Coding for Psychiatric Services in 2013

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Disclaimer

- Emily Hill & Associates provides coding advice and assistance to multiple physician organizations
- Neither I nor any member of my immediate family has a financial relationship or interest with any proprietary entity producing health care goods related to the content of this CME activity

Objectives

- Identify the key structural changes to the Psychiatric section of the 2013 CPT Manual.
- Understand how to use Evaluation and Management Services to report psychiatric services
- Apply the new coding structure to clinical practice

Why The Coding Changes?

- CMS received comments during the 4th Five-Year Review of the Medicare Fee Schedule suggesting psychotherapy codes were misvalued
- CMS subsequently referred codes to the RUC for review
- Code review began in Spring of 2010 and resulted in select codes being sent back to CPT for revision

Why The Coding Changes?

- Codes for Psychotherapy without E/M were reviewed at the October 2010 RUC meeting
- Resulted in recommendation that CPT create new coding structure for the entire section of psychotherapy services
- Workgroup created to address the concerns
- CPT Panel meeting in February 2012 and approved new coding structure

New Framework

- Psychiatric Diagnostic Procedures
  - Two new codes: with and without medical services
- Psychotherapy
  - Stand-alone codes
  - Add-on codes to be used with E/M codes
- New add-on code for interactive complexity (all other interactive codes deleted)

New Framework

- New add-on code for medication management to be reported in conjunction with stand-alone psychotherapy codes
- Two new codes for Psychotherapy for Crisis
- Allows all codes to be reported in all settings (deleted codes based on site of service)
- New times for psychotherapy codes
- Changes result in increased use of E/M codes by Psychiatrists

New Framework

- New codes were reviewed through the RUC process for work and practice expense RVUs
- CMS released 2013 Medicare Physician Fee Schedule with interim RVUs in November
- CMS general approach is to maintain and/or approximate current values for services
- CMS will review entire family of codes after surveys completed for all codes

Reporting E/M and Psychiatry Services

- Per CPT:
  - Some Psychiatry Services may be reported with E/M or other services
  - E/M services may be reported for treatment of psychiatric conditions rather than using Psychiatry Services codes

Reporting E/M and Psychiatry Services

- Per CPT:
  - Hospital care for psychiatric inpatient or partial hospitalization may be reported using E/M codes 99221-99233
  - If services such as ECT or psychotherapy are provided in addition to hospital E/M services, both E/M and other service can be reported
  - Consultation codes may be reported as appropriate

Psychiatric Diagnostic Procedures:90791-90792

- 90791 Psychiatric diagnostic evaluation
- 90792 Psychiatric diagnostic evaluation with medical services
  - **Cannot** be reported with an E/M code on same day by same provider
  - **Cannot** be reported with psychotherapy service code on same day
  - Codes may be reported **once per day**

Psychiatric Diagnostic Procedures:90791-90792

- May be reported **more than once for a patient** when *separate diagnostic evaluations* are conducted with the patient and other informants (family members, guardians, significant others)
  - Services should be reported using patient's name

Psychiatric Diagnostic Procedures:90791-90792: Medicare

- Accepts concept of diagnosis through a relative or close associate providing direct care for the patient *when the focus of the service is gathering additional information about the beneficiary*
  - Cannot substitute for an evaluation of the beneficiary
  - Plans to monitor the frequency of reporting per patient.

Psychiatric Diagnostic Procedures:90791-90792

- 90791 Psychiatric diagnostic evaluation
  - Integrated biopsychosocial asessment including
    - History
    - Mental status
    - Recommendations
  - May include communication with family, others, and review and ordering of diagnostic studies

Psychiatric Diagnostic Procedures:90791-90792

- 90792 Psychiatric diagnostic evaluation with medical services
  - Includes services in 90791 PLUS
    - Medical assessment
    - Physical exam beyond mental status as appropriate
  - May include communication with family, others, *prescription medications*, and review and ordering of *laboratory* or other diagnostic studies

Psychiatric Diagnostic Procedures:90791-90792

- 90791: 2.80 RVUs
  - Same as 90801 for 2012
- 90792: 2.96 RVUs
  - 0.16 for work of medical services
  - Increase based on 2012 RVU difference between psychotherapy with and without medical management

Psychotherapy: 90832-90838

- 90832 Psychotherapy, **30 minutes** with patient and/or family member
- 90834 Psychotherapy, **45 minutes** with patient and/or family member
- 90837 Psychotherapy, **60 minutes** with patient and/or family member
- Medicare: RVUs based on 2012 inpatient psychotherapy values

Psychotherapy: 90832-90838

- New code structure eliminated codes for psychotherapy with medical management
- Created “add-on” psychotherapy codes to be reported with E/M codes
- “Add-on” codes must be reported in addition to a primary code and are identified in CPT by symbol (**+**)
- Medicare: RVUs are decreased by 0.27 from corresponding stand-alone psychotherapy codes

Psychotherapy: 90832-90838

- + 90833 Psychotherapy, **30 minutes** with patient and/or family member *when performed with an evaluation and management service*
- + 90836 Psychotherapy, **45 minutes** with patient and/or family member *when performed with an evaluation and management service*
- + 90838 Psychotherapy, **60 minutes** with patient and/or family member *when performed with an evaluation and management service*

Psychotherapy: 90832-90838

- Psychotherapy services include *ongoing assessment and adjustment of* psychotherapeutic interventions, and may include involvement of family member (s) or others in the treatment process
- *Times* associated with codes are for *face-to-face services* with patient and/or family member

Psychotherapy: 90832-90838

- Patient must be present for all or some of the service.
- Medicare states patient must present for *significant portion of the service*
- Choose code closest to actual time
  - 90832, 90833 (30 min) for 16-37 minutes
  - 90834, 90836 (45 min) for 38-52 minutes
  - 90837, 90838 (60 min) for 53 and more minutes

Psychotherapy: 90832-90838

- *Medical issues* inform treatment choices for psychotherapeutic interventions, and
- Information from *therapeutic communications* are used to evaluate the presence, type, and severity of medical symptoms and disorders

Psychotherapy: 90832-90838

- If patient receives medical E/M service and psychotherapy service on the same day by the same provider, report:
  - E/M code at the appropriate level **AND**
  - Psychotherapy add-on code (90833. 90836, 90838)
- Two services must be *significant and separately identifiable*
- A separate diagnosis is not required

Psychotherapy: 90832-90838

- Reporting both E/M and psychotherapy codes
  - Type and level of E/M is selected first based on the key components (history, exam, MDM)
    - Time may not be used as basis of E/M code selection
  - Psychotherapy service code based on time providing psychotherapy
    - Time providing E/M activities is not considered in selection of time-based psychotherapy code

Psychotherapy for Crisis: 90839-90840

- 90839 Psychotherapy for crisis; first 60 minutes
- +90840 Each additional 30 minutes
- Used to report total duration of face-to-face time with the patient and/or family providing psychotherapy for crisis
  - Time does not have to be continuous
  - Provider must devote full attention to patient and cannot provide services to other patients during time period

