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Psychiatry Coding & Reimbursement Alert

Coding Quiz Answers: Compare Your Answers to Psychodiagnostic Evaluation Coding Quiz

Read our experts' opinions on deciphering these scenarios.

Scenario 1: Psychodiagnostic Evaluation by Psychologist

What to report: In this case scenario, you will have to report 90791 (Psychiatric diagnostic evaluation) for the initial evaluation that your psychologist performed.

You report 90791 when your clinician performs an initial psychiatric diagnostic evaluation of a patient that includes recording the history, performing a mental status examination, review and order of diagnostic studies as needed and for communication with family or other sources.

Practices report 90792 (Psychiatric diagnostic evaluation with medical services) if, in addition to the above mentioned services, the clinician performs any medical services such as an extended physical examination, review of systems (ROS), checking vital signs, assessment of the patient's condition, prescription of psychiatric medications (as needed), assessing the patient for any adverse effect of drugs, and assessment of other medications that the patient is currently on and assessing the patient for any possible drug interactions.

Since the initial evaluation was performed by your psychologist, you cannot report 90792 because clinical social workers and clinical psychologists are generally not licensed to provide medical services and, therefore, are not allowed to report 90792 for an initial diagnostic evaluation of a patient.

For the same reason, clinical psychologists are not allowed to report an E/M code for their services. So, you should not report an E/M code such as 99203 (Office or other outpatient visit for the evaluation and management of a new patient ...) or 99213 (Office or other outpatient visit for the evaluation and management of an established patient ...) for the evaluation performed by your psychologist.

Scenario 2: Reporting a Follow-up Psychodiagnostic Evaluation

What to report: In this case scenario, you will have to report 90791 for the reevaluation that your psychologist performed for the patient.

Per CPT®, codes 90791 and 90792 are used for diagnostic assessment(s) and reassessment(s), if required, so you can report an additional unit of 90791 if your clinician performs a reevaluation of the patient.

Some payers may have a frequency limit on how often your clinician can perform a reevaluation of the patient (e.g., once within three years). If the patient's health plan has such a limit, you may need to provide documentation to the payer that proves the medical necessity of performing the fresh evaluation.

You cannot report an established patient E/M code as your clinical psychologist is not allowed to report E/M codes for his services.

In the case scenario, your psychologist had to reevaluate the patient as the symptoms were worsening and the patient

had discontinued the previous treatment. You can report 90791 for the reevaluation that your clinician had to perform.

Scenario 3: Psychodiagnostic Evaluation With Communication Issues

What to report: In this case scenario, you will have to report 90791 along with the add-on code +90785 (Interactive complexity [List separately in addition to the code for primary procedure]) to help compensate for the extra time and effort that your clinician had to put in to overcome communication difficulties.

When reporting 90791 for an initial psychiatric evaluation, you'll have to note that this code is not a time-based code. So, you should only report one unit of the code irrespective of the amount of time that your clinician spends in performing this service on one calendar date of service. Even if your practitioner performs this service during more than one session in a single day, you'll still bill only one unit of 90791.

However, when your psychologist's efforts in conducting the psychodiagnostic evaluation are complicated by communication difficulties, you can claim extra reimbursement for the extra time and effort that your psychologist put in to complete the evaluation of the patient. You report the add-on code, +90785, with 90791 to let the payer know that your clinician had to overcome communication issues and to claim added ethical reimbursement for the additional time and effort spent.

You cannot report a prolonged services add-on code such as +99354 (Prolonged evaluation and management or psychotherapy service[s][beyond the typical service time of the primary procedure]in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour [List separately in addition to code for office or other outpatient Evaluation and Management or psychotherapy service]) as this code is used as add-on code for E/M servicesand psychotherapy codes, and not when your clinician spent extra time with the patient due to communication issues.

"Code 90791 is neither an E/M code nor a psychotherapy service, so, by definition, you cannot report +99354 in addition to 90791," says **Kent Moore**, senior strategist for physician payment at the American Academy of Family Physicians. "Also, CPT® includes a parenthetical after +99354 that lists the codes with which it may be used; code 90791 is not among them."

Scenario 4: Psychodiagnostic Evaluation with Pharmacological Management

What to report: In this case scenario, you will have to report 90791 for the reevaluation of the patient. You cannot report the pharmacological management performed by your clinician with a separate code.

Like in scenario two, your clinician had to perform a reevaluation of the patient since the patient's symptoms were on the rise and he was facing some adverse effects even though he was on medications. So, you will have to report 90791 for the reevaluation as this evaluation was done due to the medical necessity of performing the service.

Since your clinician also performed pharmacological management for the patient, you might be thinking of reporting +90863 (Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services [List separately in addition to the code for primary procedure]) in addition the evaluation of the patient. However, you cannot report the pharmacological management as a separate service here.

If you look at the descriptor to +90863, it includes the phrase, "when performed with psychotherapy services," which indicates that this add-on code can only be reported with psychotherapy codes (90832, 90834, or 90837). So, you can use this add-on code only with these psychotherapy codes when your clinician performs pharmacological management in addition to psychotherapy.

In addition, you will also face edit bundles from Correct Coding Initiative (CCI) edits if you try reporting +90863 with 90791. The edit bundle carries the modifier indicator '0,' which means you cannot overcome the edits by using any

modifiers."If you attempt to report 90791 and +90863 for the same patient on the same date, the payer will only pay you for 90791, if they are following CCI edits," Moore says.