

American Academy of Child and Adolescent Psychiatry

CPT CODE TRAINING MODULE

For January 1, 2013, and Beyond

**MAINTAINED BY THE COMMITTEE ON HEALTHCARE ACCESS AND
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CPT TRAINING MODULE

TABLE OF CONTENTS

History and Context of CPT	3
Three Components of Relative Value Units (RVUs)	5
Sustainable Growth Rate, Congress and 5-Year Reviews	5
Fraud and Abuse	7
Code Categories	9
CPT Codes for Child and Adolescent Psychiatrists.....	12
• Evaluation and Management Services (99xxx)	12
• Interactive Complexity.....	12
• Psychiatric Diagnostic Codes	13
• Psychotherapy Codes	14
• Other Psychiatric Services	17
• Modifiers.....	18
Other Codes	18
Psychiatry Codes Summary	20
Partial Glossary	22
References	24

CPT TRAINING MODULE FOR CHILD AND ADOLESCENT PSYCHIATRISTS

HISTORY AND CONTEXT OF CPT

Background

In the beginning, there was fee for service, whether barter or cash. During World War II, Congress imposed price and wage freezes. Orders for manufactured goods (material for the war effort) were increasing and companies were short on labor. They needed to recruit. Without ability to raise wages to attract workers, what was to be done?

Business came up with the idea of BENEFITS. Benefits included vacation, pension and agreement to help pay for medical expenses (*health insurance*). Companies could offer improved benefit packages and workers would come to work for them. The concept of employer's paying for medical insurance grew rapidly.

Twenty years later, Medicare was enacted (1965) and implemented (1967). Healthcare expenses rose. So did employer's cost of paying for health insurance and healthcare expenditure continued to increase nationally. While other developed countries devoted no more than 5% of their Gross Domestic Product to health care, the United States was spending no less than 10% on its healthcare. By the 1970s, health benefits added \$500 to the cost of every automobile made in this country.

Congress's Solution

The Health Care Finance Administration (HCFA) was established within the Department of Health and Human Services of the Federal government to rein in the spiraling costs of administering Medicare. HCFA's charge was to:

- Control expenses.
- Guarantee that the services billed and paid for are the ones that are delivered. For example, if HCFA pays for an adolescent in an acute psychiatric bed, the adolescent must receive documented acute care, as opposed to residential or custodial care. Or, if HCFA pays for a comprehensive outpatient examination, the examination must be truly comprehensive, with documented evidence that it *is* different from a less thorough examination.
- Adopt procedure codes to accurately describe medical procedures. HCFA chose the Current Procedural Terminology (CPT) codes developed by CPT Editorial Board of the American Medical Association. (In 1992 many private insurance companies began using them as well. Now, all major insurers rely on CPT codes for payment.)
- Assign reimbursement values for each CPT code, based on interpretation of Congressional mandates. To assist them in the process, Congress authorized development of The Resource-based Relative-value Scale (RBRVS) (Hsiao, 1987). Currently, Medicare payment to physicians is based on the RBRVS.

Unlike many other developed countries, in the United States private companies assumed responsibility for parts of the social safety net: health care and retirement. Elsewhere,

governments take primary responsibility for these services.

In the 1970s, Congress wanted to encourage insurance companies to offer health insurance programs and pension plans (Employee Benefit Plans) to companies. President Ford signed the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provided:

- Federal, not state, control of pension funds
- Exemption of insurance companies from lawsuit
- Assign fiduciary responsibility to funds administrator, even if it is the insurance company.

Because of the fiduciary's need to maintain pension fund's solvency and because healthcare cost had an increasing impact on the company's bottom line, fund administrators became more critical and selective when purchasing health care coverage. Through ERISA, companies had the authority to determine what health care services, packages and limitations their employees could receive, without risk of lawsuit against them or the insurance company.

Before ERISA, insurance companies had to make good faith effort to settle claims or face lawsuit. ERISA changed the liability standard from "bad faith" to "arbitrary and capricious." Even if this higher standard were met, no punitive damages could be awarded. In addition, before filing a claim, the claimant must first exhaust all administrative appeals (internal) to obtain a settlement. The settlement cannot exceed what the insurance company would have to pay if the claim had originally been approved (no punitive damage). The settlement does not include attorney fees for this administrative process; they are the claimant's responsibility.

Going into the 1992 Presidential elections, healthcare "reform" was a major issue for both Presidential candidates. The Jackson Hole Group advised both nominees. Systems of managing care were recommended and many businesses adopted them to reduce healthcare costs. (On June 14, 2001, HCFA's name was changed to the more descriptive Center for Medicare and Medicaid Services (CMS). CMS will be used throughout the remainder of the module.) Congress passed no healthcare legislation until 2003 when President G.W. Bush signed the Medicare Modernization Act. This law created Medicare Part D, the prescription drug benefit plan that went into effect in 2006. The next major overhaul occurred four years later when President Obama signed the Patient Protection and Affordable Care Act.

Claiming to have learned from the mistakes of "managed care," the authors of the rules and regulations for this piece of legislation attempted to put physicians and other qualified healthcare professionals in charge of managing resources and healthcare. Instead of insurance company and business created Health Maintenance Organizations, Accountable Care Organizations (ACOs) are the new vehicle to rein in costs while providing world-class care. Medicare, the largest insurance program in the country, provides incentives for quality care and penalties for suboptimal care.

In June, 2012, the Supreme Court in a 5-4 decision ruled that the Affordable Care Act was constitutional (under the Congressional authority to raises taxes and a concurrent opinion finding the authority under the commerce clause). The Act takes full effect in 2014.

