The New, Confusing CPT Codes: Tips for Documenting and Billing to Get Paid What You Deserve

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As of January 1, 2013, psychiatrists should be billing for services by using Evaluation and Management Current Procedural Terminology (CPT) codes for any encounter related to medical services. Because detailed information about these CPT codes became available only toward the end of 2012, clinicians had little time to be trained in their use, resulting in widespread confusion about when and how to use these codes for reimbursement. The authors describe strategies that psychiatrists can use to ensure appropriate reimbursement for patient care, such as how to code the initial psychiatric evaluation, acute or chronic conditions, medical decision-making complexity, psychotherapy, counseling, coordination of care, and crisis care. The authors suggest use of templates, with checklists, during patient examinations to facilitate documentation.

Psychiatric Services 2015; 66:418–420; doi: 10.1176/appi.ps.201400321

As of January 1, 2013, psychiatrists should be billing for services using Evaluation and Management (E/M) Current Procedural Terminology (CPT) (1) codes for any encounter related to medical services. Detailed information about these codes became available only toward the end of 2012, leaving scant time for busy clinicians to receive education and training on their use. Furthermore, some health insurance companies have inconsistent rules about implementation and utilization of CPT codes. The result has been confusion about when and how to use these codes to be appropriately reimbursed.

We assume that by now most readers have some basic knowledge of the CPT codes. However, we and others at our company—Cigna Behavioral Health—have compared psychiatrists' encounter notes with the corresponding billing claims and have noticed that psychiatrists are missing some billing opportunities (unpublished data, Shah V, 2013). In this Open Forum, we describe several strategies to help clinicians get paid what they deserve for the hard work of taking care of patients.

CODING BASICS

The new CPT codes essentially fall into five groups: initial evaluation codes; E/M codes for any medical services–related encounter; psychotherapy, which can be the primary focus of the encounter or can be used in combination with an E/M code; interactive code; and crisis services. Note that there are no longer different codes for "office" versus "facility" locations.

The first two digits of the five-digit E/M codes are usually 99. An E/M code for a particular service is often divided into three to five levels, depending on the complexity of the patient encounter or time spent. E/M codes typically consist of three components: history, examination, and medical decision making. Both history and examination are rated, in order of increasing complexity, as "problem focused," "expanded problem focused," "detailed," or "comprehensive," and medical decision-making complexity is rated as "straightforward," "low," "moderate," or "high." For a subsequent outpatient visit code (99211–99214), two levels of complexity must be met or exceeded. For example, for 99213, both history and examination would need to be scored as "expanded problem focused"—or just one of them would need to be scored in this way if the complexity of medical decision making was scored as at least "low." For new encounters, all three levels must meet or exceed criteria to qualify for a specific level of E/M services. [A table showing the alignment of complexity levels across components is available in an online supplement.]

The Centers for Medicare and Medicaid Services advise using the E/M code representing the medically necessary level of service. For example, for a stable patient requiring only a prescription refill of antidepressants every three months, you need not conduct or document a comprehensive history that includes psychiatric, family, and social history, nor do you need to conduct a complete examination that includes muscle strength and gait—or the equivalent of a 99215. The effort for a 99212 or 92213 is all your patient needs.

TIPS FOR USING THE CODES

The following tips can help optimize your documentation and billing.

Initial Evaluation: 90792 or an E/M Code?

For an initial evaluation, psychiatrists may use either 90792 or one of the E/M codes. Here we review the decision-making process that a psychiatrist would follow, using the Medicare fee schedule as an example, to determine whether to use 90792 or an E/M code. Note that the Medicare fee schedule applies only when billing for Medicare patients. All other commercial payers

have their own fee schedules that may or may not reflect the relationship between code payments contained in the Medicare fee schedule. However, the decision-making process is similar once the codes and reimbursements are applied. [A table in the online supplement lists these codes and reimbursements.]

The decision about whether to use 90792 or an E/M code depends on a mathematical calculation that is based on reimbursement after you take into account the specifics of your practice. One benefit of using 90792 is that it is similar to the previously used CPT code 90801 and requires little change in your documentation. You should be familiar with the regional Medicare carrier Local Carrier Decisions (LCDs) to determine local 90792 requirements, as well as with situations in which multiple 90792 codes for the same Medicare patient can be billed. Also, note that 90792 (but not an E/M code alone) can be billed along with CPT code 90785 (interactive complexity code), which may be of particular significance to a child and adolescent psychiatrist.

