BH BILLING and Coding A review of coding and documentation

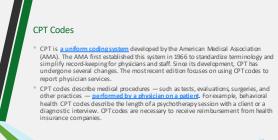
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Coding Definitions

- What is the difference between a CPT code and a HCPCS code?
- HCPCS codes are used for billing Medicare & Medicaid patients The Healthcare Common Procedure Coding System (HCPCS) is a collection of codes that represent procedures, supplies, products and services which may be provided to Medicare beneficiaries and to individuals enrolled in private health insurance programs.
- CPT is a code set to describe medical, surgical ,and diagnostic services; HCPCS are codes based on the CPT to provide standardized coding when healthcare is delivered.







Why CPT Codes Are Essential for Clinicians

[®] CPT codes are essential parts of practice management for clinicians and health care staff because they determine compensation and the practice's overall success. To receive the correct reimbursement rates, clinicians must ensure the codes on insurance claim forms accurately reflect the services they provided before submitting the claims to insurance companies.







How Do CPT Codes Work?

- The ICD code set describes the diagnosis and why the treatment was necessary, and the CPT code explains the services provided. Examples of <u>mental health ICD codes</u> include thefollowing.
- F41.9: Anxiety disorder
- F31.31: Bipolar disorder, current episode depressed, mild
- F42: Obsessive-compulsive disorder
- F43.11: Post-traumatic stress disorder, acute
- For example, a social worker might use F41.9 with CPT code 90832, which is the code for <u>individual psychotherapy for 30 mirutes</u>, to bil for assession with a client experiencing anxiety. You would indude both codes on a health insurance claims form.



The Good!

- There are three categories of CPT codes. We only use one!
- There are modifiers for complexity E/M codes. Only prescribers use those!!
- There are only a small number of BH codes!!!



The Most Common BH CPT Codes

- 90791: Psych Eval w/o medical services
- 90832: 30 minutes of individual psychotherapy
- 90834: 45 minutes of individual psychotherapy
- 90837: 60 minutes of individual psychotherapy
- $^{\circ}$ 90846: 50 minutes of family psychotherapy without the client present
- 90847: 50 minutes of family psychotherapy with the client present
 90849: Multiple-family group psychotherapy
- ----, 9-----, 9-----, 9-----, 9-----, 19-----, 19-----, 19-----, 19------, 19------, 19------, 19------, 19----
- 90853: Group psychotherapy



Psychotherapy Crisis Codes

- 90839: First 60 minutes of psychotherapy for crisis
- 90840: Add-on code for each additional 30 minutes of psychotherapy for crisis
- 99050: Add-on code for services provided when the office is usually closed
- 99051: Add-on code for services provided during regularly scheduled hours on evenings, weekends, or holidays
- If a crisis session falls below 60 minutes, you will bill for a regular psychotherapy code, such as 90834.









Extended Definitions					
Code	Туре	Definition	Explanation	Documentation/ Requirements/Appr ox. Time Requirements	
90832	Pagda a the rapy	and/or family member (OMH	Paghoth expyrishe treatment of mental literes and behalorid disturbance in which the physical disturbance in which the physical professional, through address a therapeutic common indion, attempts to alleviate the emotion disturbance, service or charge, and enourage personality gowth and dewelopment.	- Babblish diagnosis via review of symptom, standardized sore ening, etc. - Alental status exem - "Selled" intervention - "Selled" for care	
				мрса	



90832, 34, 37

Diagnoses for therapy – reason for treatment, time of therapy(in minutes) that is face-to-face, method of therapy, assessment of symptoms, summary of therapy, identified goak and objectives for the therapy and the patient status with these, identified plan for return, homework and follow up, treatment planning, supervision as required by itensure level.

90832: Standard 30 min (16 min-37 time frame)

90834: Standard 45 min (38 min-52 time frame)

90834: 53 min or more



90839

Psychotherapy for crisis is an urgent assessment and history of a crisis state, a mental status exam, and a disposition. The treatment includes psychotherapy mobilization of resources to defuse the orisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma.

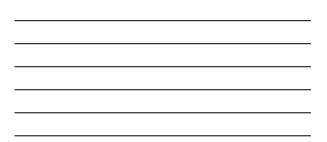
60 mins recommended, (30to 74 mins may vary bystatepayer)

The presenting problem is typically life threatening or complex and requires immediate attention to a patient in high distress. All therapy services are time based and time must be documented within the record.





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Payer	Code	Description	Schedule
Commercial Insurance	CPT 99408	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes	\$33.41
	CPT 99409	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes	\$65.51
Medicare	G0396	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes	\$29.42
	G0397	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes	\$57.65
Medicaid	H0049	Alcohol and/or drug screening	\$24.00
	H0050	Alcohol and/or drug service, brief intervention, per 15 minutes	\$48.00



Mental Health Test and Assessment Codes

- 96105: Aphasia assessment
- 96110: Developmental screening
- 96112: Developmental test administration with interpretation
- 96113: Each additional 30 minutes of developmental test administration with interpretation
- 96116: Neurobehavioral status exam, 60 minutes
- 96121: Each additional hour of neurobehavioral status examination
- 96125: Standardized cognitive performance testing, 60 minutes