Politics aside, since the early 1980s, physicians have been paid by procedure, whether office visit or surgical. Instead of basing payments to physicians on charges, CMS paid according to a standardized payment schedule based on the resource costs needed to provide each service.

THREE COMPONENTS OF RELATIVE VALUE UNITS (RVUs)

Three components determine the resource cost of providing a service:

- physician work
- practice expense
- professional liability insurance expense

Physician Work

The physician work component accounts, on average, for 54% of the total relative value for each service. The factors used to determine physician work include:

- the amount of physician time involved
- the technical skill and physical effort required
- the mental effort and judgment required
- the stress to the physician resulting from potential risk to the patient from the procedure

Practice Expense

Practice expense RVUs account for an average of 41% of the total value for each service. These PE values reflected office costs like play equipment, rent, utilities, billing expenses, etc. Since 2004, all new or revised codes presented to the RUC must include both work and PE values. The RUC then recommends a specific value for each to CMS.

Professional Liability Cost

The professional liability cost component is derived from a formula. Since 2010, allergy and immunology replaced psychiatry as the specialty with the lowest malpractice cost. Consequently, psychiatry is no longer the denominator in the formula.

Scope of CPT and RUC

CPT codes and the reimbursement values assigned to them are, strictly speaking, applicable only to services billed to Medicare through any of its regional carriers. Private payers choose whether to use the codes and reimbursement values adopted by CMS for the procedures they reimburse. AACAP members must query *each* insurance carrier directly regarding the extent to which it adheres to the CMS values for each CPT code.

SUSTAINABLE GROWTH RATE (SGR), CONGRESS AND 5-YEAR REVIEWS

The sum of these 3 components (work units + practice expense units + malpractice expense units) yields the relative value unit (RVU). The RVU is then multiplied by a *conversion factor* (a monetary figure determined by CMS) and adjusted for geographical variability to arrive at the payment. The purpose of the conversion factor is to provide a mechanism whereby CMS can maintain the Medicare's rate of growth to sustainable levels - the SGR or sustainable growth rate. The SGR is an abstract and controversial economic concept that Congress has overridden

for the past 20 years. To illustrate, the 2006 conversion factor was 37.8975 and was scheduled for adjustments of -5% (2007) and -5.3% (2008); the final Congressional vote replaced that change (the result of applying the SGR formula) with a 0.5% increase retroactive to July 1, 2008. The 2008 conversion factor was 38.087. Said another way, since 2006, the CF has dropped 10.39%. The SGR automatic change should have been 35%, but Congress did what Congress does and kicked this can down the road, too.

Table: CY 2012 Physician Fee Schedule Conversion Factor (CF)

YEAR	CONVERSION FACTOR (from SGR calculation)	PRE-LEGISLATION CF UPDATE	ACTUAL CF (after the fix)
2006	\$37.8975		\$37.8975
2007	\$35.9848	-5.3%	\$37.8975
2008	\$34.0682	-5.3%	\$38.0870
2009	\$30.1510	-11.5%	\$36.0666
2010	\$28.3868	-5.9%	\$28.3868
2011	\$25.4999	-10.2%	\$33.9764
2012	\$24.6712	-27.4%	\$34.0376
2013	\$24.8441	-27.0%	TBD

Relative value units are assigned to CPT codes by CMS after receiving recommendations from the Relative-Value Update Committee (RUC) of the AMA. The RUC's recommendations are based on the presentation of the specialty society that requests the code valuation. The RUC has 31 members. These physicians, along with a representative from allied medical fields, arrive at specific work and practice expense values that are then sent to CMS for review and publication in the Federal Register.

What was the impact? Healthcare expenditures increased from 7.2% GDP (1970) to 12.5% GDP (1990) to 17.9% GDP (2010). In fact, as a per cent of GDP, healthcare expenditures increased more than 4.7% per year every year since 1970, and during the 20 years between 1970 and 1990, 17 of the 20 years the increases were >10%. It had increased at a record slow growth in 2009 (3.8%) and close to that in 2010 (3.9). As a percent of GDP, healthcare expense has risen from 5% in 1960 to nearly 18% in 2010. (By comparison, Germany spends less than 8% of its GDP on healthcare.)

	1970 (\$billions)	1990 (\$billions)	2010 (\$billions)
National Health Expenditures	74.9	724.3	25,93.6
Private	31.7	439.5	1,870.8
CMS	13	183.8	937.6
Gross Domestic Product	1,038	5,801	14,527
Health Exp Share of GDP	7.2%	12.5%	17.9%

SOURCE: Center for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, 2012.

Sherry Barron-Seabrook, M.D., is our current RUC Adviser and completed her term on the Research Subcommittee in September 2012. Many AACAP members completed RUC surveys

spring of 2012. Surveys for the new 2013 codes (interactive complexity and psychotherapy for crisis – see below) will be distributed in February 2013. The RUC uses these results to determine the most realistic figures for physician work and practice expense for each service. In 1997, AACAP administered a survey for the 908XA, a series of codes adopted by HCFA on January 1 1997, as G codes. Working with the American Psychiatric Association, American Nurses Association, American Psychological Association, and the National Association of Social Workers, AACAP helped forge a consensus recommendation for these codes, which were recommended by the RUC for HCFA’s adoption. HCFA published its decision in the *Federal Register Final Rule* in November 1997. A similar process, also including the American Psychiatric Nurses Association, occurred from 2010 to 2012 to produce the 2013 psychiatry CPT codes, published in November 2012 in the *Federal Register Final Rule*.

