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Psychiatry Coding & Reimbursement Alert

CPT® 2014 Update: Update Your E/M Code Lists With New Interprofessional E/M Codes in 2014

Plus: Don't forget to add the new Category II codes to existing PQRS measures.

When your psychiatrist reviews and discusses a patient's condition with a referring physician over the phone or via the internet on or after Jan.1, 2014, you'll be able to report this service based on time spent.

Effective Jan. 1, CPT® will include four new codes that describe the work of two medical professionals who discuss a patient's condition via phone or internet, as follows:

- 99446 (Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review)
- 99447 (... 11-20 minutes of medical consultative discussion and review)
- 99448 (... 21-30 minutes of medical consultative discussion and review)
- 99449 (... 31 minutes or more of medical consultative discussion and review).

"The interprofessional codes are interesting," says **Suzan Berman, MPM, CPC, CEMC, CEDC,** manager of physician compliance auditing for West Penn Allegheny Health Systems, Pittsburgh, Penn. "More and more, the provider community is communicating with patients and each other via the internet through secure email lines, etc. These codes appear to be in recognition of these situations. It affords a physician the ability to provide a virtual consultation to another physician without having the patient come to all the different appointments."

Keep in mind: These new codes are consultative in nature, which means you must provide a written report back to the requesting physician to qualify for the code, as indicated by the phrase "including a verbal and written report."

Apply These New Consult Choices to This Example

A family physician is treating a patient for anorexia nervosa and calls your psychiatrist for a consultation regarding treatment advice. The family physician forwards relevant historical records (including physical examination findings, laboratory data, and imaging results) on the patient prior to the telephone consultation.

Before the call, your psychiatrist reviews the patient's history and assesses her signs and symptoms. Your psychiatrist then spends 25 minutes over the phone with the FP clarifying the nature of the patient's problem and discussing his observations and interpretations of tests. He also presents the FP with an analysis of the patient's problem, including suggested management options as well as alternative diagnoses and management approaches, including plusses and minuses of each.

Your psychiatrist responds to questions from the FP during the call to clarify diagnostic and treatment approaches. As needed, the psychiatrist may also share with the FP relevant scientific background on anorexia nervosa needed to understand his recommendations or respond to the FP's questions. Your psychiatrist may even make suggestions for long-term handling of the patient's problem, such as individual cognitive behavioral therapy and family therapy along with counseling for dietary management.

Since your psychiatrist spent 25 minutes discussing about the patient's condition over the phone, you can report his services using 99448.

Confront These Issues Before Using These Codes

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There are limitations on the use of these new codes. "For instance, if the psychiatrist has already agreed to a transfer of care of the patient or if the sole purpose of the conversation is to is to arrange a transfer of care or other face-to-face service, he may not report the conversation with the FP using one of these codes," observes Kent Moore, senior strategist for physician payment at the American Academy of Family Physicians. Likewise, the consultant should not have seen the patient in a face-to-face encounter within the last 14 days; in that case, the service is considered part of the post-service work of that face-to-face encounter. If the telephone/Internet consultation leads to an immediate transfer of care or other face-to-face service with the consultant in the next 14 days or next available appointment date of the consultant, he or she should not report these codes.

This service should not be reported more than once within a seven-day interval.If more than one telephone/Internet contact(s) is needed to complete the consultation request, the whole service and the cumulative discussion and information review time should be reported with a single code. "That means, for example, if the FP calls the next day with some follow-up questions that require another 10 minutes of the psychiatrist's time on the phone, you should report code 99449 to cover both phone calls," advises Moore. Telephone/Internet consultations of less than five minutes should not be reported.

More questions: Note that these codes are time based codes. So, you'll have to base your code selection on the amount of time that was spent for the discussion. Coders and consultants alike have many questions about these new codes.

"I am a bit curious about why they are broken into time and how that time will be measured (reading, discussing, interpreting, further research, etc.). How will the time be documented?" Berman asks. "What will the reimbursement look like in comparison with having the patient actually come into the office?"

"The physicians will want to know if it is something they might be able to utilize," says Chandra L. Hines, practice supervisor of Wake Specialty Physicians in Raleigh, NC, who echoes many coders interested in determining whether insurers will include payment for these codes, since they are consultations.

Keep an eye on Psychiatry Coding & Reimbursement Alert for more on whether these are payable once the 2014 insurance fee schedules are released.

Don't Miss Out on These New Category II Codes

CPT® 2014 will also introduce these new Category II codes that are relevant to psychiatry coders for performance and quality measurement. They are:

- 3755F (Cognitive and behavioral impairment screening performed [ALS][AAN])
- 3759F (Patient screened for dysphagia, weight loss, and impaired nutrition, and results documented [ALS][AAN])
- 3760F (Patient exhibits dysphagia, weight loss, or impaired nutrition [ALS][AAN])
- 3761F (Patient does not exhibit dysphagia, weight loss, or impaired nutrition [ALS][AAN]), and
- 4540F (Disease modifying pharmacotherapy discussed[ALS][AAN])

"These new codes appear to be part of the quality measurement set for amyotrophic lateral sclerosis (ALS), which was developed by the American Academy of Neurology," observes Moore."ALS, also known as Lou Gehrig's disease, is a disease of the nerve cells in the brain and spinal cord that control voluntary muscle movement," adds Moore.The introduction of these new Category II codes will mean that your psychiatry practice will now have more options for quality measures to the extent it is involved in the diagnosis and treatment of ALS patients.

In addition: The descriptor to the existing Category II code 1040F will be changed in 2014 wherein "DSM IV" will now read "DSM VTM." So the new descriptor will read "DSM-VTM criteria for major depressive disorder documented at the initial evaluation (MDD, MDD ADOL)" in 2014. "This update was likely made by the Physician Consortium for Performance Improvement, which developed the measure," notes Moore.

Note: See Psychiatry Coding & Reimbursement Alert, Vol. 2, No. 9, for more information on CPT® changes that'll apply to psychiatry coding in 2014.

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