g., insight-oriented, behavior modifying, or supportive psychotherapy); approximately 20-30 minutes **and**,

 90876♦approximately 45-50 minutes

These two procedures incorporate biofeedback and psychotherapy (insight oriented, behavior modifying, or supportive) as combined modalities conducted face-to-face with the patient. They are distinct from biofeedback codes 90901 and 90911, which do not incorporate psychotherapy and do not require face-to-face time. Medicare will not reimburse for either of these codes.

90880♦Hypnotherapy – Hypnosis is the procedure of inducing a passive state in which the patient demonstrates increased amenability and responsiveness to suggestions and commands, provided they do not conflict seriously with the patient's conscious or unconscious wishes. Hypnotherapy may be used for either diagnostic or treatment purposes. This procedure is covered by most insurance plans.

90882♦Environmental Intervention for Medical Management Purposes on a Psychiatric Patient's Behalf With Agencies, Employers, or Institutions – The activities covered by this code include physician visits to a work site to improve work conditions for a particular patient, visits to community-based organizations on behalf of a chronically mentally ill patient to discuss a change in living conditions, or accompaniment of a patient with a phobia in order to help desensitize the patient to a stimulus. Other activities include coordination of services with agencies, employers, or institutions. This service is covered by some insurance plans, but because some of the activities are not face-to-face, the clinician should check with carriers about their willingness to reimburse for this code.

90885♦Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes – Although this would seem to be a very useful code, because reviewing data is not a face-to-face service with the patient, Medicare will not reimburse for this code and

some commercial carriers have followed suit. Medicare considers the review of data to be part of the pre-/postwork associated with any face-to-face service.

90887♦Interpretation or Explanation of Results of Psychiatric, Other Medical Examinations and Procedures, or Other Accumulated Data to Family or Other Responsible Persons, or Advising Them How to Assist Patient – Medicare will not reimburse for this service because it is not done face-to-face with the patient, and clinicians should verify coverage by other insurers to ensure reimbursement. It is appropriate to use an E/M code in the hospital where floor time is expressed in coordination of care with the time documented.

90889♦Preparation of Report of Patient's Psychiatric Status, History, Treatment, or Progress (Other Than for Legal or Consultative Purposes) for Other Physicians, Agencies, or Insurance Carriers – Psychiatrists are often called upon to prepare reports about the patient for many participants in the healthcare system. This code would be best used to denote this service. However, because this is not a service provided face-to-face with a patient, Medicare will not reimburse for this code either, and clinicians should verify coverage by other insurers.

90899♦Unlisted Psychiatric Service or Procedure – This code is used for services not specifically defined under another code. It might also be used for procedures that require some degree of explanation or justification. If the code is used under these circumstances, a brief, jargon-free note explaining the use of the code to the insurance carrier might be helpful in obtaining reimbursement. If it is used for a service that is not provided face-to-face with a patient, the psychiatrist should check with the patient's insurer regarding reimbursement.

95970, 95974, 95975♦Neurostimulators, Analysis–Programming – These codes have been approved for vagus nerve stimulation (VNS) therapy for treatment-resistant depression. Clinicians performing VNS therapy should use the appropriate code from the 95970, 95974, and 95975 series of codes found in the neurology subsection of the CPT manual. Medicare will not reimburse for these codes.

M0064♦Brief Office Visit for the Sole Purpose of Monitoring or Changing Drug Prescriptions Used in the Treatment of Mental Psychoneurotic and Personality Disorders – M0064 is not, in fact, a CPT code. It is a HCPCS Level II code (CPT codes are HCPCS Level I), part of the HCPCS system used by Medicare and Medicaid. M0064 should only be used for the briefest medication check with stable patients.

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Evaluation and Management Codes

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With the elimination of code 90862 and the addition of the add-on codes for psychotherapy when done with evaluation and management (E/M), psychiatrists will be using far more E/M codes than they have in the past. Previously, many psychiatrists just used the E/M codes for their inpatient and nursing facility encounters, but now they will be used for outpatient care as well.