Congressional mandate requires that the RUC review the RBRVS every 5 years to make certain that the relative values of the codes still reflect current practice. The AACAP along with the societies listed above completed another comprehensive review of the codes in 2012. That review resulted in significant changes in the way child and adolescent psychiatrists report services. The fate of the more commonly used codes is listed below. The intent of the list is to illustrate that most of the familiar codes and code numbers have been deleted. See page 12, “CPT CODES FOR CHILD AND ADOLESCENT PSYCHIATRISTS,” for the new code definitions and how to report our services.

2013 FATE OF THE 2012 COMMONLY USED CPT PSYCHIATRY CODES

Service	CPT Code	2013 Status
Diagnostic interview examination	90801	DELETED
Interactive diagnostic interview examination	90802	DELETED
Individual psychotherapy	90804, 90806, 90808, 90816, 90818, 90821	DELETED
Interactive individual psychotherapy	90810, 90812, 90814, 90823, 90826, 90828	DELETED
Individual psychotherapy with E/M	90805, 90807, 90809, 90817, 90819, 90822	DELETED
Interactive individual psychotherapy with E/M	90811, 90813, 90815, 90824, 90827, 90829	DELETED
Family psychotherapy	90846, 90847, 90849	Retained
Group psychotherapy	90853	Retained
Interactive group psychotherapy	90857	DELETED
Pharmacologic management	90862	DELETED

FRAUD AND ABUSE

The only legal way to be paid for a service is to bill using the correct CPT code. You also must document that the level of service claimed was delivered. Prior to 1996 there was no distinction between fraud and sloppy billing practices. In 1996, the standard of “intent to knowingly and willingly deceive” was adopted, but if one consistently billed incorrectly and had no audit system to find and correct billing errors, one may be vulnerable to this standard.

Kennedy-Kassebaum (1996):

- Added “knowingly and willingly” standard to false claims legislation. Before 1996, physicians could be accused of violating the law if they simply made a mistake. Now, the standard is “knowingly and willingly,” BUT ignorance of coding rules is NOT an acceptable explanation for repeated coding errors.
- Made “falsifying” a private claim a federal offense like falsifying a Medicare/Medicaid claim.
- Added 700 investigators to the Inspector General’s office at CMS.
- Fines collected support the salaries of the investigators.
- Example: Instructing one’s billing agent to code a psychotherapy add on for any visit is a knowing and willing action that could place the physician at risk if the level of service does not meet criteria (at least 16 minutes of service beyond the E/M service).
- Physician is responsible (and liable) for all coding done in that physician’s name.

False Claims – billing for services not provided.

Up coding Examples: Reporting the psychotherapy add on code for less than 16 minutes of psychotherapy. Coding 90214 while documentation supports a lower level of service.

Code edits Billing codes that do not belong together (Correct Coding Initiative – CCI)
Examples: Violating AdminiStar software program – most edits involve surgical procedures like separate billing for amputation of digits and foot when performing a below the knee amputation. Edits for the current psychiatry codes are being developed.
(<http://cms.hhs.gov/physician/cciedits/default.asp>)

Medically Unlikely Edits (MUE)

Codes that are *unlikely* to be billed together. These edits may be appealed on a case-by-case basis. Originally, the edits were “medically unbelievable,” but because of physician objection, the term “unlikely” was substituted for “unbelievable.”

Examples: 2 psychotherapy sessions for the same patient on the same day. As above, MUE’s for the current psychiatry code set are being developed.

Consequences:

- Pay damages up to 3 times the amount of the claim.
- Mandatory penalties of \$5,000 to \$10,000 per claim, regardless of the size of the claim.
- The Investigator General's office receives a return of about \$20 for each \$1 used to fund an investigation. That return is used to support the salary of the investigators.
- Whistle-blowers act in the name of the government and may seek the same damages. The Department of Justice may intercede and the realtor could still receive 15% to 25% of the claim. Realtor may proceed alone and keep up to 30% of the final recovery.

CODE CATEGORIES

The Health Insurance Portability and Accountability Act (HIPAA, 1996) required CMS to issue a request for proposals for alternative coding systems. The AMA realized that CPT needed to be changed and initiated the CPT 5 project to develop necessary modifications. In August 2000, CMS announced that it would continue to use CPT as the coding system for medical procedures for Medicare patients. Two additional code categories (II and III) debuted in CPT 2002 (see below).

Category I: these are the current procedure codes. All of the E/M and psychiatry codes are included in Category I.

Category II: These are OPTIONAL codes designed for physicians and/or auditors to track certain services that the Performance Measure Advisory Group (PMAG) - composed of experts from the Agency for Healthcare Research and Quality (AHRQ), The Joint Commission, American Medical Association (AMA), CMS, and the Physician Consortium for Performance Improvement (PCPI) - have determined contribute to quality care and good outcomes. They include performance measures like diabetic foot exam or the initiation of an anti-arrhythmia drug after a heart attack. These quality measures may also be used to determine Pay for Performance reimbursement, currently being considered by private payers. These are 5 digit codes with an "F" occupying the fifth digit slot, e.g. 1234F.

