WELCOME TO THE 2ND ANNUAL
IDAHO INTEGRATED BEHAVIORAL HEALTH NETWORK
CONFERENCE
Coding and Documentation
IBH, Evaluations & Therapeutics

Part I  CPT Service Coding & Documentation
Part II  ICD-10-CM Diagnosis Coding & HCCs
Part III  Psychiatric Collaborative Care/AIMs UW Program

April 25, 2019
Meri Harrington, CPC, CEMC
Brown Consulting Associates, Inc.
Training Description

*The Great Reveal* – Discover how *your* service codes and *your* diagnosis codes help to define *your* professional value. Value exists whether you are paid or not. Behavioral Health professionals have reason to understand the codes and the value attached to their services. Clinicians document to support the codes assigned to third parties. Codes are submitted in *your* name for *your* services. Workshop sessions will explore services and coding familiar to you as well as new services, new diagnosis codes and new values. As always, required documentation will be discussed. Value is for your patients, for your clinics and for you, the professional. This workshop will be enhanced with guidance and training by Debra Morrison of the University of Washington’s AIMS Center.
Training Agenda

1. Study of CPT/HCPCS service codes & required documentation
2. Diagnosis codes define health conditions & social health circumstances influencing health status
3. Coding tools can bridge the gap between requirements & official medical production by the clinician
4. Understanding revenue benefits all parties
5. Psychiatric Collaborative Care Model – Developed by UW and presented today by Debra Morrison, Senior Project Manager & Practice Coach for the AIMs Center
Learning Objectives

As Result of Today’s Training

The professional will:

... endorse value & requirements for diagnosis and service codes

... reconfirm documentation for IBH and other BeH services

... acknowledge correlation between codes, documentation & RCM

... identify resources to be the engine for change relative to your state and your payers

... explore potential IBH assistance/guidance relative to services, and financial considerations
Terminology and Abbreviations for BCA Sessions

**BeH or BH**
- Behavioral Health service, or Mental Health service, or Psychiatric service
- Referencing a qualifying “Behaviorist” [defined below]

**Behaviorist**
- Masters-prepared, or PhD/PsyD/CP, clinical therapist permitted by state/federal law to diagnose psychiatric/mental health/behavioral health conditions
- A Behaviorist in today’s training context is qualified to diagnose BeH conditions and is qualified to provide psychotherapy services
Terminology/Abbreviations for Today’s BCA Sessions

- **BHC Behavioral Health Consultant** (One who is working in the medical clinician environment, with patients at the request of PCP)

- **Psychiatric Consultant** (Per Medicare & AMA/CPT; in context of ...collaborative care services) “...medical professional trained in psychiatry qualified to prescribe full range of medications [MD DO NP PA CNM] (not likely to see patient and, ...is not expected to prescribe medications.)

- **Status Change** CoCM coding language (e.g., known patient after hospital admission, maybe new diagnosis(es))
Terminology/Abbreviations for Today’s BCA Sessions

Terms Matter! – A “care manager” is NOT a case manager.

Clinical Staff [CS] working as a care manager...related to HCPCS code G0511, and is assigned only by FQHCs/RHCs & described BHI Service. It is interesting to know that code G0511 also describes FQHC/RHC Chronic Care Management services.

- Individual serving as a [CS] is by “clinical staff” rather than admin/mgt staff.
- For the CS/G0511, there is no particular academic degree requirements.

Behavioral Health Care Manager [BHCM], HCPCS code G0512/CoCM (Psychiatric Collaborative Care Model)

Review your BCA Single-Point Lesson

CPT’s Psychiatric Collaborative Care Management Services (codes 99492 – 99494) General Behavioral Health Integration Care Management (code 99484)

are very similar to, but are not equal to

HCPCS’s BHI & Psychiatric Collaborative Care Model (G0511 & G0512) for use only by FQHC/RHC clinics.
Terminology/Abbreviations for Today’s BCA Sessions

“Cut & Paste” or “Carry Forward” Auditing terms used to describe moving medical record information from one note to another note without proper identification, resulting in the appearance of said information as “current” information as of the date of new placement.

Social Determinate Diagnoses – Diagnosis codes that can help explain social barriers to health and wellness such as, homelessness, food insecurity, lack of healthcare resources, etc.
### Behavioral Health Integrated Care Team

**Who is who in a changing environment?**

<table>
<thead>
<tr>
<th>Role</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care</strong></td>
<td>PCPs: MD/DO/NP/PA/CNM</td>
</tr>
<tr>
<td><strong>Behaviorist</strong></td>
<td>Various masters-prepared therapists</td>
</tr>
<tr>
<td><strong>Psychiatric Consultant</strong></td>
<td>Psychiatrist or other qualified...</td>
</tr>
<tr>
<td><strong>BH Care Manager</strong></td>
<td>Clinical Staff Care Mgr.</td>
</tr>
<tr>
<td><strong>BeH Prescriber</strong></td>
<td>Psychiatrist, Psychiatric NP or PCPs/others</td>
</tr>
<tr>
<td><strong>Others as needed</strong></td>
<td>Resources, Nutrition ++</td>
</tr>
<tr>
<td><strong>Clinic Management</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Dx &amp; Service Coding</strong></td>
<td></td>
</tr>
<tr>
<td><strong>QA/QI &amp; Compliance</strong></td>
<td>IT ... others</td>
</tr>
</tbody>
</table>

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The Traditional Model

*Yesterday and Today*

**Traditional BeH Model** *Specialty Care*

long-standing, independent, appointment-based service provided in the office of a qualifying BeH professional
Integrated Behavioral Health Care

*Three Models in Today’s Contemporary Health Delivery*

1. **Co-located Model:** Behaviorist providing *Specialty Care* services in an office which is located in a medical clinic.

2. **Primary Care Model:** *Behavioral Health clinician* embedded in medical clinic as ‘care-team member’
   - BeH serves as consultant and trainer to the PCP & clinic medical staff
   - BeH provides brief (15-30 min.) therapeutics during PCP visit, in the exam room for patients with behavioral health concerns and/or chronic medical concerns
   - Over a “short run” patient may continue to be seen in medical clinical visit by BeH or may, as clinically indicated, be moved to a *specialty care* environment.
   - The model involves a focus on population health
   - The Idaho Hybrid Model...
3. **Psychiatric Collaborative Care Model (CoCM)**

   *CMS reimburses specific services through the Medicare program; CoCM Model enhances usual primary care by added two key services:*

   1. Care Management patient support
   2. Regular inter-specialty consultation to the PCP & primary medical care team, particularly regarding patients whose conditions are not improving
   3. Both CPT services and HCPCS services codes are available for assignment of CoCM. *See BCA Single point lesson Handout*
The Professional Credentials