Use of the E/M codes may result in less or more reimbursement than use of 90792, depending on the complexity of the patient encounter. E/M codes require familiarity with coding that is based on the complexity of the encounter.

Acute or Chronic Conditions?

When considering CPT codes 99214 or 99215, code either elements of the acute condition or the status of chronic conditions, whichever scores higher, under the History of Present Illness (HPI). History consists of four subsections: Chief Complaint; HPI; Review of Systems; and Past Psychiatric, Family, and Social History. Brief and extended HPIs are distinguished by the amount of detail needed to accurately characterize the clinical problem or problems. A brief HPI consists of one to three elements of the HPI. An extended HPI consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions.

A detailed explanation of how the entire history section is scored is beyond the scope of this report, but keep in mind that the extended HPI can be scored either on the basis of the number of chronic conditions that you are treating (and these do not have to be formally diagnosed) or on the basis of the number of elements of one or more acute conditions that you evaluate (context, timing, duration, quality, severity, modifying factors, associated signs and symptoms, and so forth). Pick the higher of these two.

Review of Systems

Remember to take credit for assessing side effects of medication when appropriate. If no pertinent systems are reviewed, the review of systems (ROS) subsection of the HPI is considered "problem focused," whereas a review of one pertinent system earns a rating of "expanded problem focused." "Detailed" is applied when two to nine systems are reviewed, and reviewing ten pertinent systems is rated as "comprehensive." Although you may not need to conduct or document an ROS for medically stable patients, be sure to count discussions about medication side effects under the appropriate system—for example, sleep or appetite as constitutional, palpitations as cardiac, decreased libido as genitourinary, and so forth. Assessing side effects is part of what doctors do and should be reimbursed.

Examination

Be sure to document and claim credit for what you are probably doing anyway. The number of elements documented determines whether the examination is considered problem focused (one to five elements), expanded problem focused (six to eight elements), detailed (nine to 13 elements), or comprehensive (14 elements, which includes at least three vital signs plus either muscle strength and tone or gait and station). Although you do not need to conduct or document a comprehensive examination for every patient (for example, muscle strength assessment can be omitted for most patients who do not have relevant complaints), it is easy enough to document other components of an examination, such as appearance, that you are automatically assessing from the moment the patient enters the room. Consider developing an appropriate checklist that has the relevant elements of each exam component—for example, "Affect: Range: _____; Quality_____; Congruence with mood_____; Appropriateness_____." In this way, the documentation can be relatively quick and painless.

Medications and Medical Decision-Making Complexity

Prescribing medication raises the risk level to "moderate" under this subcategory of medical decision making. In addition to the history and examination sections of the clinical note, the amount that you will be paid when using the new CPT codes is based in part on the complexity of medical decision making, which is determined by the number of diagnoses and treatment options, the complexity of the data involved (for example, external record reviews or tests ordered), and the level of risks and complications. The scoring of this entire section is beyond the scope of this report, but keep in mind that even a fairly safe medication carries some risk—thus the score of "moderate" for this category. The overall medical decision-making complexity may be low for stable patients, but for others it may not be.

Billing for Both E/M and Psychotherapy

The levels of detail and complexity of the medical encounter determine the E/M code, and time spent on E/M activities is separate from psychotherapy time. Psychotherapy is "the treatment of mental illness and behavioral disturbances in which the physician or other qualified health care professional, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development" (1). The add-on psychotherapy codes are 90833 (16–37 minutes), 90836 (38–52 minutes), and 90838 (≥53 minutes). If your work involves no medical activities, you can simply use the stand-alone psychotherapy codes 90832, 90834, or 90837. With or without E/M codes, document the time spent doing psychotherapy and the number of participants. Include a brief summary of psychotherapy issues that were addressed and the technique used. To keep things simple, we suggest first describing the E/M encounter in the typical format. Then choose the appropriate E/M code on the basis of the key components: history, examination, and medical decision-making complexity. Next write the

psychotherapy note, as described above, noting the number of minutes spent. Finally, pick the appropriate psychotherapy add-on code (reflecting time spent on psychotherapy).