Mental Health Test and Assessment Codes

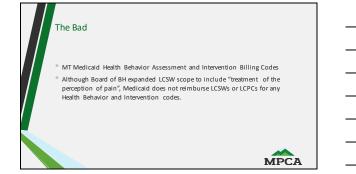
- 96127: Brief emotional or behavioral assessment
- 96130: Psychological testing evaluation services provided by a physician or qualified health professional, 60 minutes
- 96131: Each additional hour of psychological testing evaluation services performed
- 96132: Neuropsychological testing services, 60 minutes 96133: Each additional hour of neuropsychological testing services performed
- 96136: Psychological or neuropsychological test administration and scoring by a physician or qualified health professional, 30 minutes
- 96137: Each additional 30 minutes of neuropsychological test administration and scoring by a physican or qualified health professional 96138: Psychological or neuropsychological test administration and scoring by a technician, 30 minutes
- 96139: Each additional 30 minutes of neuropsychological test administration and scoring by a technician





- 96156: Health assessment or reassessment
- 96160: Patient-focused health risk assessment
- 96161: Caregiver-focused health risk assessment







Health behavior assessment and intervention services are used to identify and address the psychological, behavioral, emotional, cognitive, and interpersonal factors important to the assessment, treatment, or management of physical health problems. This means the member's primary diagnosis must be physical in nature and the focus is on the factors complicating medical conditions and treatments. These codes describe assessments and interventions to improve the member's health and well-being utilizing psychological and/or psychosocid interventions designed to ameliorate specific physical disease-related problems.





MT Medicaid Health Behavior Assessment and Intervention Billing Codes

- The health behavior assessment and intervention billing codes require a primary health diagnosis; therefore, these codes are only billable by the following licensed practitioners: psychologists, physicians, mid-level practitioners, and psychiatrists.
- CPT96156 Health behavior assessment or reassessment
 CPT96158 Health behavior intervention, individual, initial 30 minutes
- CPT96159 Fach additional 15 minutes
- ° CPT96160 Administration of patient-focused health risk assessment
- ° CPT96161 Administration of caregiver-focused health risk assessment
- ° CPT96164 Health behavior intervention, group, initial 30 minutes
- ° CPT96165 Each additional 15 minutes
- CPT96167 Health behavior intervention, family with patient present, initial 30 minutes
 CPT96168 Each additional 15 minutes



The Ugly

- Documentation, Documentation, Documentation
- The patient's medical record must support all Medicare claims. The medical record for covered services must:
- Be complete and legible
- Record start and stop times or total face-to-face time with the patient (because some codes are time-based)



For each patient encounter

- Document the patient's progress, response to changes in treatment, and diagnosis revision
- Document the rationale for ordering diagnostic and other ancillary services or ensure it is easily inferred
- Document Assessment, clinical impression, and diagnosis
- Date and legible provider identity
- Physical examination findings and prior diagnostic test results
- Plan of care



For each patient encounter

- Reason for encounter and relevant history
- Identify appropriate health risk factors
- \bullet Make past and present diagnoses accessible for the treating and consulting physicians
- Sign all services furnished or ordered



And the Strange

- RHC and FQHC Reimbursement Methodology
- ⁶ All RHC and FQHC services are reimbursed per visit. Services eligible for an encounter payment are reimbursed utilizing the facility-specific prospective payment system (PPS) rate.
 ⁶ The PPS rate is a facility specific, predetermined rate, regardless of the allowable RHC or FQHC
- The PPS rate is a facility specific, predetermined rate, regardless of the allowable RHC or FQHC service. Since RHCS and FQHCS are reimbursed at their PPS rate for most services, they do not have their own fee schedule.
 RHCS and FQHCS utilize the Outpatient Prospective Payment System (OPPS) fee schedule for
- RHCs and FQHCs utilize the Outpatient Prospective Payment System (OPPS) fee schedule for reimbursable codes, including allowable dental service codes. Please note, the OPPS fee schedule is forreference of allowable versus non-allowable codes only. A code sphering on the OPPS fee schedule does not indicate if the code is an RHCor FQHC service, or if the code is considered a incident to a core provider encounter.
- Certain services are deemed non-RHC or non-FQHC services and are paid at the appropriate fee schedule amount. The Department determines which non-FQHC and non-RHC services are eligible for reimbursement outside of PPS enimbursement.



And a little more...

- Non-RHC or non-FQHC services reimbursed outside of the PPS reimbursement methodology are not factored into the PPS rate. The list of services that are not calculated into the PPS rate includes:
- Peer support services
- Long acting reversable contraceptives (LARCs)
- Promising Pregnancy Care
 Originating telemedicine site



Resources

https://medicaidprovider.mt.gov/

- https://www.cms.gov/medicare/medicare
- https://www.apaservices.org/practice/reimbursem ent/healthcodes/testing/bill-multiple-daysproviders? ga=2.151240698.297531184.1668710567-966990224.1668710567
- https://www.apaservices.org/practice/reimbursem ent/health-cod es/healthbehavior/webinar
- https://www.apaservices.org/practice/reimbursem.ent/health-cod.es/healthbehavior/webinar
- https://www.bcbsmt.com/static/mt/provider/pdf/mt_telehealth_faq.pdf