The evaluation and management codes were introduced in 1992 to cover a broad range of services for patients, in both inpatient and outpatient settings. E/M code descriptors provide explicit criteria for selecting codes, and the clinical vignettes given in Appendix C of the CPT Manual provide examples of situations that fulfill these criteria.

Evaluation and management codes cover a family of *general medical services* provided in various settings, i.e., office, hospital, nursing home, emergency department, etc. While E/M codes are frequently used for hospital inpatient services, inpatient and outpatient consultations, and nursing facility services; they are less frequently used in psychiatry for office and other outpatient services, emergency department services, and domiciliary, rest home services.   It is extremely important to read the guidelines to the Evaluation and Management section of the CPT Manual because they explain how to choose the appropriate level of service when using E/M codes.

Level of Service
The level of service for an E/M code encompasses the skill, effort, time, responsibility, and medical knowledge necessary to evaluate, diagnose, and treat medical conditions. There are seven components that are used to define E/M levels of service:
- history,
- examination,
- medical decision making,
- counseling,
- coordination of care,
- nature of presenting problem, and
- time.

The three key components used in selecting the level of service within each category or subcategory of E/M service are:
- the extent of the history
- the extent of the examination
- the complexity of medical decision making involved

The clinician's ability to determine the appropriate level of service being provided to the patient within each category or subcategory of evaluation and management services is dependent on a thorough understanding of the Definition of Terms (found in the Evaluation and Management Services Guidelines that precede the listing of the E/M codes in the CPT Manual) and the Instructions for Selecting a Level of E/M Service (also in the Guidelines). The brief synopsis that follows is not an adequate substitute for a careful review of these sections of the CPT Manual.

There are three to five levels of service for each category or subcategory of E/M services. Each level of service represents the total work (skill, time, effort, medical knowledge, risk) expended by the clinician during an incident of service. For example, hospital inpatient services are divided into *initial hospital care* and *subsequent hospital care,* with three levels of service for initial care (99221-99223) and three levels of service for subsequent care (99231-99233); all of the levels based on depth of history and examination and complexity of the decision making involved, and the descriptors for the codes provide a typical time for the code as well. Consultations are divided into *office or other outpatient consultations, initial inpatient consultations.* There are five levels of service for office consultations (99241-99245), and initial inpatient consultations (99251-99255). Consultations are provided at the request of another healthcare provider to whom a written report must be given.The CPT Editorial Panel voted to delete the follow-up inpatient consultations and the confirmatory consultations. The appropriate E/M service code (i.e., Established patient, office or other outpatient service) should be used based on the setting and type of service. Clinicians should become thoroughly familiar with the

descriptors and codes within each family of services as well as with the guidelines that spell out the methodology for selecting the level of service provided.

History
There are four levels of history in the E/M codes: problem focused, expanded problem focused, detailed, and comprehensive. The more detailed the history, the greater the work effort.

Examination
The same four categories define the examination: problem focused, expanded problem focused, detailed, and comprehensive. The more extensive the examination, the greater the work effort. For psychiatry, a complete mental state examination (single system examination) qualifies as a comprehensive examination.

Decision Making
There are four levels of medical decision making presented in the E/M codes: 1. Straightforward; 2. Low complexity; 3. Moderate complexity; and 4. High complexity. The more complex the medical decision making, the greater the work effort.

The complexity of the medical decision making depends on: the number of diagnoses or management options; the amount and/or complexity of data to be reviewed; and the risk of complications and/or morbidity or mortality.

For example, the lowest level of service for Office or Other Outpatient Consultations (99241) requires:
- a problem focused history;
- a problem focused examination; and
- straightforward medical decision making
Average time: 15 minutes

While the highest level of service for Office or Other Outpatient Consultations (99245) requires:
- a comprehensive history;
- a comprehensive examination; and
- medical decision making of high complexity
Average time: 80 minutes

The clinician selects 99241 or 99245 (or any of the levels in between, 99242, 99243, 99244) on the basis of the work performed (i.e., extent of history and examination, complexity of medical decision making). The average times given for each code are guidelines for the clinician and are not a requirement when using the key components (history, examination, and medical decision making) in selecting the level of service.