*Federal/State Law & Third-Party Payers May Have Influence*

### Psychiatric & Behavioral Health Credentials

<table>
<thead>
<tr>
<th>AAMFT</th>
<th>CMFT</th>
<th>LMHS</th>
<th>MSSW</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAPH</td>
<td>CP</td>
<td>LP</td>
<td>MSW</td>
</tr>
<tr>
<td>ABECSW</td>
<td>CSW</td>
<td>LPA</td>
<td>NAMHC</td>
</tr>
<tr>
<td>ABFamP</td>
<td>D/AABM</td>
<td>LPC</td>
<td>NBCC</td>
</tr>
<tr>
<td>ABMP</td>
<td>D/ABPN</td>
<td>LPE</td>
<td>NCC</td>
</tr>
<tr>
<td>ABPH</td>
<td>DO</td>
<td>LSP</td>
<td>NP</td>
</tr>
<tr>
<td>ACP</td>
<td>DPM</td>
<td>LSW</td>
<td>NRHSPP</td>
</tr>
<tr>
<td>ACSW</td>
<td>DSW</td>
<td>MA</td>
<td>PA</td>
</tr>
<tr>
<td>ANA</td>
<td>EdD</td>
<td>MC</td>
<td>PhD</td>
</tr>
<tr>
<td>BCCS</td>
<td>EdS</td>
<td>MD</td>
<td>PMHNP</td>
</tr>
<tr>
<td>BCDSW</td>
<td>LCP</td>
<td>MEd</td>
<td>PsyD</td>
</tr>
<tr>
<td>BSN</td>
<td>LCSW</td>
<td>MFC</td>
<td>RHCP</td>
</tr>
<tr>
<td>CADC</td>
<td>LGSW</td>
<td>MFCC</td>
<td>RISW</td>
</tr>
<tr>
<td>CCCP</td>
<td>LICSW</td>
<td>MFCT</td>
<td>RN</td>
</tr>
<tr>
<td>CCMHC</td>
<td>LMFC</td>
<td>MS</td>
<td>RNCS</td>
</tr>
<tr>
<td>CCSW</td>
<td>LMFCC</td>
<td>MSc</td>
<td>ScD</td>
</tr>
<tr>
<td>CFNP</td>
<td>LMFT</td>
<td>MSN</td>
<td>SW</td>
</tr>
<tr>
<td>CISW</td>
<td>LMHC</td>
<td>MSS</td>
<td></td>
</tr>
</tbody>
</table>

### Medicare

- MDs and DOs
- NPs, PMHNPs, PAs
- Clinical Psychologists
- CSW/LCSWs

### Medicaid/Others

Selected masters-prepared counselors? Others?

*Clinic must verify*

Consider also state law

*Know what your license and your clinic policy permits.*
Barriers Frustrate Professionals

EMR Documentation Integrity Concerns

1. EMR has not delivered on promises of easier, quicker or better quality records.
2. Clinicians frustrated by time consumed in EMR process.
3. Unidentified “cut and paste” entries create confusion.
4. The EMR’s Problem List can be a problem!
5. Where is the Behavioral Health Treatment Plan?
6. Coders have difficulty helping – not familiar with clinician process.
7. Clinicians are not familiar with coding rules/guidelines/reporting.

Past Survey Says...
✔ Struggles with the EMR
✔ Varying Coding Regulations
EMR-Driven Documentation, a Problem?
If so, make it a solution!

- You have **endorsed** the concept of collaborative care team-care approach with an end-goal of better patient outcomes.
- You are **obligated** to use an EMR template which was likely modified from a medical template.
- You **recognize** there are certain documentation standards and requirements and you wish to comply.

*A medical record which is seen as useful by all stakeholders will improve communication, care and outcomes. Modify the template.*
Medicare’s “Incident to...” Rules Basics

Medicare “rules” written in federal terms have layers of detail

Medicare’s “Incident to...” Involves Payment & Practice

- Service billed as though ‘supervising clinician did the work’
- Established Dx under treatment by supervising clinician
  
  [MD/DO/NP]

- Service is billed & paid as though done by billing clinician
- Requires compliance with CMS “Supervision Guidelines” *(next slide)*
- Some, *not all* payers have adopted Medicare’s “Incident to” concept
Medicare’s “Supervision” Basics
Medicare “rules” written in federal terms have layers of detail

Medicare’s “Supervision” Defined by Categories

Medicare’s supervision categories listed below define the “extent and details of supervision required in order to be able to bill certain CPT/HCPCS services.

- **Personal** - Supervising clinician [or proxy] is *in consult room*
- **Direct** – SC in clinic but not in session *may be a covering clinician*
- **General** – SC *available but not present* in clinic but available
Service Coding Resources

The codes & rules for entities who request 3rd party payment

AMA & HCPCS CPT Code Book

BCA BeH Recipe Card - 2019

State Medicaid Program(s)

Federal Medicare Program(s)
Third-Party Audit Failure
An Adventure to Avoid!

Reasons for third-party audit failure:
1. No documented Treatment Plan
2. No anticipated outline for planned frequency and duration of planned services (in TP)
3. No “proof” psychotherapy in note
4. No mention for need for follow-up in notes
5. No safety plan documented
6. Therapist believed time pre-entered in the EMR as though it was part of the CPT code description was enough

Past Survey Says...
✔ Items below
Coding Pearls in Today’s Environment

*Clinicians hold responsibility for codes assigned, even when assigned by others*

1. **Moving forward:** Diagnosis coding and clinical outcomes are/will drive reimbursement outcomes.

2. **Looking back:** Medical business models never presumed tasking clinicians with coding, shared responsibilities are recognized.

3. Coding is more about reporting acuity and service than payment. If service is performed, report service regardless of expected payment.

4. Code **what** you do (CPT) & **why** (Dx); document to support the service.
Coding Pearls in Today’s Environment

5. The existence of a **code does not guarantee** reimbursement.

6. Just because you **did not get paid**, does not mean the billing was incorrect.

7. Just because you **got paid**, does not mean it was billed correctly.

8. What is **true today**, may be **false tomorrow**...things are changing rapidly.
Your Services – Some, but not all, Have Codes

*How are the unpayables & uncodables “counted” in your clinic?*

<table>
<thead>
<tr>
<th>Payables</th>
<th>Unpayables/Uncodables</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Psychiatric Dx Evaluation (PDE)</td>
<td>A. Warm Hand-Off</td>
</tr>
<tr>
<td>2. Individual, Family or Group Therapy</td>
<td>B. Meet and Greet</td>
</tr>
<tr>
<td>3. Health &amp; Behavior Assmt./Interv.</td>
<td>C. Resource Pairing/“social work”</td>
</tr>
<tr>
<td>4. Behavioral Health Integration</td>
<td>D. Some HCPCS codes</td>
</tr>
<tr>
<td>5. Virtual Communication [<em>News!</em>]</td>
<td>E. Clinician-initiated phone calls</td>
</tr>
<tr>
<td>6. Maybe some HCPCS codes <em>(MCaid?)</em></td>
<td>F. Unusual “therapy” techniques</td>
</tr>
<tr>
<td>7. E/M Codes <em>(Medical prescribers only)</em></td>
<td></td>
</tr>
</tbody>
</table>

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# How Services Are Paid and How You Determine Charges

