Codify
BY AAPC

Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: 2 Scenarios Give Your Depression Coding A Lift

Knowing your carriers' mental-health coverage limits is key for preventing denials

If you're unsure how to report your physician's counseling services for patients with depression, you're not alone. Clear the confusion by knowing when to code by time and the appropriate diagnoses to use for medical justification.

Consider Coding By Time For Initial Counseling

Physicians are often the first to treat a patient's depression before a mental health professional takes over. To learn the nuts-and-bolts of reporting depression treatments, you should review the following two scenarios and the expert-approved coding solutions.

Scenario #1: A 65-year-old established patient who's recently lost his job presents with complaints of insomnia, loss of appetite and frequent headaches. Under physician supervision, the nurse takes the patient's history and performs a problem-focused exam. The physician counsels the patient for 10 minutes. Then, he diagnoses him with depression (311, Depressive disorder, not elsewhere classified), prescribes medication and develops a treatment plan.

Coding solution: You should report the appropriate established patient E/M code (99211-99215) based on the time the physician spent counseling and coordinating care.

To help you do this, be sure the physician documents that the office visit "was predominately counseling (health advice)" that took more than 50 percent of the physician's face-to-face time with the patient, says **Mary Falbo, MBA, CPC,** president of **Millennium Healthcare Consulting** Inc., a healthcare consulting firm based in Lansdale, PA.

The physician should document the content of the discussion and assign the appropriate depression code, such as 311, she adds.

For instance, using the above scenario, you could report **CPT 99213** (Office or other outpatient visit for the E/M of an established patient ...) as long as the physician's documentation supports a total visit of at least 15 minutes, of which 50 percent was counseling. Remember to link ICD-9 code 311 to 99213.

Heads-up: When the physician can't reach a definitive diagnosis of depression, you should rely on signs-and-symptoms coding, Falbo says. For example, if the patient has fatigue (780.7x, Malaise and fatigue) and a lack of sleep (307.41, Transient disorder of initiating or maintaining sleep), you would use those diagnoses as the medical justification for the E/M visit.

Also, be aware that some physicians prefer that an E/M service meet the three key elements - history, exam and medical decision-making - before they bill for the counseling-focused office visit.

"We almost never use E/M codes based on time, and rather, the docs focus on meeting the three key components required for new patient codes (99201-99205) and two for the established (99211-99215)," says **George Ward**, billing supervisor with **South of Market Health Center** in San Francisco.

Watch Out For Visit Limitations

Scenario #2: The physician sees a patient for a follow-up visit to discuss the patient's depression treatment plan. The physician changes the patient's medications and provides counseling. Based on the visit's medical documentation, you report 99213, linking the physician's diagnosis 296.3x (Major depressive disorder, recurrent episode) to the E/M code.

You've reported past follow-up treatments with the same patient using 296.3x and the appropriate E/M code without a problem. But this time the insurer denies the claim.

Coding solution: Remember that when the physician bills for depression treatment, the visit will very likely fall under Medicare or a private payer's mental-health coverage, Falbo says.

"After a while, the patient will meet his or her coverage limits" for mental-health visits, which means the payer will deny claims billed outside of the limits, she says.

Protect yourself: Don't let denied claims make the physician think you're not coding accurately or you've missed something in the insurer's guidelines. Instead, help your office "develop a system or form that states that if the patient's insurance company does not pay for the mental-health visit, then the patient is liable for the bill," Falbo says. "The patient should check with his or her insurance to make sure what coverage he or she has."

Some coders recommend sticking with signs and symptoms in place of depression codes to prevent carriers' denials. But you shouldn't fall for this practice. "[I]f the doctor diagnoses that a patient has depression, then that's it, as there is nothing that a coder can or should do to change it," Ward says.

Know CMS' Mental-Health Payment Policy

Even when a Medicare payer accepts your E/M code and depression diagnosis, you should be ready for an alternative payment policy. Why? When paying mental-health services, a Medicare patient is responsible for 50 percent of the bill, and Medicare is responsible for the other 50 percent.

Also be aware that private insurance may have a different payer processing their mental health claims. For example, United Healthcare covers its mental-health services through United Behavioral Health, and Blue Cross Blue Shield of North Carolina processes mental-health claims through Magellan Behavioral Health.