Time and Level of Service
Time (as a component in selecting the level of service) has two definitions in the E/M guidelines. The clinician must review these definitions (see CPT 2010, E/M Services Guidelines) in order to fully understand the rationale for the two definitions.

For office and other outpatient visits and office consultations, intraservice time is defined as the *face-to-face* time spent providing services to the patient and/or family members. Time spent pre- and post-service (time that is not face-to-face) is not included in the average times listed for office and outpatient consultation services. The work associated with the pre- and post-

encounter time has been calculated into the total work that forms the basis for how each code is reimbursed, and, therefore, the average face-to-face times listed with each E/M code are considered fair proxy for the total work effort.

For inpatient hospital care, hospital consultations, and nursing facility care intraservice time is defined as *unit floor time.* Unit floor time includes all work the clinician performs on behalf of the patient while present on the unit or at the bedside. This work includes direct patient contact, review of chart, writing orders, reviewing test results, writing progress notes, meeting with the treatment team, telephone calls, and meeting with the family. Pre- and post-time work such as reviewing patient records in another part of the hospital has been included in the calculation of total work as described above in the definition of face-to-face time.

There is one final and important twist in using time in the selection of the level of service. When counseling and/or coordination of care (see CPT 2013 **page tbd**) accounts for more than 50 percent of the patient and/or family encounter unit/floor time, then time becomes the *key factor* in selecting level of service. The clinician makes the selection by matching the time of the encounter (face-to-face or unit/floor) to the average time listed for the appropriate E/M service. In this instance there is no consideration of the extent of the history, the exam, the medical decision making required, or the nature of the presenting problem; time is the sole determinant.

Counseling is defined as a discussion with the patient and/or family 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 entails discussions about the patient's care with other providers or agencies. These two services are considered contributory factors and although important to E/M service, are not required to be provided at every encounter.

The following are examples of counseling and coordination of care. A clinician spends 35 minutes on the hospital floor (third hospital day for patient) and over 50 percent of that time was spent in counseling and/or coordination of care. The correct code is 99233 (subsequent hospital care), average time 35 minutes. In this case, history, examination, and medical decision making are no longer the factors that determine the selection of the level of service. Instead, the clinician documents the extent of the counseling/coordination of care in the daily progress note.

A patient returns to a psychiatrist's office for a medication check. The encounter takes a total of 25 minutes, during which time more than 12.5 minutes is spent explaining to the patient about how a newly prescribed medication works, how to establish a routine so that no doses will be missed, and the possible side-effects of the medication and what to do if they occur. The appropriate E/M code would be 99213 (office or outpatient service for an established patient), based on the 25-minute time rather than on a detailed history and examination and moderately complex medical decision making that would be required to use this code if counseling and coordination had not taken up more than 50 percent of the time.

Use of Modifiers
Modifiers are two-digit suffixes (e.g., –22, Unusual Procedure Services) that are added to procedural codes to indicate the service or procedure has been provided under unusual circumstances. The modifiers most likely to be used by psychiatrists are:

–22 Unusual Procedure Services

This modifier is used when the work associated with the service provided is greater than that usually required for the listed code.

–25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service
This modifier is used to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual pre- and postoperative care associated with the procedure performed.

–26 Professional Component
This modifier is used for procedures that are a combination of a physician component and a technical component. When the physician component is reported separately, this modifier is added to the usual procedure.

–52 Reduced Services
This modifier is used to report a service that is reduced in time.

The following is an example of how to use modifiers:
The therapy session requires extension from 50 minutes to 65 minutes because of the emergence of important material just before the session was scheduled to end. The session would be coded 90806-22 and a short explanatory note should be appended to the insurance form, explaining the use of the code.

Documentation
Documentation is an extremely complex issue, an issue we can only touch on here. For example, there may be special documentation requirements for Medicare found in the local Medicare contractor's Local Coverage Determination (LCD) policies; or when psychiatrists use E/M codes for treating Medicare patients, the HCFA (CMS) documentation guidelines should be used (but the clinician must decide whether to use the 1995 or 1997 guidelines—see below); and commercial insurers may have their own requirements.