Relative Value Unit (RVU) is a weighted value whereby the "value" of a code is calculated based on clinician work, overhead & malpractice. Example: Medicare bases payment allowable on $36.04 per RVU. Roughly, 90832 = $68.47. Determine your own conversion factor, then multiple your conversion factor by the RVU to establish your charges.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Add-on Code</th>
<th>CPT/HCPCS Code Description</th>
<th>April 2019</th>
<th>Prescriber</th>
<th>Nonprescriber</th>
<th>Idaho 2019 RVU &quot;Total&quot; Value</th>
<th>Your Current Charge</th>
<th>Divide current charge by RVU to determine your current Con Fac.</th>
<th>Decide upon your new consistent Conversion Factor</th>
<th>Multiply new CF by RVU for your NEW charge consideration</th>
</tr>
</thead>
<tbody>
<tr>
<td>90791</td>
<td>BCA's Non-Prescriber Clinician Psychiatric Section Fee Schedule &amp; RVUs</td>
<td>[not for MD/DO/NP/PA, see instead 90792]</td>
<td>X X</td>
<td>3.89</td>
<td>NA</td>
<td>$200.00</td>
<td>$51.41</td>
<td>$60.00</td>
<td>$233.40</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psychotherapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90832</td>
<td>Psychotherapy, [16-37 min. with patient] ($68.47)</td>
<td>X X</td>
<td>1.90</td>
<td></td>
<td>16-37 minutes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90834</td>
<td>Psychotherapy, [38-52 minutes with patient]</td>
<td>X X</td>
<td>2.53</td>
<td></td>
<td>38-52 minutes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90837</td>
<td>Psychotherapy, 60 min w/patient Note - may assign also code 99354-Prolonged Service, for well documented qualifying additional time.</td>
<td>X X</td>
<td>3.69</td>
<td>53+ minutes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prolonged Service Add-on Codes (Use w/Psychotherapy 90837 when qualifying document is provided)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ 99354</td>
<td>Prolonged evaluation E/M or psychotherapy service(s) (beyond the typical service time of the primary service); [first 30-74 min.]</td>
<td>X X</td>
<td>3.80</td>
<td>with 90837 +30-74 minutes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ 99355</td>
<td>each addl. 30 min. - 30 additional minutes after the already additional 74 minutes represented by 99354 &amp; after the already published 53 min. represented by 90837. Review CPT for detail.</td>
<td>X X</td>
<td>2.80</td>
<td>with 99354 +75-104 minutes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Health and Behavior Assessment/Intervention</td>
<td></td>
<td>No</td>
<td>X</td>
<td>0.65</td>
<td>each 15 minutes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
BCA Audit Results

*Numbers Matter!*

BCA's 2018 BeH Collective Code Assignments

<table>
<thead>
<tr>
<th>Code</th>
<th>16-37 min</th>
<th>38-52 min</th>
<th>53-89 min</th>
<th>99354 Prolong</th>
<th>9615X HBAI</th>
<th>WHO/MG Other</th>
<th>90839 Crisis</th>
<th>Grp &amp; Family</th>
<th>90785 I Compx</th>
<th>CoCM</th>
<th>Virtual Comm</th>
</tr>
</thead>
<tbody>
<tr>
<td>90791</td>
<td>4%</td>
<td>16%</td>
<td>47%</td>
<td>5%</td>
<td>4%</td>
<td>8%</td>
<td>9%</td>
<td>1%</td>
<td>4%</td>
<td>1%</td>
<td>1%</td>
</tr>
</tbody>
</table>
BCA Audit Results
Audits and Training Matter!

BCA's 2018 BeH Service Coding
Educational Audit Results

Correct: 66%
Undercoded: 8%
Overcoded: 5%
Underdoc: 4%
Miscoded: 6%
At-risk Documentation: 11%

BCA Diagnosis Code "Error" Indicators

1.1 Dx is not supported in the record. 9%
1.2 Dx documented not assigned in A/P. 19%
1.3 Dx is documented as unconfirmed. 9%
1.4 Dx #1 not most work-intensive problem. 8%
1.5 Dx lacks specificity compared to record. 31%
1.6 Dx error; auditor specify in comments. 4%
0.0 Dx Error; incorrect code not by clinician. 7%
0.1 Dx Inaccurate EMR description 13%

BCA Risk Adjustment Value (HCC)

PV Potential value indicated (not reported) 9%
OV Overvalued (unsupported specificity) 19%
UV Undervalued (supports higher specificity) 41%
HC HCC Risk Value Captured 31%
# Psychiatric Diagnostic Evaluations (PDE)  
Psychotherapy Codes (PT)

## BCA's Behavioral Health Non-Prescriber Visit Code Recipe Card

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>CPT Definition for &quot;Psychotherapy&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>90791</td>
<td>PDE by non-medical clinician, e.g. LCSW (see back of card for documentation)</td>
<td>“Psychotherapy is the treatment of mental illness and behavioral disturbances in which the physician or other qualified health care professional, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.”</td>
</tr>
</tbody>
</table>

### A. Psychiatric Diagnostic Evaluation (PDE)  
[Done by qualified non-medical clinician]

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Time</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>90832</td>
<td>Choose therapy code based on face-to-face time.</td>
<td>30 minutes</td>
<td>16-37 min</td>
</tr>
<tr>
<td>90834</td>
<td>Patient must be present for all, or most, of the visit.</td>
<td>45 minutes</td>
<td>38-52 min</td>
</tr>
<tr>
<td>90837</td>
<td>Identify therapy modalities used in your note.</td>
<td>60 minutes</td>
<td>53-89 min</td>
</tr>
<tr>
<td>+99354</td>
<td>Prolonged psychotherapy (may code only with 90837)</td>
<td>30-74 additional min.</td>
<td></td>
</tr>
</tbody>
</table>

### B. Psychotherapy Encounter  
See CPT definition (right)

### C. Psychotherapy for Crisis  
Review CPT. See also HCPCS S9484

Complex... life threatening... high distress... immediate attention... mobilization of resources... include mental status exam... include some psychotherapy

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>90839</td>
<td>First documented 60 minutes of intervention</td>
<td></td>
</tr>
<tr>
<td>+90840</td>
<td>each additional 30 minutes</td>
<td></td>
</tr>
</tbody>
</table>

### D. Psychotherapy w/patient and/or family

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>90846</td>
<td>Family therapy, patient not present</td>
<td>Note those present, themes, observations, etc.</td>
</tr>
<tr>
<td>90847</td>
<td>Family and patient present</td>
<td>50 min.</td>
</tr>
</tbody>
</table>

### E. Health and Behavioral Assessments & Interventions (HBAI)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review CPT. Focus of service is not 'mental health' - is relative to biopsychosocial</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

New 2019 Virtual Code FQHCs/RHCs

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0071</td>
<td>Virtual Communication 5 or &gt; minutes</td>
<td>NO if r/t billable visit past 7 days, or shall be seen within 24 hrs or a next available appt.</td>
</tr>
</tbody>
</table>

Review current Medicare info before using
The Bones of the PDE

!*It is impossible to have too much information in an excellent PDE!*  

1. **Reason for evaluation, including who referred and why**

2. **Complete psychiatric history**  
   1. Past history of psychiatric disorders, traumas, substance use, etc.  
   2. Any previous treatment, including inpatient treatment and medications  
   3. Family history of behavioral health disorders and any treatment  
   4. Medical, Family and Social Histories

3. **Data studies (e.g., GAD, PHQ, Vanderbilt) – With your interpretation!**

4. **Outside record requested or review**

5. **Mental Status Exam (MSE)**
The Bones of the PDE - continued

6. Current medication list and treating clinicians
7. Assessment – The current diagnoses
8. Safety Plan and instruction
9. Plan for care – Include your goals and patient goals
10. Collaborative team members
11. Treatment plan developed (or initiated)
12. Anticipated time frame for treatment

- One-visit service code
  State when incomplete & more time needed...
- No coding time guidelines
- Culminates in a Treatment Plan with Recommendations
- Review detail in the CPT code book
Treatment Plan

* A drop-dead PDE component requirement!