In CPT 2013, there are 23 potentially relevant Category II codes for Major Depression Disorder (MDD), Major Depression Disorder in Adolescents (MDD ADOL), and Substance Use Disorder (SUD). There are 16 codes related to dementia (DEM). (For a complete listing of Category II codes by clinical topic, see <http://www.ama-assn.org/resources/doc/cpt/cpt-cat2-codes-alpha-listing-clinical-topics.pdf>)

Patient Management:

- 0545F Plan for follow-up for major depressive disorder, documented ([MDD ADOL](#))

Patient History:

- 1040F DSM IV criteria for Major Depressive Disorder documented at the initial evaluation (MDD, MDD ADOL)
- 1000F Tobacco use assessed (CAD, CAP, COPD, PV) (DM)
- 1175F Functional status for Dementia assessed and results reviewed (DEM)
- 1181F Neuropsychiatric symptoms assessed and results reviewed (DEM)
- 1182F Neuropsychiatric symptoms, one or more present (DEM)

- 1183F Neuropsychiatric symptoms absent (DEM)
- 1490F Dementia severity classified mild (DEM)
- 1491F Dementia severity classified moderate (DEM)
- 1493F Dementia severity classified severe (DEM)
- 1494F Cognition assessed and reviewed (DEM)

Physical Examination:

- 2014F Mental status assessed (CAP) (EM)
- 2060F Patient interviewed directly on or before date of diagnosis of major depressive disorder (MDD ADOL)

Screening Process:

- 3011F Lipid panel results documented and reviewed (CAD)
- 3085F Suicide risk assessed (MDD, MDD ADOL)
- 3088F MDD mild (MDD)
- 3088F MDD moderate (MDD)
- 3090F MDD severe without psychotic features (MDD)
- 3091F MDD severe with psychotic features (MDD)
- 3092F MDD in remission (MDD)
- 3093F Documentation of new diagnosis of initial or recurrent episode of MDD (MDD)
- 3351F Negative screen for depressive symptoms as categorized by using standard depression screening/assessment tool (MDD)
- 3352F No significant depressive symptoms as categorized by using a standardized depression assessment depression tool (MDD)
- 3353F Mild to moderate depressive symptoms as categorized by using a standardized depression screening/assessment tool (MDD)
- 3354F Clinically significant depressive symptoms as categorized by using a standardized depression screening/assessment tool (MDD)
- 3700F Psychiatric disorders or disturbances assessed (Prkns)
- 3725F Screening for depression performed (DEM)

Therapeutic, Preventive or Other Interventions:

- 4000F Tobacco use cessation intervention counseling (COPD, CAP, CAD)(DM)
- 4001F Tobacco use cessation intervention pharmacologic therapy (COPD, CAP, CAD)(DM)(PV)
- 4004F Patient screened for tobacco use AND received tobacco cessation counseling (PV)
- 4060F Psychotherapy service provided (MDD, MDD ADOL)
- 4062F Patient referral for psychotherapy documented (MDD, MDD ADOL)
- 4063F Antidepressant psychopharmacotherapy considered and not prescribed (MDD ADOL)
- 4064F Antidepressant pharmacotherapy prescribed (MDD, MDD ADOL)
- 4065F Antipsychotic pharmacotherapy prescribed (MDD)
- 4066F ECT provided (MDD)
- 4067F Patient reviewed for ECT documented (MDD)

- 4158F Patient counseled about risks of alcohol use (HEP-C)
- 4306F Patient counseled regarding psychosocial AND pharmacologic treatment options for opioid addiction (SUD)
- 4320F Patient counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence (SUD)
- 4322F Caregiver provided with education and referred to additional resources for support (DEM)
- 4328F Patient queried about sleep disturbance (Prkns)
- 4350F Counseling provided on symptom management, end of life decisions, and palliation (DEM)
- 4525F Neuropsychiatric intervention ordered (DEM)
- 4526F Neuropsychiatric intervention received (DEM)

Patient Safety:

- 6101F Safety counseling for dementia provided (DEM)
- 6102F Safety counseling for dementia ordered (DEM)
- 6110F Counseling provided regarding risks of driving and the alternatives to driving (DEM)

HEDIS measures that could become Category II codes for attention deficit disorder are currently being considered.

Category II code exclusion modifiers:

- 1P - medical reasons; e.g., absence of the organ or limb, contraindicated
- 2P - patient reasons; e.g., refusal, economic, social, and religious
- 3P - system reasons; e.g., lack of resources, insurance limitations
- 8P - reason not otherwise specified

Category III: These are TEMPORARY codes for new and emerging technologies. They may be covered by given carriers if you personally arrange for that. They are not covered by Medicare. If these codes are not assigned a category I code within 5 years, they will be retired. These codes are 5 digits with a "T" occupying the fifth digit slot - e.g. 1234T. In 2011, transcranial magnetic stimulation was assigned a category I code (90867, 90868) after several years as a category III code.

Many new code proposals are being assigned category III status to determine whether they are indeed widely used by physicians or other qualified healthcare professionals and have an evidence base for efficacy, not simply a manufacturer's or industry's sponsorship.

In summary, "regular" CPT codes are grouped as Category I codes in this edition of CPT. Two other code categories are also included in the book. Category II codes are optional and used to track performance measures like eye exam, foot exam, depression screen, etc. which may be part of another general examination. Category II codes exist for Major Depression Disorder, Major Depression in Adolescents, and Substance Use Disorder. Others are being developed for psychiatry. Category III codes are used to track new and emerging technologies. You must negotiate directly with the insurance carrier for payment. They are not part of the Medicare

payment system.