Although accurate documentation of services and procedures is vital for good medicine, documentation has become an increasingly troublesome practical issue for clinicians. It is especially problematic for psychiatrists because of confidentiality issues and the amount of clinical information produced during psychotherapy sessions. Also, documentation for psychotherapy codes is one issue, while documentation for E/M codes is another.

In 1995 the Health Care Financing Administration published documentation guidelines for evaluation and management services. In 1997 revised E/M documentation guidelines were issued.   Currently, physicians can choose to base their documentation on either the 1995 or 1997 Documentation Guidelines for Evaluation and Management Services. Following either set will fulfill documentation requirements to the satisfaction of the Medicare program, and should be acceptable to private insurers as well. Generally, psychiatrists will want to use the 1997 guidelines, which allow for a single-system psychiatric exam.

The Health Insurance Portability and Accountability Act (HIPAA), which was approved in December 2000 and became effective in April 2001, has very specific requirements for the privacy of patient records, and has very clear ramifications for the documentation of psychotherapy. HIPAA distinguishes between psychotherapy notes (notes a therapist may keep about the patient's personal life as distinguished from the patient's medical history and

treatment) and the medical record, and holds these personal notes to a higher level of confidentiality. Since 2003, when all physicians were expected to be in compliance with HIPAA, the standard of practice is that psychotherapy notes be kept so that they can be easily separated from the rest of a patient record.

Reimbursement Issues
It is very important for the clinician to understand that just because a code exists for a service in the CPT Manual, this does not guarantee that an insurance carrier or third-party payer will reimburse for that code. For example, Medicare will not pay for code 90882, Environmental Intervention, nor will it pay for certain codes done on the same day as others. You need to be aware of these exceptions. Clinicians may also find their contracts with managed care organizations specify certain codes that are not reimbursable, or that patients' insurance policies specify certain services that are not covered. It is essential to find out about any of these issues before treatment begins.

RBRVS and Medicare Reimbursement Policies
Because Medicare's Resource-Based Relative Value Scale (RBRVS) system for the payment of clinicians has become the basis of fee schedules, even for commercial carriers, a discussion of coding issues associated with Medicare reimbursement is useful even for those psychiatrists who do not treat Medicare beneficiaries.

Since 1992, the Medicare program has reimbursed physician services based on the Resource-Based Relative Value Scale (RBRVS). RBRVS is a system that allows the mathematical calculation of Relative Value Units (RVUs) for every CPT code. The cost of providing each service described in CPT is divided into three components: physician work, practice expense, and professional liability insurance. RVUs are assigned to each component, then added together and multiplied by a conversion factor that is determined annually by CMS and voted on by Congress. The resulting figure is the Medicare fee for each service. Medicare fees vary slightly throughout the country due to adjustments for geographical differences in resource costs. For instance, the fees in New York are higher than those in Mississippi.

Medicare generally excludes from payment all non-face-to-face services such as telephone calls, environmental interventions, record reviews, and case management, although there may be some variation in local payment policies.

The way to avoid delay of payment or audits because of disputes over use of codes that you're not absolutely certain about is to prospectively negotiate with insurers about the use of any codes that are not unquestionably standard.

Conclusions
Careful, correct coding is vital to the practicing psychiatrist. Take it seriously. Not only will correct coding help achieve prompt and appropriate payment for treatment, it will also provide protection from charges of fraud and abuse. Accurate documentation of the services you have provided, and coded for, is the most certain means of protection against allegations of abusive or fraudulent billing. Accurate documentation is also extremely helpful in defending against malpractice allegations. You need to stay current on coding issues.
- Buy and read the AMA's annually published CPT Manual
- Stay in touch with your District Branch and the APA's Office of Healthcare Systems and Financing about coding and billing issues.

- Psychiatrists who provide services under Medicare must educate themselves on policies specific to Medicare. You must be sure to read any correspondence sent to you by your Medicare contractor.

You should code and bill for all services rendered regardless of local or national payer policies – the developing database may help change payment policies that negatively affect reimbursement of mental health services.