**Must Have**

1. Patient demographics, social information, some psychiatric history
2. Diagnosis/es requiring treatment
3. Goals and objectives for treatment
4. Timeline/tracking of progress
5. Review/revision date

**May Also Have**

6. PHQ/GAD/Other measurable scales with initial scores
7. Planned modalities
8. Barriers to success
9. Perceived strengths
10. Other items as needed
Psychotherapy, CPT Definition

Official AMA definition of your premier service!

“Psychotherapy is the treatment for mental illness and behavioral disturbances in which the physician or other qualified health care professional, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.” (AMA’s CPT Codebook - 2019)
BCA’s Psychotherapy 12 Step Documentation Program

1. Clearly label notes “Psychotherapy”
2. Chief Complaint/Reason for visit, initial or follow-up (If new, who referred and why)
3. Your observations and/or exam (MSE)
4. Major themes of therapy today [modalities such as CBT]
5. Skills used to produce therapeutic change
6. Patient’s interpersonal/interverbal changes
Psychotherapy 12 Step Documentation Program

7. Functional status (Impairment, severity/complexity of illness)

8. Assessment w/Dx treated today. [improved, worsening?]
   Include also diagnoses that affect your care today

9. Progress toward goals

10. Homework and other expected self-care

11. Compliance with treatment plan

12. Actual time face-to-face (length of session)
The History of Your EMR Template

BeH - Typically using a ‘Modified SOAP Format’ for Therapy Notes

S  Subjective:  What the client says (CC, HPI, ROS, Hx)
O  Objective:  Your examination (MSE) & your observations
A  Assessment:  Your diagnosis – your conclusions and comments about current Dx status, client progress toward goals. (Your opinion and the patient’s opinion)
P  Plan:  Your plan for next steps and/or recommendations
Your Secret is Out?

- HIPAA/Privacy concerns
- Standard of Practice concerns
- Not in concert with policy
- *Medical Record Keeping* is another patient education tool
Psychotherapy Service – Group Quiz

Identify the documented therapy

1. **Follow-up scheduled therapy #14; 30 minutes FTF:** Patient arrives stating she was able to set limits with her sister, feels sister understands the previous behavior not acceptable. Pt voiced she will continue limit-setting. Feels brighter this week, continues to be unhappy most of the time. Pt acknowledging having several of these thinking patterns. Good progress toward goals, return in one week.
Psychotherapy Service
Identify the documented therapy

2. Client working with church sound system. 4th Month/weekly: Continues with Recovery Center, working with Steve in discussion of the crisis center that is going to be opened. Continues AA group several times a week. Sleep is improved as schedule is better. Realizes how important it is to discuss the weeks plans at the beginning of the week. Return two weeks.

Assessment
1. MDD, unspecific
2. Substance Use Disorder
3. Anxiety unspecified
4. Homelessness
Psychotherapy Service

Identify the documented therapy

3. **Methods used:** CCT, CBT, Mindfulness, Stress Management & Supportive

**Response to Interventions/progress towards goals:** 50 min. visit

Pt has been doing his best to work through "the flu of a life time." Has returned to work this week. With work being consistent he is feeling confident about his ability to make it through. He noticed over the last few weeks how much he enjoys being domestic but "one or the other, can't be both"...having to balance house work and home becomes too much and he finds himself being resentful. He is working out what he needs to feel supported and balanced but did express seeing "how I doubt what others bring to the table." Pt feels that with the season change "it helps me make time to explore my emotional needs."
Psychotherapy Service

Additions as a “wish list” by not-a-therapist, Meri Harrington

New #3. HPI: 34 yom, FU monthly FU for PTSD and “depression”. Not missed any work, has been “swing dancing w/GF. He feels like is better managing triggers.

Pu has been doing his best to work through “The flu of a life time.” He as well as the rest He could return to work this week. With work being consistent he is feeling confident about his ability to make it through the next month or so but is concerned “as always” about what work will look like through the winter. He noticed over the last few weeks how much he enjoys being domestic but “it needs to be one or the other and can’t be both.” He found that having to balance house work and home becomes too much and he finds himself being resentful. He is working out what he needs to feel supported and balanced but did expresses seeing “how I doubt what others bring to the table.” Pu feels that with the season change “it helps me make time to explore my emotional needs.”

Session Content: “Using CBT today therapist recognized..., pointed out... reinforced clients work with improved self-care skills. HW: Explore & expand home-work balance techniques learned today; he shall share examples next visit r/t his awareness of his own emotional needs. We updated the Treatment Plan”

A/P: Dx - PTSD since 2015; stable, symptoms continue to improve
He continues to work full-time and living independently; he agrees that through therapy process, showing gains with depressive episodes... stress reduced. He thinks he will talk to NP XXXXX about decreasing medications.
4. **Therapy Today:** Pt brought a notebook filled with information she wanted the BHC to read about recent trauma. BHC provided psychoeducation r/t retraumatization and trauma treatment course. Provided Cognitive Behavioral Treatment. Facilitated processing of psychosocial stressors. Pt discussed her frustration at not feeling understood or that she can talk about recent assault. BHC encouraged her to discuss trauma when she is in WOT [*window of tolerance*] and she can process. Discussed and processed feelings and thoughts related to above. BHC read one page of notebook with pt and discussed her thoughts and feelings about sharing experience.

**Start time: 10:52am  End time: 11:35am**
4. **Therapy Today:** Pt brought a notebook filled with information she wanted the BHC to read about recent trauma. BHC *provided psychoeducation r/t retraumatization and trauma treatment course.* Provided Cognitive Behavioral Treatment. *Facilitated* processing of psychosocial stressors. Pt discussed her frustration at not feeling understood or that she can talk about recent assault. BHC *encouraged* her to discuss trauma when she is in [window of tolerance] and she can process. *Discussed and processed* feelings and thoughts related to above. BHC read one page of notebook with pt and discussed her thoughts and feelings about sharing experience.

**Start time:** 10:52am  **End time:** 11:35am
Every Visit Note Should Tell TODAY's story...

_HPI is a good place to begin today’s story_

Write your free-text "HPI" to identify how the patient says she/he is doing (with Dx/problems) since last visit.