Counseling and Coordination of Care

Be sure to document time. Some patient encounters may require a significant amount of time, either counseling a patient directly or speaking on the phone with other clinicians—for example, to determine when to refer a patient to the emergency room or for an inpatient hospitalization. You should get paid for this time. In fact, when counseling or coordination of care accounts for more than 50% of the face-to-face encounter, the total time spent determines which E/M code to use. Psychotherapy is treatment, whereas counseling is more educational and consists of discussing with a patient recommended tests or test results; impressions; prognosis; risks and benefits of treatment options; instructions for management, treatment, or follow-up care; treatment compliance; risk factor reduction; and other forms of education (1). Coordination of care includes coordinating care with other physicians, other qualified health care professionals, or agencies, consistent with the nature of the problem and the patient's or family's needs (1). Be sure to document that at least 50% of the time spent was for coordination of care, along with the nature of counseling or care coordination. In these cases, a 25-minute encounter earns a 99214 code, 15 minutes earns 99213, and ten minutes earns 99212 [details are presented in a table in the online supplement].

Add-on Code for Interactive Complexity

You can report the add-on code 90785 in conjunction with other codes (that is, not alone) to describe communication difficulties that complicate care. Interactive complexity refers to specific communication factors that complicate the delivery of a psychiatric procedure (1). Use this code when you use specific equipment, such as toys or assistive communication technology; when dealing with maladaptive communication among participants; or when a sentinel event, such as abuse, must be reported to a third party. The code 90785 may be used with psychiatric evaluation codes (90791 and 90792), individual stand-alone psychotherapy codes (90832, 90834, and 90837), add-on psychotherapy codes (+90833, +90836, and +90838), and the group therapy code (90853). The code 90785 may not be used with E/M services when no psychotherapy service is reported. Documentation should include the presence of any third party present during the patient encounter and a description of communication difficulty and the intervention. Medicare will not pay for an interpreter or translator (2), although the American Medical Association's CPT book identifies the use of an interpreter or translator as one reason for using CPT code 90785. Furthermore, charging the patient or an insurance company for an interpreter may result in violation of Title III of the Americans with Disabilities Act (3).

Crisis Psychotherapy Code

A new code for crisis situations includes assessment and psychotherapy and is generally used by crisis teams. Crises often involve some medical complexity. Therefore, depending on the clinical requirements of the situation, it may make more sense financially to use the E/M code instead—for example, 99214 or even 99215—along with an add-on code for psychotherapy. However, crisis codes do not include medical services, and if you provide psychiatric support to a crisis response team that bills for this code, you can use an E/M code to bill for your medical services.

Other Strategies

Create templates, with checklists, for your encounter notes to help you quickly move through the components of the exam that can be documented by checking boxes or filling in blanks according to cues, or use one we created that aligns prompts for billing codes with elements of your clinical encounter [available in the online supplement]. If you purchase a scale, a tape measure for height, and a sphygmomanometer, you will be able to obtain vital signs easily when indicated. Finally, analyze your billed E/M codes quarterly or biannually, and compare their frequencies to psychiatric Medicare data. The American Psychiatric Association has excellent online resources, including an E/M template to help decipher the new CPT codes (www.psych.org/cptcodingchanges).

CONCLUSIONS

Understanding change and preparing to deal with it helps optimize its impact. The new CPT code system for behavioral health introduces certain advantages, such as higher reimbursement for providing care to sicker patients. It also aligns us with our medical colleagues in terms of billing practices. On the other hand, because of the many CPT codes and the numerous rules associated with them, the risk of overcoding exists, which may result in an audit by the payer. The tips discussed here will help you maximize the utility of the new CPT codes and, in the process, get paid what you deserve.

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The authors thank Douglas A. Nemecek, M.D., M.B.A., chief medical officer for behavioral health at Cigna, and David Mino, M.D., M.B.A., and Roy DelaMar, B.A., for helpful comments.

The authors report no financial relationships with commercial interests.

Received July 17, 2014; revisions received October 22 and November 12, 2014; accepted December 4, 2014; published online February 17, 2015.

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