CPT CODES FOR CHILD AND ADOLESCENT PSYCHIATRISTS

CPT 2013 has completely redesigned the structure of the commonly used psychiatric codes. Since 1997, psychiatric CPT codes have been divided into “diagnostic or evaluation interview procedures” and “psychiatric therapeutic procedures” (and further sub-divided into office v facility psychotherapy; other psychotherapy and other psychiatric procedures). The new structure requires psychiatrists to use the following code categories to report services:

- Evaluation and Management (E/M)
- Interactive complexity
- Diagnostic evaluation
- Psychotherapy
- Other psychotherapy
- Other psychiatric services

Evaluation and Management (E/M)

Parity laws have triggered changes in the way psychiatric care is reimbursed and now most payers reimburse psychiatrists for E/M services. Payers in New York State are mandated to do so. CPT reflects these changes and DELETED 90862 (pharmacologic management) effective January 1, 2013, with instructions to use E/M codes for these services. The availability of E/M codes to psychiatrists allows psychiatric services to be reported with the same range of complexity and physician work as has long been available to practitioners of all the other medical specialties.

Medicare always allowed psychiatrists to use E/M codes but, until 2010, few other payers reimbursed psychiatrists for E/M codes for outpatient services. Psychiatrists had primarily been authorized to use the simple, “one size fits all” 90862 code for pharmacologic management. Code 90862 poorly described the complexity of current psychiatric practice and accounted for 60% of psychiatrist billing. This code was written at a time when the standard for pharmacologic management was prescription of one or occasionally two psychotropic medications at a time. Current standard of care is often far more complex. The work and medical decision making now required is best described by the E/M codes.

E/M codes may be used to report evaluation and management services alone (no other service reported that day) or E/M services with the addition of psychotherapy. Psychotherapy must be reported as an “add-on” code to the primary procedure, the E/M service. This change effectively reverses “psychotherapy with or without E/M” to “E/M with or without psychotherapy.” More details and other parameters of psychotherapy, such as time, presence of interactive complexity, and site of service, are discussed below. On the AACAP website, [AACAP's Reimbursement for Practitioners](#), see our webinars for specific, detailed information on the new codes as well as selecting and documenting E/M codes.

Interactive Complexity

Codes for Interactive Diagnostic Interview Examination, Interactive Individual Psychotherapy, and Interactive Group Therapy are deleted. These codes captured only one component of

communication difficulties complicating psychiatric services, particularly services rendered to children. A new Interactive Complexity add-on code, +90785, describes 4 types of specific, recognized communication difficulties and describes the types of patients and situations most commonly associated with these complicating factors.

Interactive Complexity, code +90785, is an add-on code specific for psychiatric services. Add-on codes may only be reported in conjunction with other codes, never alone.

The 4 specific communication difficulties during the service (maladaptive communication among visit participants, interference from caregiver emotions or behavior, disclosure and discussion of a sentinel event, and language difficulties) represent significant complicating factors that increase the work of the primary psychiatric procedure. Interactive complexity +90785 may be reported in conjunction with the following psychiatric procedures: psychiatric diagnostic evaluation 90791, 90792, psychotherapy 90832-90837, psychotherapy add-on codes +90833-+90838 when reported with E/M, and group psychotherapy 90853. Interactive Complexity refers to communication difficulties *during* the psychiatric procedure and may NOT be reported with E/M Services WITHOUT psychotherapy.

The specific communication difficulties are present with patients who typically:

- Request others to be involved in their care during the visit, such as adults accompanied by one or more participating family members or interpreter or language translator,* or
- Require the involvement of other third parties, such as child welfare agencies, parole or probation officers, or schools.

Interactive complexity may be reported with the above psychiatric procedures when at least one of the following communication difficulties is present:

1. The need to manage maladaptive communication (related to, e.g., high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicates delivery of care.
2. Caregiver emotions/behavior that interfere with implementation of the treatment plan.
3. Evidence/disclosure of a sentinel event and mandated report to a third party (e.g., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.
4. Use of play equipment, physical devices, interpreter or translator* to overcome significant language barriers.

When performed with psychotherapy, the interactive complexity component (+90785) relates only to the increased work intensity of the psychotherapy service, but *does not* change the time for the psychotherapy service.

Psychiatric Diagnostic Evaluation

The Psychiatric Diagnostic Interview Examination (90801) and the Interactive Psychiatric Diagnostic Interview Examination (90802) are deleted and replaced by two new codes for

*Per CMS, 90785 generally should not be billed solely for the purpose of translation or interpretation services as that may be a violation of federal statute.

psychiatric diagnostic evaluation. These new codes differentiate between diagnostic services done without medical services (90791) and with medical services (90792). The interactive component of the diagnostic evaluation, formerly included in code 90802, is now captured by reporting the new interactive complexity add-on code +90785 in conjunction with 90791 or 90792.

Code 90791 - Psychiatric Diagnostic Evaluation without medical services.

The evaluation may include communication with family or other sources, and review and ordering of diagnostic studies. Use +90785 in conjunction with 90791 when the diagnostic evaluation includes Interactive Complexity services.

Code 90792 - Psychiatric Diagnostic Evaluation with medical services.

The evaluation may include communication with family or other sources, prescription of medications, and review and ordering of laboratory or other diagnostic studies. Use +90785 in conjunction with 90792 when the diagnostic evaluation includes Interactive Complexity services.

Note

- “With medical services” refers to medical “thinking” as well as medical activities, such as physical examination, prescription of medication, and review and ordering of medical diagnostic tests. Medical thinking must be documented, e.g. consideration of a differential diagnosis, medication change, change in dose of medication, drug-drug interactions, etc.
- In certain circumstances one or more other informants (family members, guardians, or significant others) may be seen in lieu of the patient.
- Codes 90791, 90792 may be reported *more than once* for the patient when separate diagnostic evaluations are conducted with the patient and other informants on different days.
- Use the same codes, 90791 and 90792, for later reassessment, as indicated.
- Do not report codes 90791 and 90792 on the same day as a psychotherapy or E/M service.