Psychotherapy for Crisis: 90839-90840

- 90839 (60 min) used for first 30-74 minutes
  - Reported only **once per day**
- 90840 (each additional 30 min) report for up to 30 minutes each beyond 74 minutes
  - Example: 120 min of crisis therapy reported:
    - 90839 X 1
    - 90840 X 2
- Less than 30 minutes reported with codes 90832 or 90833 (psychotherapy 30 min)

Psychotherapy for Crisis: 90839-90840

- Presenting problem typically life-threatening or complex and requires immediate attention to a patient in high distress
- Codes include:
  - Urgent assessment and history of crisis state
  - Mental status exam
  - Disposition

Psychotherapy for Crisis: 90839-90840

- Treatment includes:
  - Psychotherapy
  - Mobilization of resources to diffuse crisis and restore safety
  - Implementation of psychotherapeutic interventions to minimize potential for psychological trauma

Psychotherapy for Crisis: 90839-90840

- Codes **cannot** be reported in addition to:
  - 90791, 90792 (diagnostic services)
  - 90832-90838 (psychotherapy)
  - 90785 (interactive complexity)
- Medicare:
  - RVUs not assigned for 2013
  - Carrier priced pending specialty societies' surveys of work and practice expense

Interactive Complexity: 90785

- +90785 Interactive complexity
- Add-on code to be reported with:
  - Diagnostic Evaluations (90791-90992)
  - Psychotherapy (90833-90838)
  - E/M codes (99201-99255; 99304-99377; 99341-99350)
  - Group Psychotherapy (90853)
- Medicare: Assigned RVU of 0.11 based on differential for 2012 codes

Interactive Complexity: 90785

- Refers to specific communication factors complicating delivery of psychiatric service
- Common factors:
  - Discordant or emotional family members
  - Young and verbally undeveloped
  - Impaired patients

Interactive Complexity: 90785

- Factors typically present with patients who:
  - Have others legally responsible for care
  - Request others to be involved in care during visit
  - Require the involvement of other third parties

Interactive Complexity: 90785

- Code can be reported when at least **one** of the following is present:
  - Need to manage maladaptive communication that complicates care delivery
  - Caregiver's emotions or behaviors interferes with ability to assist in treatment plan
  - Evidence or disclosure of sentinel event and mandated report to state agency with initiation of discussion of event and/or report

Interactive Complexity: 90785

- Reporting requirements con't.
  - Use of play equipment, or other physical devices, interpreter, or translator for communication with patient who:
    - Is not fluent in same language as provider
    - Has not developed, or has lost, expressive or receptive communication skills necessary for treatment

Interactive Complexity: 90785

- Medicare:
  - Generally should not be billed solely for the purpose of translation or interpretation services
  - Federal laws prohibit discrimination based on disability or ethnicity
  - Code would thus require higher beneficiary payments and copayments for the same service

Pharmacologic Management

- Code 90862 deleted for 2013
- Pharmacologic management reported with *E/M service codes*
- If reporting psychotherapy and E/M, pharmacologic management is considered **part of E/M service**
- Do not count time of pharmacologic management in psychotherapy codes

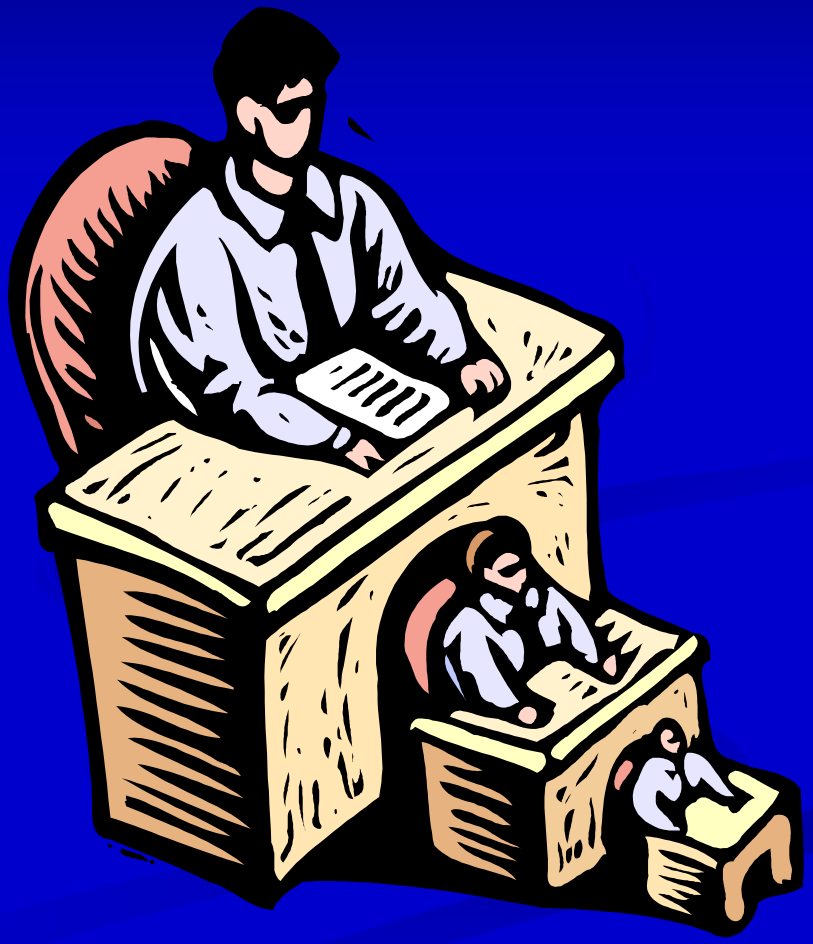
Pharmacologic Management

- +90863 Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services
- Add-on code reported only with psychotherapy codes 90832, 90834, 90837 (stand-alone psychotherapy codes)
- Not to be reported by physicians, NPs, PAs
- Medicare: Considers this invalid code-No RVUs assigned

Part II: Evaluation and Management Codes

Understanding E/M Services

- Developed in 1992 to accommodate RBRVS
- Describes outpatient and inpatient “visits”
- Divided into categories, subcategories, and levels of service