**Example:** Open with... “46 year old female is here for scheduled FU for GAD & moderate MDD. She has been remembering to use her XYZ technique in stressful interactions w/daughter, and it has helped. She has been walking daily, has not missed any work days. sleeping 6 hours/night –Says she is beginning to realize she is better and handles triggers to some extent.”
Every visit note should tell TODAY's story...

Close today’s story in the A/P for improved record quality and collaborative value.

Assessment/Plan

1. **GAD** continues to be stable with continued slow improvement. Able to control some confrontational behaviors (with daughter) “trigger management” working.

2. **MDD, moderate**: reasonably stable without PHQ change. She says she wants to talk to NP XXXXX at her May 12th visit about possible med changes. She is encouraged to follow through with the cooking club, although concerned about rejection, then mentioned maybe she will take her daughter. Return 2 weeks.

*Treatment Plan updated and A/P to team for collaboration.*
Assessment & Plan – A/P

Every visit note tells today’s story which ends with Assessment & Plan

*Remember, the physician will go straight to A/P for information.

Consider instead...

Assessment & Plan

F33.1 Major depressive disorder moderate, stable Client continues to show steady improvement in management of symptoms. Engaged with our list of “healthy options.” Functional improvement at work and relationships. Is encouraged with his progress. (written by not-a-therapist, M. Harrington)

Patient Instructions

Continue with self-care plan, FU for counseling, one month
See PCP 5/15/19 (My summary note forwarded to X. YYYY, MD)
C. Psychotherapy for Crisis 90839

<table>
<thead>
<tr>
<th>C</th>
<th>Psychotherapy for Crisis</th>
<th>Review CPT</th>
<th>See also HCPCS S9484</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Complex... life threatening... high distress... immediate attention... mobilization of resources... Include mental status exam... Include some psychotherapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90839</td>
<td>First documented 60 minutes of intervention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ 90840</td>
<td>each additional 30 minutes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Problem is typically life-threatening or complex
Requires immediate attention
Patient is in high distress

Clinician provides psychotherapy, mobilizes resources to defuse crisis and restore safety
Minimum of 30 minutes
If more than 74 minutes add +90840
E. Health and Behavioral Assessment/Interventions

*CPT HBAI Codes 96150-96155*

<table>
<thead>
<tr>
<th>Health and Behavioral Assessments</th>
<th>[Each 15 minutes = 1 unit of code]</th>
</tr>
</thead>
<tbody>
<tr>
<td>96150</td>
<td>Initial assessment [one unit of code for each 15 minutes]</td>
</tr>
<tr>
<td>96151</td>
<td>Re-assessment [at a distant later time, per 15 minute units]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health and Behavioral Interventions</th>
<th>[Each 15 minutes = 1 unit of code]</th>
</tr>
</thead>
<tbody>
<tr>
<td>96152</td>
<td>Individual face-to-face [one unit of code for each 15 minutes]</td>
</tr>
<tr>
<td>96153</td>
<td>Group of 2 or more [one unit of code for each 15 minutes]</td>
</tr>
<tr>
<td>96154</td>
<td>Family with patient present [one unit of code for each 15 minutes]</td>
</tr>
</tbody>
</table>
HBAI Must-Haves

1. Medical diagnosis – “as diagnosed by....”
2. Evidence of assessment or intervention, as appropriate
3. Short term treatment, include your plan!
4. Time statement (reported per 15 minutes) – may use more than one unit per date of service... watch payer policy!
PCP requested visit with 9 yo with new Dx of Type 1 diabetes. Allowed child to share his fear of shots/blood sugar testing, blood sugar testing, & “disease.” He doesn’t want his peers to know “something is wrong”. Validated feelings for this significant change, reinforced facts, dismissed fiction & educated options for discreet testing/injections at school. Gave mom titles of excellent books for children with diabetes to help him process and normalize responses.

Patient will benefit from a couple more visits eval/intervention re: acceptance and self-care. He will see me on 14th after PCP visit. He and Mom have outline for discussions, she will help him journal these and bring to next session.

**Assessment:** Type 1 DM as diagnosed by Dr. Smith. FU planned.
Virtual Communication, G0071 Comments
Additional FQHC/RHC Reimbursement Since January 1, 2019

What type of technology is required for VC?

- telephone call
- integrated audio/video system or
- through a store-and-forward method such as sending a picture or video to the RHC or FQHC practitioner for evaluation/FU within 24 hours.
- FQHC/RHC practitioner may respond by telephone, audio/video, secure text messaging, email, or use of a patient portal.
Virtual Communication HCPCS Code G0071
Additional FQHC/RHC Reimbursement Since January 1, 2019

Additional payment for communication technology-based services or remote evaluation by Psych PhD/LCSW/MD/DO/NP/PA/CNM

a) At least 5 minutes of service by FQHC clinician (medical, psychologist, LCSW) who has had billable visit within the past year

b) The “discussion/evaluation” is not related to Dx seen in visit during past 7 days, no urgent visit needed (next 24 hrs., or next available appt.)

c) Of course, must be documented with content, concern, advice & time

d) Not a “visit rate” but is an additional payment of $13-14, if copay = $1-3
Virtual Communication, G0071 - continued
Patient contacts clinician & communicates for 5 or more minutes

1. Patient contacts the clinician *(Estimated payment $13.00 -$14.00, copay applies)*
2. For services of nurse/other? No, Use for MD/DO/NP/PA or PsyD/PhD or LCSW
3. Beneficiary consent for billing is required? Yes
4. Is code OK for condition monitoring? No!
5. Is there a Medicare limit on number of services? No
6. **Billing:** May be *billed* on the same claim as visit
7. **Billing:** May be billed same month as ‘care management’ codes

Additional FQHC Info See MBPM, Chapter 13, Section 240
BCA’s Documentation Take-Homes

The Record has Everything to Do with Coding

1. Clarify reason for each visit
2. Create the “story” from how has the patient been doing since your last encounter though the current diagnosis(es), the status of diagnoses, and your instructions and recommendations
3. Be sure your professional therapy work effort is clear in the record
4. Mindful documentation to guide collaboration with Team
5. Manage the Treatment Plan
ICD-10-CM Diagnosis Coding

Part II – Diagnoses and HCCs

THE TRUTH, THE WHOLE TRUTH AND NOTHING BUT THE TRUTH
PROVING THE MEDICAL NECESSITY FOR SERVICES PROVIDED
CAN PROVIDE VALIDITY FOR SLOW OR NO TREATMENT PROGRESS
ICD-10-CM versus DSM-5

*DSM-5 and ICD-10 are “companion publications”*
## Diagnosis Coding  ICD-10 vs DSM-5

*Companion Publications*

<table>
<thead>
<tr>
<th>ICD-10-CM</th>
<th>DSM 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance use, abuse or dependence</td>
<td>Substance use as mild, moderate or severe</td>
</tr>
<tr>
<td>ADHD as predominantly inattentive, hyperactive, or combined</td>
<td>ADHD further identified by severity and partial remission</td>
</tr>
<tr>
<td>PTSD as acute or chronic</td>
<td>PTSD not defined as acute or chronic</td>
</tr>
</tbody>
</table>
Five Basic Diagnosis Coding Guidelines

Called “Guidelines”, but Compliance is HIPAA Mandated

1. **1st listed** dx identifies condition requiring the greatest work effort today, as determined by the clinician and supported in the record.