Psychotherapy

All of the individual psychotherapy codes (90804-90829) are deleted. A new series of psychotherapy codes replaces these codes, with the following differences:

- Site of service is no longer a criterion for code selection.
- Time specifications are changed to be consistent with CPT convention. (See *Time* below.)
- “Individual” is eliminated from the code titles and psychotherapy time may include face-to-face time with family members as long as the patient is present for a significant part of the session.
- Interactive psychotherapy codes are deleted. Interactive Complexity is reported with the add-on code +90785. This new code expands the types of communication difficulties that CPT recognizes (see above, Interactive Complexity).
- Psychotherapy (without medical evaluation and management services) (formerly reported as 90804, 90806, 90808, 90810, 90812, 90814, 90816, 90818, 90821, 90823, 90826, 90828) are now reported with psychotherapy codes 90832, 90834, and 90837.

- Psychotherapy with medical evaluation and management services (formerly reported as 90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827, 90829) are now reported with codes for E/M services plus a psychotherapy add-on code, +90833, +90836, and +90838.

The new series of psychotherapy add-on codes, +90833, +90836, +90838, allows psychiatrists to report psychotherapy with the full range of E/M codes. The code for the E/M service delivered is selected first (based on key components, *never* time) and then the time for the psychotherapy is determined.

The typical psychotherapy with E/M session is not the provider doing psychotherapy and then doing E/M (or vice versa), but is a combined service. This feature has been recognized by CPT: “Medical symptoms and disorders inform treatment choices of psychotherapeutic interventions, and data from therapeutic communication are used to evaluate the presence, type, and severity of medical symptoms and disorders” (CPT 2013 Professional Edition p. 485).

To report both E/M and psychotherapy, the two services must be *significant and separately identifiable*. CPT gives a roadmap for separately identifying the medical and psychotherapeutic components of the service:

1. The type and level of E/M service is selected first based upon the key components of history, examination, and medical decision-making. (See [AACAP's Reimbursement for Practitioners](#) page for discussion of key components.)
2. Time associated with activities used to meet criteria for the E/M service is *not* included in the time used for reporting the psychotherapy service (i.e., time spent on history, examination, and medical decision making when used for the E/M service is *not* psychotherapy time). Time may *not* be used to determine E/M code selection. Prolonged Services may *not* be reported when E/M and psychotherapy (+90833, +90836, +90838) are reported.
3. A separate diagnosis is *not* required for the reporting of E/M and psychotherapy on the same date of service.

Documentation must include the required key components of the selected E/M code and the *additional* time for the psychotherapy service. *Total* time for the encounter is not needed.

If interactive complexity is part of the psychotherapy service, the Interactive Complexity code (+90785) is added as well.

Site of Service

Site of service is deleted as a criterion for psychotherapy. The new psychotherapy codes are applicable to services in all settings.

Time

Psychotherapy times are for *face-to-face* services with patient and/or family member. The patient must be present for a significant part of the service. For family psychotherapy without the patient present, use 90846.

CPT convention is that codes reported based on time are described by “exact” times, with ranges determined by the following:

- The “exact” time for a single code or the first code in a series is achieved once the actual time crosses the midpoint (in the case of the Psychotherapy codes, the 30 minute codes therefore require actual time of at least 16 minutes).
- In a series, choose the code with an “exact” time closest to the actual time. (See chart below)

Code	“Exact” Time (in minutes)	Actual Time Range (in minutes)
90832, +90833	30	16-37
90834, +90836	45	38-52
90837, +90838	60	At least 53

Psychotherapy must be at least 16 minutes to be reported.

Interactive Complexity

Code +90785 is an add-on code to report Interactive Complexity services when provided in conjunction with the psychotherapy codes 90832-+90838. As stated above, the Interactive Complexity component (+90785) relates only to the increased work intensity of the psychotherapy service, but *does not* change the time for the psychotherapy service. Time is reflected in the timed service code for psychotherapy (90832, 90834, 90837, +90833, +90836, +90838).

Other Psychotherapy

Psychotherapy for Crisis – Codes 90839 and +90840

A major new concept and addition to the psychotherapy section is the addition of codes for Psychotherapy for Crisis when psychotherapy services are provided to a patient who presents in high distress with complex or life threatening circumstances that require immediate attention. Code 90839 reports psychotherapy for crisis for the first 60 minutes and +90840 for each additional 30 minutes. These codes are reported by themselves and may *not* be reported with the psychiatric diagnostic evaluation codes (90791, 90792), the psychotherapy codes (90832–90837) and the add-on psychotherapy codes (+90833-+90838). Codes 90839 and 90840 may not be reported in conjunction with the new interactive complexity code +90785 or any of the procedures included in the “Other Psychotherapy” or “Other Psychiatric Services or Procedures” sections.

These codes do not include medical services. In a crisis situation, psychiatrists may prefer the appropriate E/M code. Non-medical mental health professionals are likely the largest group of providers for these codes.

Psychoanalysis - 90845

The code for psychoanalysis is unchanged.

Family Psychotherapy – 90846, 90847, and 90849

Codes for family psychotherapy without patient present (90846), family psychotherapy with patient present (90847), and multiple-family group (90849) are unchanged. Medical management services are not included in these codes and may be reported separately.