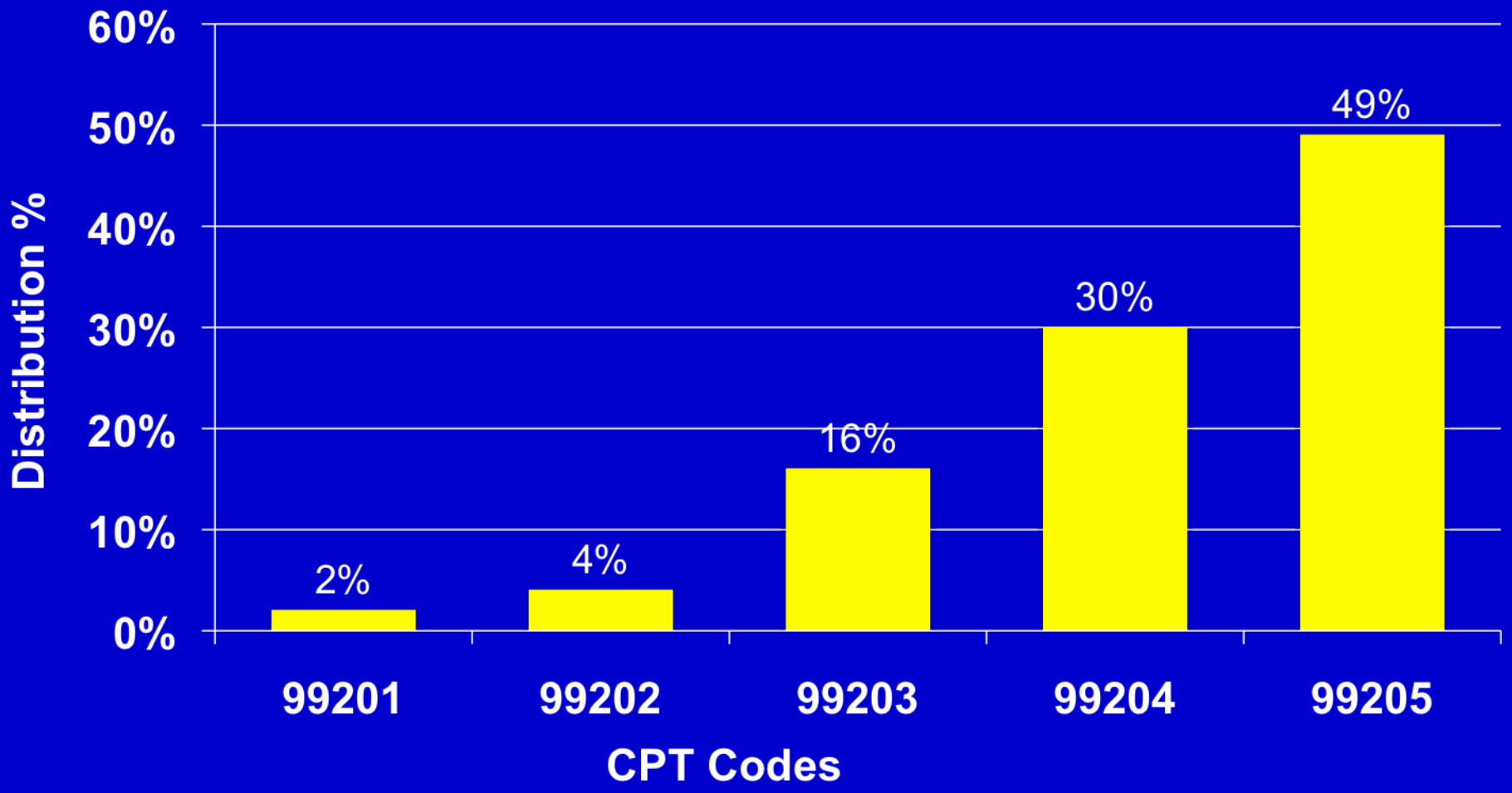
Selecting E/M Services

- Proper coding and reimbursement means:
  - Selecting code from proper category
  - Selecting appropriate level of service
  - Supporting selection with documentation
    - CPT definitions
    - CMS Documentation Guidelines

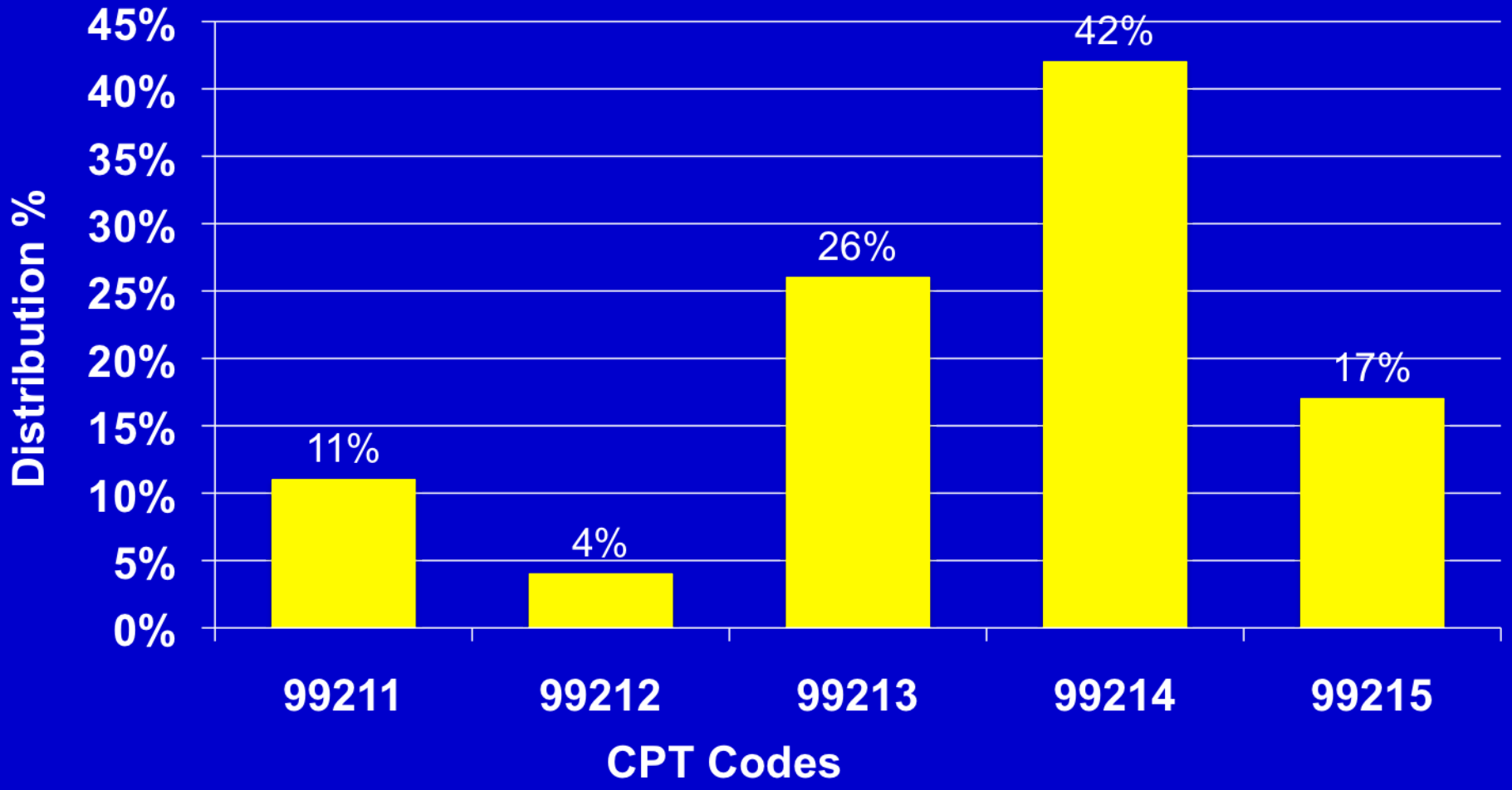
Selecting E/M Services

- Based on “physician work”
  - History, Exam, MDM, or time
- Includes services *medically necessary* to evaluate/tx the patient
- Code selection must be supported by “work” and “medical necessity”