It is important that you not try to game the reimbursement system by manipulating codes inappropriately. Medicare/Medicaid fraud, and insurance fraud in general, is a serious priority of the Justice Department.

Note: Although psychiatrists are likely to use only the codes within the Psychiatry and E/M sections of the CPT Manual to cover the services they provide, the Manual clearly states in its introduction: **"Any procedure or service in any section of this book may be used to designate the services rendered by any qualified physician."**

Recommended Reading
- American Medical Association, *Physicians Current Procedural Terminology* (published yearly, refer to most current)
- *CPT Handbook for Psychiatrists*, American Psychiatric Press Inc., Third Edition, 2004

APA's Web Site, CPT Coding Service and Additional Resources

APA CPT Coding Service
Look for timely information on coding and documentation issues on the APA's website www.psychiatry.org and in the Psychiatric News Bulletin, which is e-mailed to members weekly. New materials on APA's website are highlighted in the "APA News" Section and can also be found under "Psychiatric Practice."

The APA is actively involved in making sure that members are correctly reimbursed for the services they provide. Working closely with the Committee on RBRVS, Codes, and Reimbursement, the APA's Office of Healthcare Systems and Financing (OHSF) has established a CPT Coding Service. Because CPT questions are very specific and often very complex, a protocol has been established for queries to ensure that there will be no misunderstanding.

APA members with CPT coding questions should:
- Write an e-mail or memo with their name, APA member number, city, state, phone number, fax number, and e-mail address.
- State the question or describe the problem thoroughly, but succinctly—a short paragraph is usually all that is necessary.
- Include any relevant correspondence from Medicare carriers, insurance companies, or third-party payers.
- Cite any actions that have been taken relating to the problem, i.e., calls made, letters written
- E-mail (hsf@psych.org), fax (907-703-1089), or mail (Office of Healthcare Systems and Financing, APA, 1000 Wilson Boulevard, # 1825, Arlington, VA, 22209) the question to the

attention of <mark>Rebecca Yowell</mark>.

All questions will be answered as quickly as possible.

Courses/Workshops
APA Annual Meeting Course and Workshop – A CPT coding CME course as well as a CPT workshop are generally held each year at the APA Annual Meeting. Check the APA Annual Meeting program for more information.

APA Medicare Advisory Network
The APA's Office of Healthcare Systems and Financing maintains an online network of psychiatrists who are involved in Medicare policy issues across the country. This network allows the APA's central office to monitor how Medicare is actually working from state to state. It alerts psychiatrists across the United States to issues that are problematic and keeps them apprised as to whether their state's carrier is in compliance with Medicare rules and regulations.

The network's membership has historically been comprised of the psychiatry representatives to each Medicare carrier's Carrier Advisory Committee (CAC). Until very recently Medicare carriers have administrated Part B of Medicare (Part A has been administered by fiscal intermediaries), and the CACs have been mandated by law to ensure that carriers have input from medical practitioners when they establish local Medicare policy, specifically local coverage determinations, or LCDs; (formerly referred to as LMRPs, or local medical review policies). The psychiatry representatives to the CACs are chosen by the APA's District Branches. Medicare has almost completed the transition from carriers and fiscal intermediaries to Medicare Administrative Contractors, which oversee both Parts A and B. Thus far it appears that the CACs will continue to meet to advise these new entities just as they have Medicare carriers.

The Office of Healthcare Systems and Financing (OHSF) provides staffing for the network and provides support so that members in all regions can work together when there are issues that need to be addressed. Members of OHSF staff meet as necessary with representatives from the Centers for Medicare and Medicaid Services and with Medicare Medical Directors to solve problems communicated to them by members of the network.

For information on your local representative to the APA Medicare network representative, go to the APA web site at www.psychiatry.org. You can locate the list in the Medicare/Medicaid section under Psychiatric Practice. Medicare questions can also be directed to the attention of Ellen Jaffe in the Office of Healthcare Systems and Financing (HSF) by calling 800-343-4671 or writing her via the HSF e-mail address, hsf@psych.org.

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	99304–99306
Subsequent nursing facility care	99307-99310
Nursing facility discharge services	99315–99316
Annual Nursing Facility Assessment	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

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