Group Psychotherapy – 90853

Group psychotherapy (90853) is unchanged. The code for interactive group psychotherapy (90857) is deleted and replaced with an instruction to report 90853 with the Interactive Complexity add-on code (+90785) when appropriate for the particular group psychotherapy patient.

Other Psychiatric Services

Pharmacologic Management add-on code – +90863

This new code may only be used by qualified healthcare professionals who *may not* use E/M codes for reporting services. The primary users of this code are expected to be prescribing psychologists (currently licensed in Louisiana and New Mexico). +90863 is an add-on to a psychotherapy service and may not be used as a stand-alone code. **PSYCHIATRISTS, OTHER PHYSICIANS, AND OTHER MEDICAL CARE PROFESSIONALS MAY NOT REPORT THIS CODE.** These professionals *must* use the appropriate E/M code.

Additional codes that may be useful for child and adolescent psychiatrists are listed below. However, having an established Relative Value Unit (RVU) does not guarantee reimbursement by the insurance carriers. The physician must check with each carrier to establish reimbursement policies. If the service is listed as non-covered under the plan, the patient may be billed directly.

Code	Time (Minutes)
90865 – Narcosynthesis	unspecified
90870 – ECT	unspecified
90875 – Psychophysiological therapy	30 min
90876 – Psychophysiological therapy	45 min
90880 – Hypnotherapy	unspecified
90882 – Environmental manipulation	unspecified
90885 – Psychiatric evaluation of records	unspecified
90887 – Interpretation with family	unspecified
90889 – Preparation of report	unspecified
90899 – Unlisted psychiatric service	unspecified

Central Nervous System Assessments/Tests (Neuro-Cognitive, Mental Status, Speech Testing)

These may be performed by physicians or other qualified healthcare professionals and are typically reported per hour, face-to-face time, preparation and interpretation of a report. Developmental screening (96110) may be used for various rating scales like Brown or Connors ADD scales. It has only a practice expense, no relative value work associated with it. Report for each rating scale used.

96101	Psychological testing by psychologist or physician
96102	Psychological testing by technician
96103	Psychological testing administered by computer

96105	Assessment of aphasia
96110	Developmental screening
96111	Developmental testing,
96116	Neurobehavioral status exam
96118	Neuropsychological testing by psychologist or physician
96119	Neuropsychological testing by technician
96120	Neuropsychological testing administered with computer

Modifier Codes

Modifier codes are used to document a procedure or service that has been altered in some way due to a specific circumstance, however its definition or code has not been changed.

-22 Unusual Procedural Services

When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier '-22' to the usual procedure number. A report may also be appropriate. Documentation must support the substantial additional work and the reason for the additional work. This modifier may *not* be appended to an E/M service.

-25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Day of a Procedure

The physician may need 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 usual pre-procedure and post procedure care associated with the procedure that was performed. This circumstance may be reported by adding the modifier '-25' to the appropriate level of E/M service.

OTHER CODES

Medical Team Conferences Without Direct Contact with the Patient and/or Family

99367 Medical team conferences require face-to-face participation by at least three qualified health care professionals of *different* specialties or disciplines who all provide direct care to the patient. At least 30 minutes (range 16 – 45 minutes) must be devoted to the patient billed for this service. Also, do NOT report when participation in the team conference “is part of a facility or organizational service contractually provided by the organization or facility provider.” (CPT 2012, Professional Edition, p. 33) If the patient is present, use the appropriate E/M codes.

Telephone Services

Telephone Services are non-face-to-face E/M services provided to the patient on the telephone. The service must be provided at least 7 days *after* a face-to-face visit. If the telephone contact results in a face-to-face visit in the next 24 hours, the time becomes part of the pre-time of that visit and cannot be reported separately. (Remember to check with the patient’s insurance whether these services are covered.)

99441	Telephone E/M service provided to an established patient, parent/guardian -5-10 minutes of medical discussion
99442	11-20 minutes of medical discussion
99443	21-30 minutes of medical discussion

Online Medical Evaluation

An online electronic medical evaluation is a non-face-to-face E/M service by a physician to a patient/guardian/health care provider using Internet Resources in response to a patient's on-line inquiry. There must be a permanent storage (electronic or hard copy) of the encounter. The reportable service encompasses the sum of the communications (online-telephone-prescription provision, lab orders, etc.) that pertain to the specified encounter.

99444	Online (internet or similar electronic communication network) evaluation and management service provided by a physician to an established patient/parent/guardian/health care provider not originating from a related E/M service provided within the previous 7 days
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Care Coordination

For years, CPT struggled with a way for physicians to bill for non-face-to-face services including phone calls, teams meetings, and activities of clinical staff. Some of these services have been covered as an expected part of codes for face-to-face services, but most of them have simply not been reimbursed, despite codes in the CPT Manual describing non-face-to-face services.

In 2012, CMS recognized that these care coordination services are important and indicated a willingness to pay for them if a "different" way could be found. The AMA Care Coordination CPT Workgroup designed 2 sets of codes, one set for care of patients making a transition from a facility setting to a home setting (Transition Care Management or TCM codes, 99495 and 99496) and one set for care coordination of patients with complex chronic conditions (Complex, Chronic care Coordination or CCCC codes, 99487, 99488, and +99489) that require substantial non-face-to-face activity by office clinical staff. These codes were designed for use by primary care providers but could be useful for some child and adolescent psychiatric practices, as well.

These two code families are included in the 2013 CPT Manual. In the Final Rule (November, 2012), CMS announced that they will reimburse for the TCM, but that the work involved with the CCCC is already bundled (included) in other services and will not be paid separately.