2. Document all conditions that **require/affect care**.

3. Do not code signs/symptoms when definite dx known.

4. Code to the highest level of **specificity** known.
   - MDD, recurrent episode, severe, w/o psychotic sx – *ICD-10 F33.2*
   - Post traumatic stress disorder, chronic – *ICD-10 F43.12*
   - Opioid dependence with mood disorder - *ICD-10 F11.14*

5. **No “rule out”** or - report instead signs/symptoms or unspecified.
   - Excessive crying – *ICD-10 R45.83*
Study Your Data – Everyone Else Does!

**Diagnosis Category Comparison**

<table>
<thead>
<tr>
<th>Diagnosis Category</th>
<th>Category A</th>
<th>Category B</th>
<th>Category C</th>
<th>Category D</th>
<th>Category E</th>
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<tbody>
<tr>
<td>MDD</td>
<td>30</td>
<td>35</td>
<td>16</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Bipol</td>
<td>15</td>
<td>24</td>
<td>6</td>
<td>13</td>
<td>2</td>
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<tr>
<td>Anx</td>
<td>12</td>
<td>12</td>
<td>24</td>
<td>13</td>
<td>2</td>
</tr>
<tr>
<td>PTSD</td>
<td>4</td>
<td>7</td>
<td>4</td>
<td>7</td>
<td>7</td>
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<tr>
<td>Subs</td>
<td>35</td>
<td>7</td>
<td>30</td>
<td>35</td>
<td>16</td>
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<tr>
<td>ADHD</td>
<td>30</td>
<td>35</td>
<td>16</td>
<td>7</td>
<td>7</td>
</tr>
</tbody>
</table>
Various risk-based reimbursement models are utilized to predict medical expenditures
- CMS HCC Model (Hierarchical Condition Categories)
- Medicaid CDPS Model (Chronic Disease & Illness Payment System), Various hybrid models

Categories describe a broad set of similar diseases (ICD-10-CM codes)
- Risk variation occurs between different models focused on certain patient populations
- Broken down into hierarchical categories based on severity

*Well assigned Dx codes may result in added value, unspecified conditions may not*
The Value of Accurate Coding

*This is today’s world*

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>HCC</th>
<th>Fed Set/Allott</th>
</tr>
</thead>
<tbody>
<tr>
<td>F32.9</td>
<td>MDD single episode unspec</td>
<td>.000</td>
<td>$700.00 pmpm</td>
</tr>
<tr>
<td>F32.1</td>
<td>MDD single, <em>moderate</em></td>
<td>.395</td>
<td>$1550.00 pmpm</td>
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<tr>
<td>F10.21</td>
<td>Alcohol depnd/remission</td>
<td>.383</td>
<td></td>
</tr>
</tbody>
</table>
Major Depressive Disorder

Specify please!

<table>
<thead>
<tr>
<th>Major Depressive Disorders (MDD)</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDD, single episode code choice</td>
<td></td>
</tr>
<tr>
<td><em>Single episode</em> is the first-ever episode. DSM-5, pg 162: Dx code for MDD based on single vs recurrent and severity.</td>
<td></td>
</tr>
<tr>
<td>MDD, single episode: (The patient’s 1st Dx of MDD - may last months/year)</td>
<td></td>
</tr>
<tr>
<td>MDD, single episode, mild severity</td>
<td>MDD F32.0</td>
</tr>
<tr>
<td>MDD, single episode, moderate severity</td>
<td>MDD F32.1</td>
</tr>
<tr>
<td>MDD, single episode, severe, WITHOUT psychotic symptoms</td>
<td>MDD F32.2</td>
</tr>
<tr>
<td>MDD, single episode, severe, WITH psychotic symptoms</td>
<td>MDD F32.3</td>
</tr>
<tr>
<td>MDD, single episode, in PARTIAL remission</td>
<td>MDD F32.4</td>
</tr>
<tr>
<td>MDD, single episode, in FULL remission</td>
<td>MDD F32.5</td>
</tr>
<tr>
<td>MDD, single episode, severity cannot be specified</td>
<td>avoid F32.9</td>
</tr>
</tbody>
</table>

MDD, recurrent episode code choices (more common than single episode)

An episode* likely to last many mos/year. DSM-5, pg 162: *recurrent* = interval of ≥ 2 consecutive months between separate episodes in which criteria for MDD are not met.

| MDD, recurrent episode, mild subsequent re- dx after remission | MDD F33.0 |
| MDD, recurrent episode & moderate severity | MDD F33.1 |
| MDD, recurrent & severe, WITHOUT psychotic symptoms | MDD F33.2 |
| MDD, recurrent & severe, WITH psychotic symptoms | MDD F33.3 |
| MDD, recurrent episode in PARTIAL remission | MDD F33.41 |
| MDD, recurrent episode in FULL remission | MDD F33.42 |
| MDD, Other recurrent depressive disorder (specified in record) | MDD F33.8 |
| MDD, recurrent episode, severity cannot be specified | avoid F33.9 |

Other Depressive Episodes (Added 2016)

| Othermenstrual dysthmic disorder | F32.81 |
| Other specified depressive episode (specified in record) | F32.89 |

Two Clinicians, Same Patient Population

Notice absence of HCC value

66% 19% 16% 16% 53% 18% 0% 9% 0% 4%
The “Severity” Specifiers
*Mild, Moderate & Severe*

**Mild:** At this time, few, if any symptoms (beyond the DSM req. of 5-9) are present. Intensity of symptoms is distressing, but manageable. Symptoms result in minor impairment in social or occupational functioning.

**Moderate:** Number and intensity of symptoms and/or functional impairments are between those identified as “mild” & “severe.”

See DSM-5, page 188
The “Severity” Specifiers

*MDD* - Mild, Moderate or Severe

Major Depressive Disorder, single episode _______ (Include severity)

**Severe:** At this time the number of current symptoms is substantially in excess of the 5-9 required for diagnosis. The intensity of symptoms is seriously distressing and unmanageable, symptoms markedly interfere with social and/or occupational functioning.  

*DSM-5* page 188

**Note:** When the severity level is “severe,” provide further detail indicating whether or not symptoms of psychosis are present.  

*DSM-5* page 188 & *ICD-10-CM*
MDD in Remission

Rarely coded??

Full Remission of MDD?

DSM-5 states “The course of MDD is quite variable, such that some individuals rarely, if ever, experience remission (a period of 2 or more months with no symptoms, or only one or two symptoms to no more than a mild degree), while others experience many years with few or no symptoms between discrete episodes.”

Partial Remission of MDD?