Medicare Psychiatry E/M Distribution Outpt. Services - New



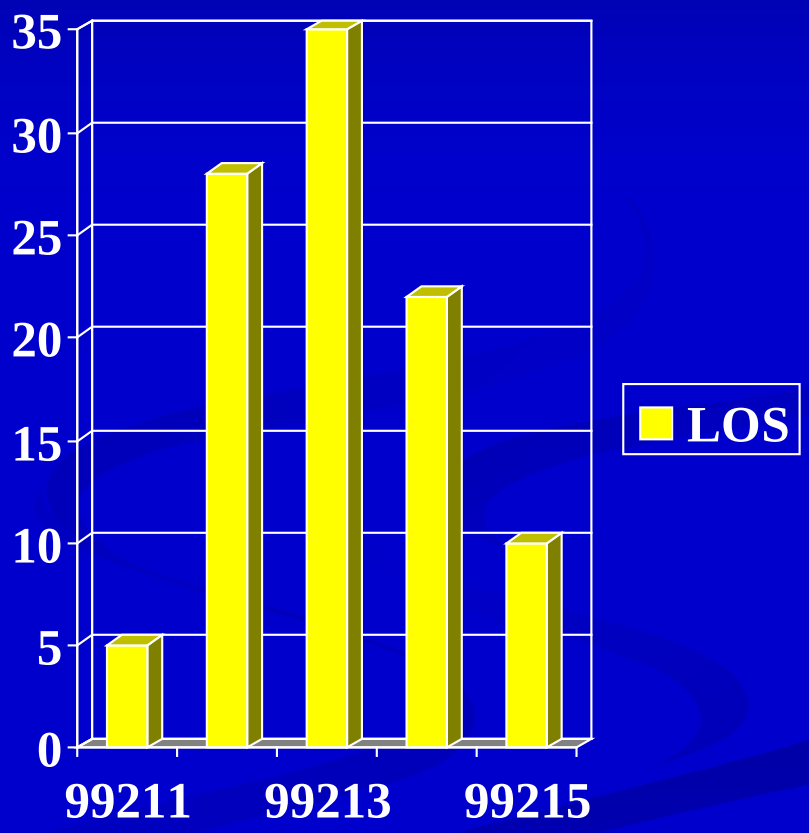
Medicare Psychiatry E/M Distribution Outpt. Services - Established



Selecting Problem-Oriented E/M Services

How Do You Choose Levels of E/M Services?

- History
- Exam
- Medical Decision Making
- Counseling
- Coordination of Care
- Nature of Problem
- Time



Key Components

- History
- Exam
- Medical Decision Making

Contributing Components

- Counseling
- Coordination of Care
- Nature of presenting problem

Reference

- Time

Category Requirements

- Visits requiring 3 of 3 key components
  - New Outpatient
  - Consultations
  - Initial Inpatient
  - Initial Observation care
  - New Home care

- Visits requiring 2 of 3 key components
  - Established Outpatient
  - Subsequent inpatient and observation care
  - Established home care

Time Factors

- Physician may perform PE, obtain history BUT may spend most of the encounter providing counseling, *OR*
- All of the visit involves counseling with patient/family

Using Time to Determine Levels

- Time may be the key factor for the selection of the level of service when *counseling and/or coordination of care dominates the encounter* (more than 50%)

Counseling

- Discussion with patient and/or family
  - Test results
  - Prognosis
  - Risks/benefits of management options
  - Instructions
  - Compliance issues
  - Risk factor reduction
  - Education

Measuring Time

- **Outpatient**: Time spent by the provider face-to-face with the patient and/or family
- **Inpatient**: Time spent both with the patient and on the patient's unit or floor
- Report using the code with the closest actual time

Typical Times for Outpatient E/M Services

Outpatient - New					
Codes	99201	99202	99203	99204	99205
Times	10 min.	20 min.	30 min.	45 min.	60 min.
Outpatient - Established					
Codes	99211	99212	99213	99214	99215
Times	5 min.	10 min.	15 min.	25 min.	40 min.
Outpatient - Consultations					
Codes	99241	99242	99243	99244	99245
Times	15 min.	30 min.	40 min.	60 min.	80 min.

Important Definitions

- Certain definitions are important for selecting the appropriate E/M category and subcategory:
  - New/Established
  - Transfer of Care
  - Consultations

New Patient

- A new patient is one who has not received *professional services* from the physician ***OR*** another physician of the *exact same specialty and subspecialty* in the *same group practice* within the *past 3 years*

New Patient

- Professional services defined as face-to-face services reported by a specific CPT code (s)
- Patients are:
  - Self-referred, referred by friend
  - Sent by a health care provider for treatment

E/M Guidelines: Transfer of Care

- **Transfer of Care:** Process by which a physician providing management for some or all of a patient's care *relinquishes responsibility* to another physician
- **Receiving physician:**
  - *Explicitly agrees* to accept responsibility for patient
  - Should not report consultation service for transfer

Reporting Transfer of Care Services

- **Outpatient Services**:
  - New or established patient codes (99201-99215)
- **Inpatient Services:**
  - Subsequent hospital care codes (99231-99233)
- If must evaluate *before* accepting patient, then may report consultation code

E/M Services: Consultation

- **Consultation** is type of E/M service provided by a physician at the request of another physician or other appropriate source:
  - To recommend care for a specific condition or problem OR
  - To determine whether to accept responsibility for entire care or care of a specific condition or problem

Criteria For a Consultation

- Must be requested by a physician or other appropriate source
  - eg, physician assistant, nurse practitioner doctor of chiropractic, physical therapist, occupational therapist, speech-language pathologist, psychologist, social worker, lawyer, or insurance company

Criteria For a Consultation

- **Written or verbal request** may be documented by either the consulting or requesting physician (or other appropriate source)
- **Requires a written report** of findings to the requesting party
  - Copy of consultant's note
  - Separate letter
  - Entry in shared medical record

“I’d say it’s your gallbladder, but if you insist on a second opinion, I’ll say kidneys.”

