Psychiatry Coding & Reimbursement Alert

Reader Question: Don't Include 90887 with E/M Services

Question: Our psychiatrist discussed treatment options with a patient's family. The patient was not present for this in-office meeting. Can I still bill Medicare an E/M service based on the time spent with the family? What about if a patient is there with the family but due to cognitive issues is not mentally present or participating?

Washington Subscriber

Answer: CPT® does allow you to report new and established patient office visits without the patient present. When counseling and/or coordination of care account for more than 50 percent of the face-to-face time that the physician spends with the patient and/or family, you may use time as the key factor when determining the E/M service level. In these cases, you do not have to use history, examination, and medical decision making as the key factors. Because counseling comprises the majority of the visit you describe, assign 99212-99215 (Office or other outpatient visit for the E/M of an established patient...) based on time.

Downside: Medicare will typically only pay for the office visit if the patient is present. Your psychiatrist needs to document the face-to-face time with the patient in order for you to bill the E/M services to Medicare based on time spent on coordination and care.

Medicare requirements specify that the physician must meet face-to-face with the patient to report an established patient E/M visit (99211-99215). The only exception, apart from "incident to" services, is if the physician must contact another individual (such as a spouse, parent, child, or other family) to secure background information to assist in diagnosis and treatment planning, according to the Medicare National Coverage Determinations Manual, Chapter 1, Part 1, Section 70.1 (www.cms.hhs.gov/manuals/downloads/ncd103c1_Part1.pdf). The patient must be unable to provide the information himself. In this case, you may be able to report a low-level visit, but expect Medicare to reject the claim unless your documentation is especially clear as to the reason that contact with the family member was necessary.

Above all, to qualify as a payable service, the consult must focus on the Medicare beneficiary's treatment. A meeting with the family to explain the patient's condition is not payable, but a meeting to determine a family member's fitness to assist the patient to manage an illness may qualify (with proper documentation).

Pitfall: Although 90887 (Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient) seems ideal to report a family consult, Medicare bundles the code into other E/M services. Therefore, you cannot report it separately to Medicare and expect payment.

If you are counseling the family and the patient together and the patient has presence of mind to understand what is being said, you can charge the E/M visit based on time when the time spent on counseling is 50 percent or more of the total visit time.

Important: The key is that the patient has to be there and be an active participant in the service, not a mindless presence. He has to understand what is going on.