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Psychiatry Coding & Reimbursement Alert

CPT® 2013 Strategies: Ace Your Psychodiagnostic Evaluation Reporting With This Advice

Hint: New guidelines allow reporting more than one unit of 90792 for extended evaluations.

When your psychiatrist performs an initial psychodiagnostic evaluation, you will have to focus on what services were provided to understand if you have to report 90792 or use an E/M code for the session.

Get to Know What Constitutes Medical Services

When your clinician performs a psychodiagnostic evaluation of a patient, you will need to know when to report 90791 (Psychiatric diagnostic evaluation) and 90792 (Psychiatric diagnostic evaluation with medical services). As you can see from the descriptors to both of these evaluation codes, the only difference between the two codes is that 90792 additionally covers medical services.

So, you will need to know what constitutes "medical services" to discern the instances when you need to report 90792 instead of 90791 for a psychodiagnostic evaluation of a patient. The medical services that are described by 90792 include the following:

- Extended physical examination, including vital signs,
- Medical history, including review of systems (ROS),
- Assessment of the patient's condition,
- Prescription of psychiatric medication (as needed),
- Assessing the patient for any adverse effect of drugs,
- Ordering and interpreting lab tests and other imaging studies,
- Assessment of other medications that the patient is currently on, and
- Consideration of modifying psychiatric treatment based on medical comorbidities.

In addition to this, the common scope of services covered under 90791 and 90792 include the following:

- Psychiatric history and complete mental status examination;
- Review and order of diagnostic studies as needed; and
- Recommendations and treatment plan (including communication with family or other sources).

Caveat: Clinical social workers and clinical psychologists should not bill out 90792 as they cannot bill E/M codes for their services. They should only bill 90791 for an initial psychiatric diagnostic evaluation that they perform. Only clinicians that are allowed to bill out E/M codes for their services are allowed to bill out 90792.

Discern When to Report 90792 in Lieu of E/M

Since your psychiatrist is allowed to bill out either 90792 or E/M codes for his services in evaluation of a patient, you will have to know when to report 90792 and when to use an appropriate E/M code for a particular evaluation based on the nature of the encounter and the work that was involved.

Per CPT®, "Psychiatric diagnostic evaluation with medical services (90792) is 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." An E/M service will constitute history, examination (which may include mental status), medical decision making, and counseling and/or coordination of care.

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So, the distinguishing factor for 90792 is the emphasis on "an integrated biopsychosocial and medical assessment." In other words, a typical E/M service tends to be more medically or physically oriented (although psychosocial issues may certainly be considered), while 90792 has a much stronger emphasis on biopsychosocial and medical integration.

CPT® instructs users to "select the name of the service or procedure that accurately identifies the service performed." As such, you may have to rely on your psychiatrist to help you identify whether a particular encounter is accurately described as just an E/M service or is, in fact, a psychiatric diagnostic evaluation with medical services.

Coding tip: You cannot report 90792 and any E/M codes for the same session. As per Correct Coding Initiative (CCI) edits, these two services are bundled with the modifier indicator '0,' indicating that these two services cannot be report together under any circumstances and the bundle cannot be overridden using any modifier. If these two services are reported for the same session, the payment for the E/M code will be denied and only 90792 will be reimbursed.

Use Add-on Code for Interactive Complexity

When your clinician'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 psychiatrist put in to complete the evaluation of the patient. In such a scenario, you will have to use the add-on code +90785 (Interactive complexity [List separately in addition to the code for primary procedure]) in addition to 90792.

"Before 2013, the psychotherapy codes were differentiated based, in part, on if the service was interactive or non-interactive," says **Dreama Sloan-Kelly, MD, CCS**, President of Kelly, Sloan and Associates, LLC whose offices are in Shirley, MA and Dallas, TX. "When interactive complexity takes place, code +90785 can be added to any psychotherapy code except 90839, 90840, 90846, 90847, and 90849 when the main service is complicated usually by an issue with communication and there is a need for others to be involved in the treatment of the patient."

"Interactive complexity codes can be used with psychotherapy and psychodiagnostic evaluation codes, but NOT with the crisis psychotherapy codes (i.e., 90839 and 90840)," says **David Swann, MA, LCAS, CCS, LPC, NCC**, Senior Healthcare Integration Consultant at MTM Services in Holly Springs, NC. This will help compensate for the extra time and effort that your clinician had to spend to overcome the communication difficulties that complicated the conduction of the diagnostic evaluation.

Don't Report More than One Unit of 90792 Per Session

Although guidelines have changed, allowing you to bill more than one unit of 90792 (or even 90791) for a patient, you will have to remember that this is allowable only when the diagnostic evaluation extended to more than one session, with the multiple sessions happening over different dates.

In addition, you will have to remember that although you can bill out more than one unit of 90792, you should not do this as a norm for every patient encounter. When reporting more than one unit of 90792, it is essential to provide documentation indicating why the particular patient needed extended evaluation, also explaining the medical necessity of the multiple sessions.

Reminder: Medicare will allow only one claim of 90792 in a year. However, in some cases, depending on medical necessity, Medicare might allow reimbursement for more than one unit of 90792. You can also report these codes when your psychiatrist is seeing the patient after a span of three years. In circumstances demanding the re-evaluation of a patient within the span of three years, you can claim for 90792.

Example of 90792: Your psychiatrist recently reviewed a patient for depression. The patient has been previously seen by your psychiatrist two years ago for the same problem. The patient's mother complained that he has not been taking his medications for sometime now and his depression has become worse altogether.

Your psychiatrist performed a review of the patient's history and performed a mental status examination along with physical examination, review of systems, and review of the medications that were prescribed and why the patient stopped the medication, along with information regarding adverse effects of the medication along with the effects that set in after the medication was stopped.

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Because your psychiatrist performed medical services in addition to a psychodiagnostic evaluation to determine the change in patient's condition to enable him to plan his future treatment, you can report 90792 for the evaluation of the patient.

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