Codify
BY AAPC

Part B Insider (Multispecialty) Coding Alert

Mental Health Coding: 3 FAQs Help You Code Psych Services Properly

Differentiate between E/M and evaluation codes with this advice.

If your practice struggles to collect reimbursement for mental health services, you're not alone. Navigating the maze of payment for psychological and psychiatric treatments can be extremely time-consuming and frustrating. Today we've got the answers to three of the most commonly-submitted mental health reimbursement questions so you can keep collecting for your services.

E/M vs. Eval Which is Correct?

Question: Our psychiatrist sometimes bills E/M codes for evaluations, but sometimes reports 90792. He says these are interchangeable. Is that accurate?

Answer: When reporting an assessment of a patient, although your psychiatrist is allowed to use both E/M services as well as 90792 (Psychiatric diagnostic evaluation with medical services), you cannot use both these codes interchangeably. You will have to base your reporting on the work involved and the services that went into the encounter.

According to CPT® guidelines, the code 90792 includes an integrated biopsychosocial and medical assessment, including history, mental status, other physical examination elements as indicated, and recommendations. The evaluation may include communication with family or other sources, prescription of medications, and review and ordering of laboratory or other diagnostic studies. In comparison, an E/M service includes history, examination (which may include mental status), medical decision making, or can be based on time spent counseling and/or coordination care.

So, when reporting an assessment of a patient, you will have to look at what services your clinician performed in order to check whether you need to report 90792 or an E/M service. If your psychiatrist's orientation of the patient's evaluation was more towards "an integrated biopsychosocial and medical assessment," you will have to report 90792 and not an E/M code for the visit.

If your clinician's evaluation of the patient was more medically or physically oriented, you will have to claim an appropriate E/M service code for the visit. You will still use these codes even if your clinician touched some psychosocial issues.

Caveat: If you are still in doubt about whether to use 90792 or an E/M code for an encounter, it is best to check with your clinician to help you identify what services went into the visit. This will help you identify which code you will need to report for the visit.

Know the Psychotherapy Time Guidelines

Question: A patient recently saw our psychiatrist for his scheduled psychotherapy session. During the visit, our clinician reviewed his medication and discussed the effects and adverse effects and made some adjustments to the dosage. He then proceeded with his psychotherapy session. Ten minutes into the session, the patient turned reticent and our clinician was forced to terminate the session. The total duration of the session was 25 minutes. Should I report only 90832, or should I report an E/M code with +90833?

Answer: You are incorrect in both of the choices that you have suggested for reporting the session. In the scenario that you have shared, your clinician only spent ten minutes performing psychotherapy. As per CPT® time rules for psychotherapy codes, your clinician will need to spend a minimum of 16 minutes for you to report either 90832

(Psychotherapy, 30 minutes with patient and/or family member) or +90833 (Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service [List separately in addition to the code for primary procedure]). Since only ten minutes were spent in psychotherapy, it does not satisfy the time limitation for reporting a psychotherapy service. So, you cannot report either of these codes for this session.

Also, it is wrong for you to look at the duration of the entire session to see if you can report a psychotherapy code for the visit. Since the time spent in pharmacological management is part of evaluation and management of the patient, you cannot add this time to the psychotherapy code and report 90832. If you do this, not only will this be denied, you might even be opening your door to an audit. Therefore, in this case, you can only report the pharmacological management of the patient.

Patient Not Present? Know What to Bill

Question: Our psychiatrist is of the opinion that when billing for psychotherapy sessions, we can calculate time spent with the family members to add up for total time. Also, he is saying that the patient need not be present for the entire session for us to bill a psychotherapy service. Is this correct?

Answer: Because the codes for reporting psychotherapy services, 90832-90838, carry the descriptor, "Psychotherapy, ...with patient and/or family member," you can report these CPT® codes when your psychiatrist performs a psychotherapy service with the patient and interacts with the family members during the session.

So, when calculating the time, you can aggregate the time spent for the psychotherapy performed on the patient as well as the time spent in interacting with the family members during the session. You will have to total the time and select the appropriate psychotherapy code. For example, if your clinician spent 35 minutes for the psychotherapy session with the patient and spent another 10 minutes with the family members, you'll have to total the time and report 90834 for 45 minutes spent on the session.

However, what your clinician is saying about the patient not necessarily being present for the entire session is not correct. CPT® guidelines for these psychotherapy codes state, "The patient must be present for all or some of the service." So, if your clinician is only interacting with the family members and the patient is not present for the entire session, you'll have to report 90846 (Family psychotherapy [without the patient present]) and not a psychotherapy code.

Note: 90846 is not a time based code. So, irrespective of the time spent for the session, you'll have to use the same CPT® code and only report it once for one calendar date of service.