Consultation Instructions

- A “consultation” initiated by a patient and/or family, and *not requested* by a physician or other appropriate source… is *not reported* using the consultation codes but may be reported using the office visit, home service, or domiciliary/rest home care codes

Other Services With a Consultation

- At the *same or subsequent* visit you may:
  - Initiate diagnostic and/or therapeutic services
  - Report any specific CPT code performed

Consultation Instructions

- *"If subsequent to the completion* of a consultation, the consultant assumes responsibility for management of a portion or all of the patient's condition(s), the *appropriate Evaluation and Management services code for the site of service should be reported."*

Terminology: Referral

- *"Referral"* often used when a physician sends a patient to another physician
- Referral interpreted as transfer of care by some payers
- Use care when documenting encounters by using words such as "consult", "opinion", "evaluation", "recommendation", etc.
- *Medicare does not recognize consultation codes*

Types of Consultations

- Outpatient
- Inpatient

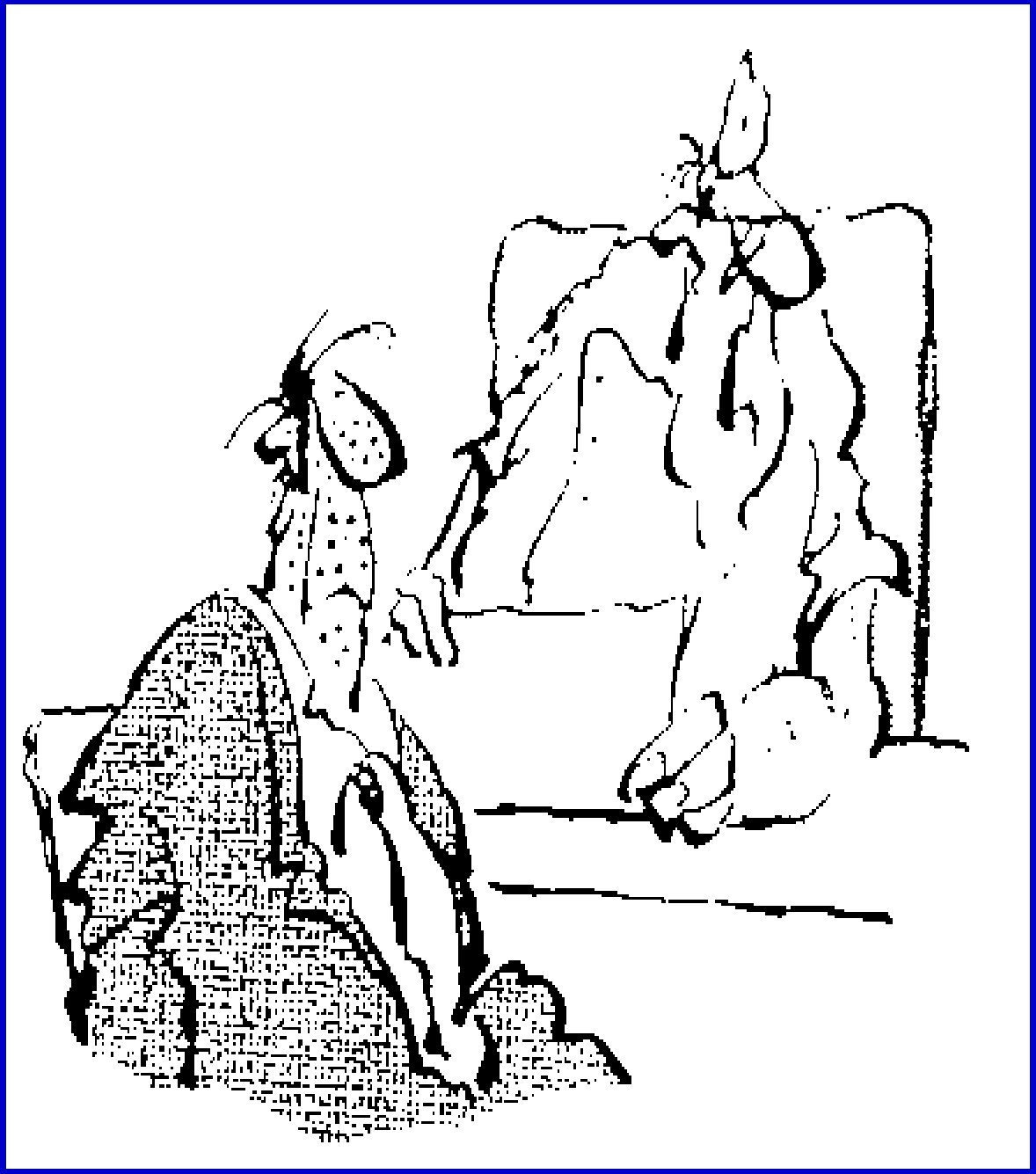
Documentation Guidelines for Key Components

Documentation Guidelines

- Documentation Guidelines (DG) developed by AMA and CMS
- In many instances, the DGs "quantify" the extent of the key components
- Two sets of guidelines in effect

1995 and 1997 Documentation Guidelines

- 1995
  - Exam based on number of organ systems/body areas examined
  - Criticized for not reflecting work of specialists
- 1997
  - Created single-organ system exams to reflect work of specialists
  - Criticized for complexity of system



“Joyce, how much do I charge people when I don’t know what’s wrong with them?”

Medical Decision Making

- Level determined by:
  - Number of diagnosis or management options
  - Amount and/or complexity of data
  - Risk to the patient

Types of Medical Decision Making

- Straightforward (SF)
- Low complexity (Low)
- Moderate complexity (Mod)
- High complexity (High)

Selecting the Level of MDM

- Does not involve “counting” of elements
- Supporting documentation can be anywhere in clinical note
- Appendix C of CPT contains clinical vignettes for various levels of service
- CPT code descriptors suggest the nature of the presenting problem

Selecting the Level of MDM

Based on 2 of 3 areas

Level of Medical Decision Making	Number of diagnoses or management options	Amount and/or complexity of data to be reviewed	Risk of complications and/or morbidity or mortality
Straightforward (99241, 99242, 99201, 99202, 99212)	Minimal	Minimal or None	Minimal
Low complexity (99243, 99203, 99213)	Limited	Limited	Low
Moderate complexity (99244, 99204, 99214)	Multiple	Moderate	Moderate
High complexity (99245, 99205, 99215)	Extensive	Extensive	High

Number of Diagnosis/ Management Options

- **Based on:**
  - Number and types of problems
  - Complexity of establishing a diagnosis
  - Management decisions

Number of Diagnosis/ Management Options

- **Influenced by:**
  - Undiagnosed problems
  - Number and type of tests
  - Need to seek advice from others
  - Problems worsening or failing to respond

Amount and Complexity of Data

- **Based on:**
  - Types of diagnostic tests
  - Need to obtain records
  - Need to obtain history from other sources