1) “symptoms of the immediately previous major depressive episode are present, but full criteria are no longer met... OR

2) there is a period lasting less than 2 months without any significant symptoms of a major depressive episode following the end of such an episode.”

DSM-5, pg 165 & 188
Focus on Substance Dependence, Abuse and Use

*DSM does not use “addiction” terminology*

People use substances for a variety of reasons. It becomes drug abuse when people use illegal drugs or use legal drugs inappropriately. This includes the repeated use of drugs to produce pleasure, alleviate stress, and/or alter or avoid reality. It also includes using prescription drugs in ways other than prescribed or using someone else’s prescription. Addiction occurs when a person cannot control the impulse to use drugs even when there are negative consequences—the defining characteristic of addiction. These behavioral changes are also accompanied by changes in brain functioning, especially in the brain’s natural inhibition and reward centers.  

National Institute of Drug Addiction (NIDA’s)
Opioid Specificity (F11)
203 Occurrences

- Opioid use, unspecified with unspecified opioid...
- Opioid use, unspecified, uncomplicated...
- Opioid dependence with other opioid-induced disorder...
- Opioid dependence with withdrawal...
- Opioid dependence, in remission...
- Opioid dependence, uncomplicated...
- Opioid abuse, in remission...
- Opioid abuse, uncomplicated...

Counts:
- 1
- 5
- 5
- 2
- 47
- 98
- 10
- 35
Other Stimulant Specificity (F15)
223 Occurrences

- Other stimulant use, unspecified with stimulant-induced psychotic disorder: 3
- Other stimulant use, unspecified with stimulant-induced mood disorder: 1
- Other stimulant dependence with stimulant-induced psychotic disorder: 2
- Other stimulant dependence with intoxication with perceptual disturbance: 3
- Other stimulant dependence, in remission: 72
- Other stimulant dependence, uncomplicated: 64
- Other stimulant abuse with stimulant-induced psychotic disorder: 6
- Other stimulant abuse, in remission: 3
- Other stimulant abuse, uncomplicated: 63
## Substance Use, Abuse, & Dependence
### Terminology Comparison

<table>
<thead>
<tr>
<th>DMS-5</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>mild</td>
<td>abuse</td>
</tr>
<tr>
<td>moderate</td>
<td>dependence</td>
</tr>
<tr>
<td>severe</td>
<td>dependence</td>
</tr>
</tbody>
</table>

Remember, In polysubstance cases, report Dx codes for each substance.
Substance Related “Disorders” by DSM

Substance-related Disorders (DO) are divided into two groups:

1. Substance Use Disorders (SUDs)
2. Substance-induced Disorders

The Substance-induced disorders are

a) Intoxication
b) Withdrawal
c) Other substance/medication-induced psychotic, bipolar, depressive, anxiety, obsessive-compulsive, sleep, sexual dysfunction, delirium and neurocognitive disorders
Severity and DSM “Specifics”

It is important to remember that **substance use disorders** occur in a broad range of severity, *based on the number of symptom criteria endorsed*.

**Severity Ranges:**
(As a general estimate)
- **Mild** – the persistent presence of 2-3 symptoms
- **Moderate** – 4-5 symptoms
- **Severe** – 6 or more symptoms

**Descriptive Feature Specifiers:**
- early remission
- sustained remission
- on maintenance therapy
- in a controlled environment

Changing severity across time is also reflected by reduction or increase in the frequency and/or dose of substance use, as assessed by the individual’s own report, report of knowledgeable others, clinician’s observations, and biological testing.
Substance Use Disorder: *Breaking Down the Criteria*

An alcohol use d/o example:

1. Alcohol is taken in larger amounts....
2. Persistent desire to cut down...
3. Time spent...
4. Cravings...
5. Recurrent use resulting in failure to fulfill...
6. Continued use despite interpersonal problems...
7. Reduction in activities...
8. Recurrent use in hazardous situations...
9. Continued use despite psych problems...
10. Tolerance...
11. Withdrawal...

Specify current severity:
- (F10.10) Mild (abuse): 2-3 symptoms
- (F10.20) Moderate (dependence): 4-5 symptoms
- (F10.20) Severe (dependence): 6 or more symptoms
Descriptive Feature Specifiers:

- early remission
- sustained remission
- on maintenance therapy
- in a controlled environment

**In early remission:** After full criteria for alcohol use disorder were previously met, none of the criteria for alcohol use disorder have been met for at least 3 months but for less than 12 months...

**In sustained remission:** After full criteria for alcohol use disorder were previously met, none of the criteria for alcohol use d/o have been met at any time during a period of 12 months...

F10.11 = alcohol abuse, in remission
F10.21 = alcohol dependence, in remission
Substance/Medication-Induced Mental Disorder

Opioid Example

a) Intoxication
b) Withdrawal
c) Other substance/medication-induced
   psychotic, bipolar, depressive, anxiety,
   obsessive-compulsive, sleep, sexual dysfunction,
   delirium and neurocognitive disorders

A mental condition may co-exist with substance abuse and not be induced by the substance.
When coding, do not assign as substance or medication induced unless documentation is crystal clear. When in doubt, ask.

F11.24 = Opioid dependence w/opioid-induced mood disorder
F11.250 = Opioid dependence w/ opioid-induced psychotic disorder with delusions
Documenting MDD & Substance Disorders

Report all conditions affecting care
- Complications/other conditions/manifestation
- Management options
- Medications, overdosing, underdosing, adverse affects

Study specificity available, pair with excellent documentation
- Severity: mild, moderate, severe (use, abuse or dependence)
- Other specifiers: In early remission, sustained remission, on maintenance therapy, in controlled environment
- Underdosing
- Intoxication, withdrawal, substance-induced mental disorder
Social Determinants of Health (Z55-Z65)
Assessing risk factors by zip code, not DNA

Studies show social disparities = higher impact on healthcare dollars spent than a patient’s family history:
For patients below the federal poverty level, 38.7% spend more than $1/5^{th}$ of annual income on premiums & out-of-pocket expense.
Delaying care, may result in long-term issues
Additional ED visits, rather than lower-cost primary care

ZIP Code may have more effect on health outcomes than DNA Code
- Z59.0 Homelessness
- Z62.22 Institutional living
- Z59.4 Lack of food/water
- Z59.6 Low income
- Z59.5 Extreme poverty
- Z60.3 Acculturation difficulty
- Z60.4 Social rejection
- Parent-child concerns
- Z62.2 Upbringing away fm parents
- Z63.32 Absence of family member
- Z62.8XX Hx of abuse/neglect
- Support group problems
- Legal circumstances
Gaining Momentum - Additional Diagnoses

