

# Building Psychiatric Provider Capacity Through More Efficient Use of E&M Codes

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The nation is experiencing a capacity crisis when it comes to psychiatric services. In the midst of calls for more funding to address the shortage of psychiatric doctors, one solution is readily available today. Proper use of Evaluation and Management (E&M) codes by psychiatrists will increase productivity – at rates similar to other healthcare specialists – and help to shift psychiatric departments from being a loss leader to, at a minimum, covering true costs. By aligning psychiatric use of E&M services with broader medical practices, providers can expand the availability of psychiatric care without necessarily adding new staff.

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MTM has worked with many community-based outpatient psychiatric departments that typically covered only 50% of their costs under the office and time-based codes available prior to 2013. In order to cover psychiatric losses, some organizations needed other providers – psychologists, social workers, counselors, and nurses – to generate revenue at over 100% of cost. Proper use of E&M codes can change this dynamic.

## Billing Shifts from Time to Complexity

Historically, psychiatrists were trained to provide time-intensive services -- sessions lasting one, even two hours were not uncommon. Prior to 2013, the two most popular psychiatric codes utilized were the 90862 (Pharmacologic Management) and the 90801 (Psychiatric Diagnostic Evaluation). But the elimination of time-based coding, billing codes for psychiatric care are now aligned with the broader medical field.

Today's E&M codes are based on the medical complexity of the patient and the work provided by the psychiatrist, and not necessarily on time. E&M codes have five levels, from low complexity (level 1) to the highest complexity (level 5). The rates paid by payers are correspondingly higher for more complex encounters. A psychiatrist spending 90 minutes with a level 3 patient will be paid less than a psychiatrist spending 20-30 minutes with a level 4 or 5 patient. Psychiatrists also have an option of using add-on codes for psychotherapy at 30, 45, and 60-minute intervals.

## Covering True Psychiatric Costs

But does the E&M billing cover costs? The real cost for providing outpatient and community-based psychiatric services is approximately \$200-\$250 per hour. In order to cover true costs, the average psychiatrist must perform between 16-18 E&M encounters per day. Appropriate and efficient use of E&M codes can reduce the overall cost of care and cover the true costs of the services, while using the wrong service code can quickly equate to financial losses.

## Coding Errors Can Lead to Financial Losses and Compliance Risks

One rule of billing is especially true in the E&M environment: proper documentation in accordance with the E&M Guidelines published by the Centers for Medicaid and Medicare Services (CMS) is required to support the service being provided. Additionally, incorrect coding – when the code reported is either higher or lower than what is supported in the documentation – can result in financial losses. But the risks go further, including compliance risks and potential audits.

Understanding how to select E&M service codes and levels is essential to financial sustainability and can be an important factor in addressing the growing need in psychiatric service capacity across the United States.

## CMS New Evaluation and Management Policy for 2019

On November 1, 2018 CMS finalized a number of changes to reduce administrative burden and improve payment accuracy for office/outpatient E&M visits covering Medicare beneficiaries. According to CMS, the changes effective on January 1, 2019 include:

- Elimination of the requirement to document the medical necessity of a home visit in lieu of an office visit;
- For established patient office/outpatient visits, when relevant information is already contained in the medical record, practitioners may document only changes since the last visit, or pertinent items that have not changed. Providers do not need to re-record the defined list of required elements if there is evidence that the practitioner reviewed the previous information and updated it as needed;
- Similarly, practitioners do not need to re-enter in the medical record information on the patient's chief complaint and history that has already been entered by ancillary staff or the beneficiary; and
- Removal of potentially duplicative requirements for notations in medical records by residents or other members of the medical team for E&M visits furnished by teaching physicians.

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MTM Services has been training psychiatrists in proper E&M coding for more than seven years. As part of that work, we support organizations' efforts to make their systems more efficient, including EHRs and the use of customized templates to maximize billing, coding, and documentation practices. We help generate additional revenue while minimizing compliance risks. In doing so, we support industrywide efforts to align psychiatric practices with best practices across medical fields and improve the capacity of organizations not only to provide more psychiatric services, but also generate the revenue to cover true costs.

**For more information on E&M Coding and the MTM Consultation Team, please visit [www.mtmservices.org](http://www.mtmservices.org) or, to schedule a free planning meeting, please email MTM director of operations [Marian Bradley](mailto:marian.bradley@mtmservices.org) or call (919) 387-9892.**