Amount and Complexity of Data

- **Influenced by:**
  - Unexpected findings
  - Independent interpretation of images, specimens, etc.
  - Discussion of results with physician performing test

Risk of Morbidity/Mortality

- **Based on:**
  - Presenting Problem
  - Diagnostic Procedure
  - Management Options

Risk of Morbidity/Mortality

- **Influenced by:**
  - Co-morbidities, underlying conditions, risk factors
  - Uncertain prognosis, exacerbations, complications
  - Decision to order Rx drugs, IV meds
  - Decision to perform invasive tests, procedures, major surgery

Documenting MDM

- Documentation should indicate:
  - Assessment, impression, diagnosis
  - Status of established diagnosis
  - Differential dx, probable, etc. for undiagnosed
  - Initiation/changes in treatment
  - Referrals, requests, advice

Documenting MDM

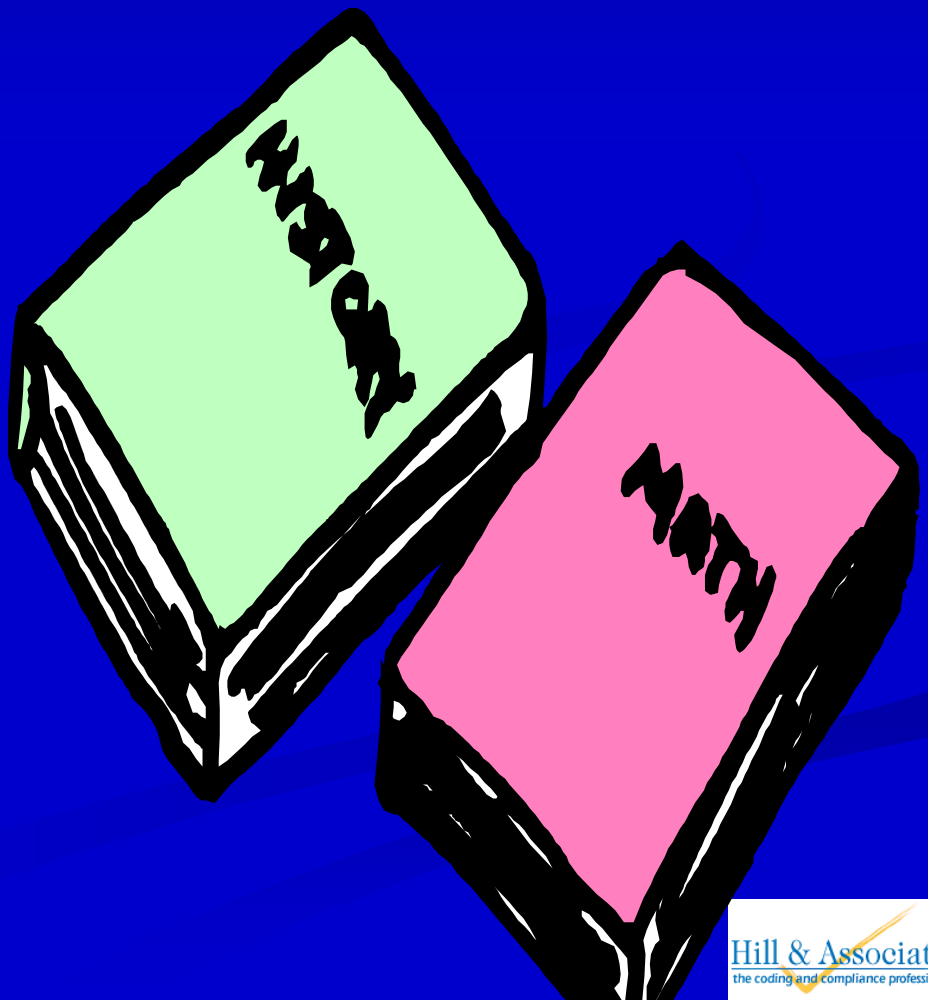
- Documentation should indicate (Cont'd):
  - Type of tests
  - Review and findings of tests
  - Relevant findings from records
  - Discussion of test results
  - Direct visualization of specimen, images, etc.

Documenting MDM

- Documentation should indicate (Cont'd):
  - Co-morbidities/underlying conditions
  - Type of surgical or invasive procedure
  - Referral for or decision to perform procedure on an urgent basis

History

- Four Types:
  - Problem-focused
  - Expanded problem-focused
  - Detailed
  - Comprehensive



Components of History

- Chief Complaint (CC)
- History of Present Illness (HPI)
- Review of Systems (ROS)
- Past, Family, and/or Social History (PFSH)

Key Documentation Guidelines

- CC required for all levels
- Extent dependent on clinical judgment
- No specific format requirements
- Describe circumstances which preclude obtaining history

Key Documentation Guidelines

- ROS/PFSH may be recorded by pt. or staff
  - Provider must supplement/confirm info
- ROS/PFSH updated by:
  - New information or noting change
  - Noting date/location of previous information
- Note all positive and pertinent negatives in ROS

History of Present Illness

- Eight elements:
  - Location
  - Quality
  - Severity
  - Duration
  - Timing
  - Context
  - Modifying factors
  - Associated signs/symptoms

Documenting the HPI

- Brief
  - 1-3 elements
- Extended (99243+, 99203+, 99214+)
  - 4+ elements, ***OR***
  - Comments on 3 or more chronic or inactive conditions

Review of Systems

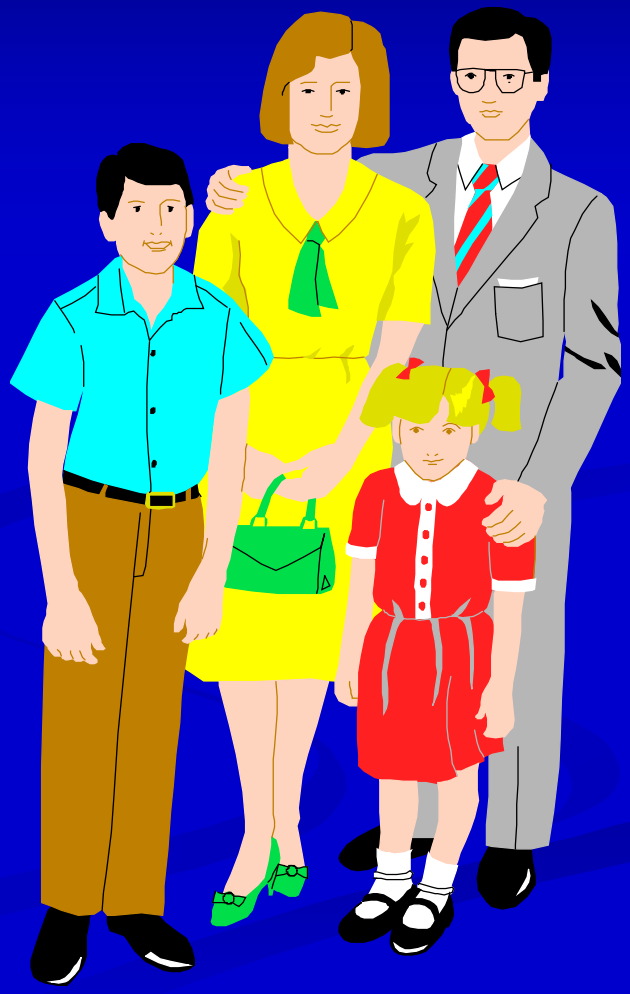
- 14 systems:
  - Constitutional
  - Eyes
  - ENT, mouth
  - Cardiovascular
  - Respiratory
  - Gastrointestinal
  - Genitourinary
  - Musculoskeletal
  - Integumentary (skin and/or breasts)
  - Neurological
  - Psychiatric
  - Endocrine
  - Hematologic/Lymp.
  - Allergic/Immun.