Explains greater than expected health care and less-than-perfect outcomes

One Clinic, 13 BeH Clinicians
1,139 Code Assignment Occurrences

<table>
<thead>
<tr>
<th>Condition</th>
<th>Occurrences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/child conflict</td>
<td>151</td>
</tr>
<tr>
<td>Hx oth spec conditions</td>
<td>124</td>
</tr>
<tr>
<td>Hx m/b d/o</td>
<td>116</td>
</tr>
<tr>
<td>Problem r/t support group</td>
<td>113</td>
</tr>
<tr>
<td>Counseling</td>
<td>95</td>
</tr>
<tr>
<td>Spouse/partner r/ship prob</td>
<td>90</td>
</tr>
<tr>
<td>Family sep/div</td>
<td>87</td>
</tr>
<tr>
<td>Sibling rivalry</td>
<td>76</td>
</tr>
<tr>
<td>Life cycle transition</td>
<td>66</td>
</tr>
<tr>
<td>Homelessness</td>
<td>64</td>
</tr>
<tr>
<td>Dis/death family mem</td>
<td>53</td>
</tr>
<tr>
<td>Hx healed trauma</td>
<td>42</td>
</tr>
<tr>
<td>Spec prob r/t primary supp</td>
<td>41</td>
</tr>
<tr>
<td>Oth spec counseling</td>
<td>21</td>
</tr>
</tbody>
</table>
New Codes – A Self-study
ICD-10-CM Coding Additions and Changes

Cannabis dependence with withdrawal (F12.23)
Cannabis use, unspecified with withdrawal (F12.93)

Postpartum depression (F53.0)
Puerperal psychosis (F53.1)
New BeH Screening & Developmental DO

Z13.30 **Encounter for screening** for MN/BH DO unspecified
Z13.31 Encounter for screening for depression
Z13.32 Encounter for screening for maternal depression
Z13.39 Encounter for screening exam for other MN/BH DOs

Z13.40 Encounter for screening for unspecified developmental delays
Z13.41 Encounter for autism screening
Z13.42 Enc. for screening for global developmental delays (milestones)
Z13.49 Encounter for screening for other developmental delays
Interesting Newborn Codes & Ecstasy Poisoning Codes

P04.14 Newborn affected by maternal use of opiates
P04.15 Newborn affected by maternal use of antidepressants
P04.16 Newborn affected by maternal use of amphetamines
P04.17 Newborn affected by maternal use of sedative hypnotics

T43.641 Poisoning by ecstasy, accidental (unintentional)
T43.642 Poisoning by ecstasy, intentional self-harm
T43.643 Poisoning by ecstasy, assault
T43.644 Poisoning by ecstasy, undetermined
Revised Codes – Factitious Disorder  *(Munchausen)*

F68.10 **Factitious disorder** imposed on self, unspecified
F68.11 Factitious disorder imposed on self, with predominantly psychological signs and symptoms
F68.12 Factitious disorder imposed on self, with predominantly physical signs and symptoms
F68.13 Factitious disorder imposed on self, with combined psychological and physical signs and symptoms
F68.A Factitious disorder imposed on another  *(Actually a new code)*
New Adult and Child Maltreatment

T74.51 Adult forced **sexual exploitation**, confirmed
T74.52 Child sexual exploitation, confirmed
T74.61 Adult **forced labor exploitation**, confirmed
T74.62 Child forced labor exploitation, confirmed
T76.51 Adult forced sexual exploitation, suspected
T76.52 Child sexual exploitation, suspected
T76.61 Adult forced labor exploitation, suspected
T76.62 Child forced labor exploitation, suspected
Forced Sexual and Labor Exploitation

Z04.81 Enc. for Ex & observation following forced sexual exploitation
Z04.82 Enc. for Ex & observation following forced labor exploitation
Z62.813 Personal Hx forced labor or sexual exploitation in childhood
Z91.42 Personal Hx forced labor or sexual exploitation

Added “Bullying & intimidation through social media” under codes
T74.3, Psychological abuse, confirmed, and
T76.3, Psychological abuse, suspected
Diagnosis Coding Scenario – HBAI

*Use medical Dx code(s) only as documented by medical clinician*

PCP says: Type 2 Diabetes, uncomplicated E11.9

Clinician wants your help with encouraging the patient to be compliant with self-care and meds. You step into the room and....
Diagnosis Coding Scenario – HBAI

Use medical Dx code(s) **only** as documented by medical clinician

Type 2 Diabetes, uncomplicated E11.9

Type 2 Diabetes with hyperglycemia E11.65*

Underdosing of insulin T38.3x6A*

Intentional underdosing of meds due to financial hardship Z91.120*

Threat of job loss Z56.2

Other stressful life events affecting family & household Z63.79

*These diagnoses must be assigned by the medical clinician. You may not change a medical clinician’s diagnosis. Be knowledgeable.*
Take Home Messages

*Diagnosis coding will drive all reimbursement*

Code everything you do without regard to payment.
Let your numbers accurately represent your work
Allow your excellent note to tell a story that all will understand
Your note represents you personally and professionally
Diagnosis Coding – Commit to the detail; so much is riding on it
Learn from others’ mistakes
Codes and Rules will never stop changing
The Life of an Encounter

1. Patient Scheduling & Registration
2. Insurance verification
3. Patient co-pay collection
4. Documentation of visit
5. Medical coding
6. Demo and charge entry
7. Claims checking and error resolution
8. Claims submission
9. Payment processing and posting
10. Denial management
11. A/R Follow-up and Appeals
12. Patient statements

Medbillingexperts.com/revenue-cycle-management-solutions.php
General BeH Integration Care Management – CPT 99484
The 20 minute per month code - similar to FQHC/RHC code G0511

- Clinical staff

- Brief Treatment Plan & service description [not necessarily a “register”]

1. Initial assessment or follow-up monitoring w/validated rating scales

2. Planning r/t BeH/psychiatric health problems, revisions prn (status change.)

3. Facilitating/coordinating treatment, e.g., PT, pharm, and/or consultant

4. Continuity of care w/a designated care team member  
   
   Read every word in CPT, 2019 on page 56 under “General Behavioral Health Integration Care Management”
FQHC/RHC BeH Integration Services – HCPCS G0511

*The 20 minute/month CPT code – similar to CPT 99484*

- Clinical staff – no academic degree requirement
- Brief Treatment Plan & service description [not necessarily a “register”]

1. Initial assessment or ongoing monitoring w/validation rating scales
2. Planning r/t BH/psychiatric health problems, revisions prn *(status change)*
3. Facilitating/coordinating treatment, e.g., PT, pharm, and/or consultant
4. Continuity of care w/a designated care team member  *CPT 2019 Pg 56*

*Read every word in Medicare Benefit Policy Manual, Chapter 13, Section 230.2, then under General BHI*
Any question, any time!
codingquestions@codinghelp.com

Brown Consulting Associates, Inc.
Our References, Your Resource

Medicare Benefit Policy Manual, Chapter 13
CPT Codebook 2019
HCPCS Codebook 201
Diagnostic and Statistical Manual of Mental Disorders [DSM-5]
   American Psychiatric Association
ICD-10-CM 2019
AIMs Program Information/University of Washington
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Coming Up Next – Part III

Psychiatric Collaborative Care Model

GUEST SPEAKER
DEBRA MORRISON, SENIOR PROJECT MANAGER AND PRACTICE COACH
UNIVERSITY OF WASHINGTON AIMS CENTER