CPT is also addressing physician (or qualified health care professional) to physician (or qualified health care professional) consultation codes when the consulted physician (or qualified health care professional) does *not* see the patient. Technical issues have prolonged this process that has been ongoing for over a decade. Hopefully, physicians who provide consultative services to a colleague without actually seeing the patient will be able to report this service in 2014. The service typically would be given via internet or telephone and will be time based.

Psychiatry Codes Summary

Service	Evaluation and Management (E/M)	Interactive Complexity	Psychiatric Diagnostic Evaluation	Psychotherapy	Psychotherapy (same day E/M)
Codes	99201-99255, 99281-99285, 99304-99337, 99341-99350	+90785	90791(no medical) 90792 (with medical)	90832 90834 90837	+90833, +90836, +90838
Comments	Includes pharmacologic management when appropriate; No psychotherapy	Add-on code in conjunction with select psychiatric service	With or without medical services; in certain circumstances one or more other informants may be seen in lieu of the patient; codes 90791, 90792 may be reported more than once for the patient when separate diagnostic evaluations are conducted with the patient and other informants; codes 90791, 90792 may be reported only once per day	The choice of code is based on the one that is closest to the actual psychotherapy time face-to-face with patient and/or family member	Add-on codes in conjunction with E/M service; the choice of code is based on the one that is closest to the actual psychotherapy time face-to-face with patient and/or family member; time associated with activities used to meet criteria for the E/M service is not included in the time used for reporting the psychotherapy service
May report same day		Primary procedure: 90791, 90792, 90832- +90838, or 90853	+90785	+90785 +90863 prolonged services (+99354-+99357)	+90785 Primary procedure: E/M
May NOT report same day		90839, 90840; E/M when no psychotherapy code reported	E/M, 90832, 90834, 90837, 90839, +90840	90839 +90840	Prolonged services (+99354-+99357)

Service	Psychotherapy for Crisis	Family Psychotherapy	Group Psychotherapy	Pharmacologic Management (same day psychotherapy)	Other Psychiatric Services
Codes	90839, +90840	90846, 90847, 90849	90853	+90863	90845, 90865-90899
Comments		With or without patient present; multi-family group	Does not include a multiple-family group	Add-on code in conjunction with psychotherapy service; may report ONLY by providers who may NOT report E/M	Psychoanalysis, multiple-family group psychotherapy, narcosynthesis, TMS, ECT, biofeedback with psychotherapy, hypnotherapy, environmental intervention, evaluation of records, interpretation or results, preparation of report, unlisted psychiatric procedure
May report same day			+90785	Primary procedure: 90832, 90834, or 90837	
May NOT report same day	90832-+90838, +90785, 90791, 90792, all other codes in Psychiatry section	+90785		(Psychiatrists MAY NOT use this code)	+90785

PARTIAL GLOSSARY

HEALTH CARE FINANCING ADMINISTRATION (HCFA) A component of the U.S. Department of Health and Human Services that administers the Medicare program and certain aspects of state Medicaid programs. Renamed CMS (Center for Medicare-Medicaid Services) after June, 2001.

PHYSICIAN CURRENT PROCEDURAL TERMINOLOGY (CPT) "...a list of descriptive terms and identifying codes for reporting medical services and procedures that physicians perform. The purpose of CPT is to provide a uniform language that accurately describes medical, surgical, and diagnostic services, thereby serving as an effective means for reliable nationwide communication among physicians, patients, and third parties" (AMA, 1992).

PHYSICIAN PAYMENT REVIEW COMMISSION (PPRC) A federal advisory body created in 1986 by Congress to design reasonable and rational payments to physicians by Medicare. After three years of study and consultation, the commission recommended that the work of William Hsiao and his colleagues at Harvard University in developing the resource-based relative-value scale be adopted as the method used to revamp the Medicare fee schedule.

RELATIVE-VALUE UPDATE COMMITTEE (RUC) Formed in 1991 to make recommendations to CMS (HCFA) on the relative values to be assigned to new or revised codes in the CPT. It is composed of 31 members; an AACAP member served from 1996-1999 in the non-internal medicine rotating seat. In 1999, the RUC established the PEAC (Practice Expense Advisory Committee) to recommend Practice Expense (PE) Relative Value Units (RVU) for each CPT code to the RUC.

RELATIVE VALUE UNIT (RVU) A unit of measure designed to permit comparison of the amounts of resources required to perform various provider services by assigning weight to such factors as personnel time, level of skill, and sophistication of equipment required to render service.

RESOURCE-BASED RELATIVE VALUE (RBRV) The actual figure or value arrived at in relative, nonmonetary work units (relative value units) that can later be converted into dollar amounts as a means for determining reimbursement for provider (such as physicians and hospital) services. The formula for RBRV for a given service is: $RBRV=(TW)(1+RPC)(1+AST)$, in which TW represents total work input by the provider; RPC is an index of relative specialty practice cost; and AST is an index of amortized value for the opportunity cost of specialized training. Total work input is defined by four attributes: time, mental effort and judgment, technical skill and physical effort, and psychological stress.

RESOURCE-BASED RELATIVE-VALUE SCALE (RBRVS) A method of reimbursement under Medicare that attempts to base physician reimbursement on the amount of resources, including cognitive and evaluative skills, required to diagnose and treat conditions. The approach weights what resources, such as practice costs and the cost of specialty training, have gone into the "manufacture" of a service or procedure. Since the 1930's physicians have been paid

according to the “customary, prevailing and reasonable” fee for a region of the country, and fee schedules reimbursed disproportionately for procedural services.

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NOTE

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