Documenting the ROS

- Problem Pertinent (99242, 99202, 99213)
  - System of complaint
- Extended (99243, 99203, 99214)
  - 2-9 systems
- Complete (99244, 99245, 99204, 99205, 99215)
  - 10 individual systems
  - *Pertinent pos/neg. plus *"all other systems neg"*
  - Comment on hx. form

Past, Family, Social History

- PFSH consists of 3 areas
  - Past History- Patient's past
  - Family History- Family medical events
  - Social History- Age appropriate review of activities



Documenting the PFSH

- Pertinent (99243, 99203, 99214)
  - 1 of 3 areas
- Complete (99244, 99245, 99204, 99205, 99215)
  - 3 of 3 for new and comprehensive assessments
  - 2 of 3 for established outpatient

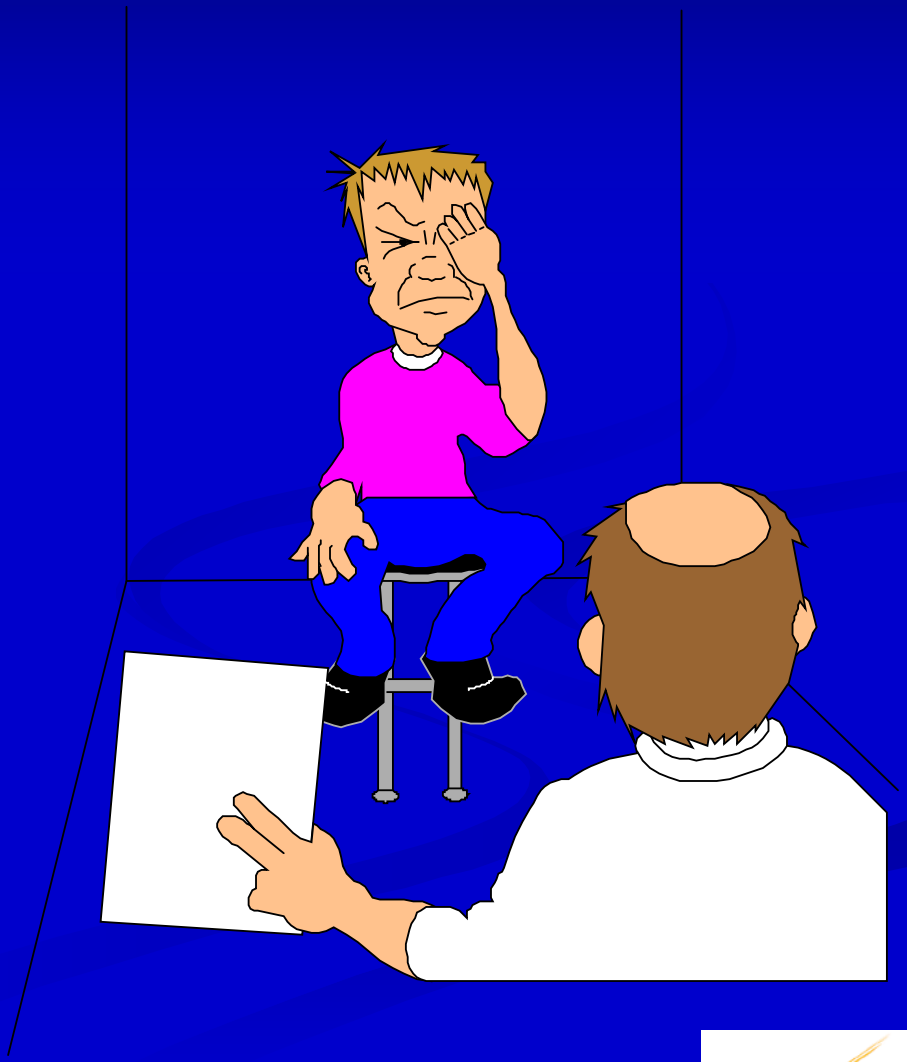
Choosing the Level of History

Type	HPI	ROS	PFSH
PF	Brief (1-3)	None	None
EPF	Brief (1-3)	Problem Pertinent	None
Detailed	Extended (4+)	Extended (2-9)	Pertinent (1 of 3)
Comp.	Extended (4+)	Complete (10+)	Complete (2 of 3 or 3 of 3)

Chief complaint required for all types.
Requirements for all components must be met for a given type.

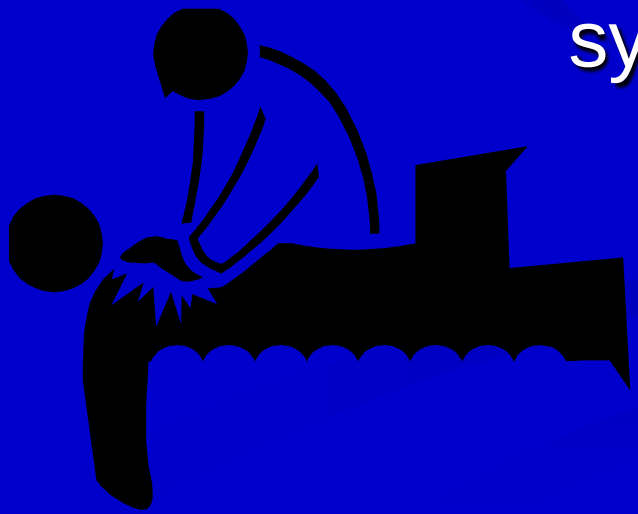
Examination

- Four Types
  - Problem-focused
  - Expanded Problem-focused
  - Detailed
  - Comprehensive



Examination Guidelines

- 1995 Guidelines
  - Based on number of organ systems/body areas examined
- 1997 Guidelines
  - Based on the number of specific elements documented in a defined organ system exam



1995 Examination

Type of Exam	1995 Requirements
Problem Focused (99201, 99212)	1 body area or organ system
Expanded Problem Focused (99202, 99242, 99213)	2-4 organ systems including affected area
Detailed (99203, 99243, 99214,)	5-7 systems including affected area
Comprehensive (99204+, 99244+, 99215)	8 or more organ systems

1997 Defined Exams

- General multi-system
- Skin
- Eyes
- ENT, mouth
- Cardiovascular
- Respiratory
- Genitourinary
- Musculoskeletal
- Heme/Lymph/Immun.
- Neurologic
- *Psychiatric*

1997 Guidelines

- Tables identify included systems/areas
- Content or “elements” detailed
- All numeric requirements must be met
- Exams not “specialty specific”
- Shaded areas apply only to comprehensive exams (99204+, 99244+, 99215)
- Other levels depend on number of elements

1997 Content & Documentation Requirements for Psychiatric E/M

Level of Exam	Perform & Document
Problem Focused (99201, 99241, 99212)	1 to 5 bulleted elements
Expanded PF (99202, 99242, 99213)	At least 6 bulleted elements
Detailed (99203, 99243, 99214)	At least 9 bulleted elements
Comprehensive (99204+, 99245+, 99215)	Perform all bulleted elements Document every element in shaded boxes and at least 1 element in unshaded boxes (bolded on handout)

Psychiatric Exam

97 Guidelines *(shaded)*

System/Body Area	Elements of Examination
Constitutional	•Measurement *any 3 of the 7* vital signs: BP_ (sitting or standing), BP_ (supine), P_, R_, T_, Ht_, Wt_ •General appearance of patient

Psychiatric Exam

97 Guidelines *(unshaded)*

System/Body Area	Elements of Examination
Musculoskeletal	•Assessment of muscle strength and tone with notation of any atrophy and abnormal movements •Examination of gait and station

Psychiatric Exam

97 Guidelines *(shaded)*

System/Body Area	Elements of Examination
Psychiatric	•Description of speech •Description of though process •Description of associations •Description of abnormal or psychotic thoughts •Description of the patient's judgment

Psychiatric Exam

97 Guidelines *(shaded)*

System/Body Area	Elements of Examination
Psychiatric	Complete mental status exam: •Orientation to time, place and person •Recent and remote memory •Attention span and concentration •Language •Fund of knowledge •Mood and affect

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.

Consultations

Outpatient Inpatient	99241 99251	99242 99252	99243 99253	99244 99254	99245 99255
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					
OP: Face-to-face	15 min.	30 min.	40 min.	60 min.	80 min.
IP: Unit/Floor	20 min.	40 min.	55 min.	80 min.	110 min.

Summary

- Codes effective January 1, 2013 and must be accepted by all payers
- Knowledge of E/M coding will be necessary to ensure that psychiatrists and other qualified professionals receive appropriate reimbursement
- APA has been contacting payers to ease transition. Watch payer bulletins!
- NCPA will be providing information regarding Medicaid and other payers as available

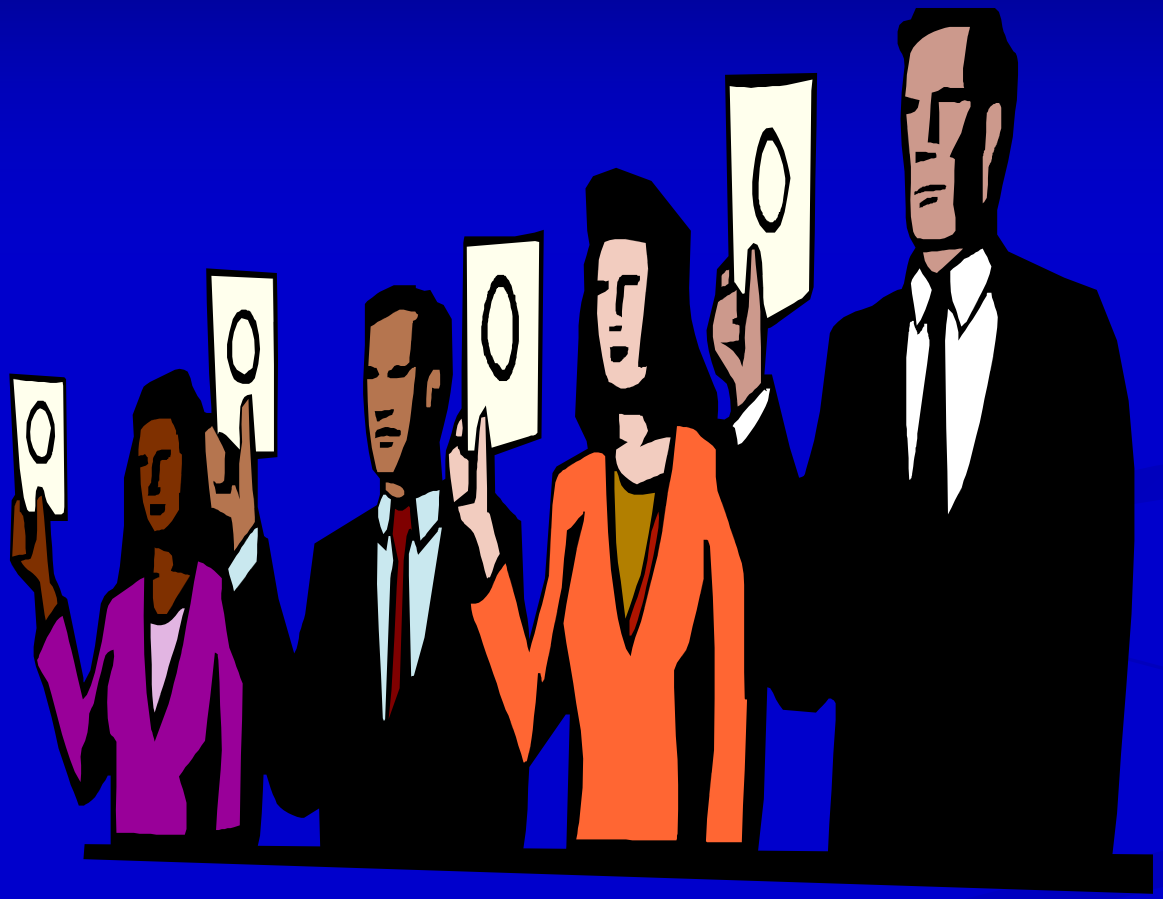
Resources

- NC Medicaid
  - Go to link below for list of codes that count toward the annual visit limit. Also has list of recipients excluded from the annual visit limit http://www.ncdhhs.gov/dma/provider/AnnualVisitLimit.htm
  - Watch for monthly and special bulletins
- NCPA
  - Look for specific info and tools as available at

Resources

- American Psychiatric Association
  - http://www.psych.org/practice/managing-a-practice/cpt-changes-2013
    - General info and crosswalks
  - www.apaeducation.org (E/M Coding-free to members, $40 for non-members
- Free E/M training
  - http://emuniversity.com/ (link on APA's website)

Questions



Thank You