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.

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CPT Codes

- CPT is a uniform coding system developed by the American Medical Association (AMA). The AMA first established this system in 1966 to standardize terminology and simplify record-keeping for physicians and staff. Since its development, CPT has undergone several changes. The most recent edition focuses on using CPT codes to report physician services.
- CPT codes describe medical procedures — such as tests, evaluations, surgeries, and other practices — performed by a physician on a patient. For example, behavioral health CPT codes describe the length of a psychotherapy session with a client or a diagnostic interview. CPT codes are necessary to receive reimbursement from health insurance companies.

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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.

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How Do CPT Codes Work?

- CPT coding tells insurance payers what you would like to get paid for. Along with the International Classification of Diseases codes, (Sometimes may use DSM) CPT codes paint a complete picture for health insurance companies, and you need both types for reimbursement.
- Need a description of the illness and a description of the treatment

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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 mental health ICD codes include the following.
- **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 individual psychotherapy for 30 minutes, to bill for a session with a client experiencing anxiety. You would include both codes on a health insurance claims form.

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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!!!

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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
- **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
- **90853:** Group psychotherapy

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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.

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Extended definitions

Code	Type	Definition	Explanation	Documentation/ Requirements/Appr ox. Time Requirements
90791	Assessment	Psychiatric diagnostic evaluation	Assessment of patient's psychosocial history, current mental status, review and ordering of any diagnostic studies and appropriate treatment recommendations	-Minimum 45 minutes, face to fac

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90791

No longer needs to be initial session for most payers.
When the patient goes for a psychiatric diagnostic evaluation, report either 90791 (Psychiatric diagnosis evaluation) or 90792 (Psychiatric diagnostic evaluation with medical services). In the past, most payers would allow you to only report one unit of psychiatric diagnostic evaluation code per patient. Now, guidelines have been revised and payers will allow you to claim for more than one unit of 90791 or 90792 if the initial psychiatric diagnostic evaluations extend beyond one session, if the sessions are on different dates. An example of this extended evaluation would be when the psychiatrist is evaluating a child and will see the child with parents and in another session, evaluate the child independently. So, depending on medical necessity, you can claim for more than one unit of 90791 or 90792 when the psychiatrist performs the evaluation in more than one session spread over more than one day. When billing for Medicare, CMS will allow only one claim of 90791 or 90792 in a year. However, in some cases, depending on the medical necessity, Medicare might allow reimbursement for more than one unit of 90791 or 90792. A modifier is not allowed to override this relationship.

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Extended Definitions

Code	Type	Definition	Explanation	Documentation/ Requirements/Appr ox. Time Requirements
90832	Psychotherapy	Psychotherapy, 30 min with patient and/or family member (CMN minimum), 16-37 minutes without additional E/M service (CPT guidelines)	**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.	- Establish diagnosis via review of symptoms, standardized screening, etc. -Mental status exam -"Skilled" intervention -Next steps for care -Review progress towards goals -Minimum 16 minutes, face to face

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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 goals 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 licensure level.

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

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

90834: 53 min or more

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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 crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma.

60 mins recommended, (30 to 74 mins may vary by state payer)

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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90840

Use add on code with
90839 for each additional 30 minutes
beyond the first 74 minute

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.

Can be in addition to therapy codes. This code is meant to add intensity, not time. Not a "difficult" patient but rather involves third parties such as correctional facilities, schools etc. Mandated reporting situations, nonverbal.

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SBIRT

Payer	Code	Description	Fee 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	$57.69
Medicaid	H0049	Alcohol and/or drug screening	$24.00
	H0050	Alcohol and/or drug service, brief intervention, per 15 minutes	$48.00

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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

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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 physician 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

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Mental Health Test and Assessment Codes

- **96146:** Psychological or neuropsychological test administration via an electronic platform with automated results
- **96156:** Health assessment or reassessment
- **96160:** Patient-focused health risk assessment
- **96161:** Caregiver-focused health risk assessment

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The Bad

- MT Medicaid Health Behavior Assessment and Intervention Billing Codes
- Although Board of BH expanded LCSW scope to include "treatment of the perception of pain", Medicaid does not reimburse LCSWs or LCPCs for any Health Behavior and Intervention codes.

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MT Medicaid Health Behavior Assessment and Intervention Billing Codes

- 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 psychosocial interventions designed to ameliorate specific physical disease-related problems.

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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 – Each 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

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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)

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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

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For each patient encounter

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

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And the Strange

- RHC and FQHC Reimbursement Methodology
- 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.
- 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 reimbursable codes, including allowable dental service codes. Please note, the OPPS fee schedule is for reference of allowable versus non-allowable codes only. A code appearing on the OPPS fee schedule does not indicate if the code is an RHC or FQHC service, or if the code is considered an 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 reimbursement.

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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

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Resources

- https://medicaidprovidermt.gov/
- https://www.cms.gov/medicare/medicare
- https://www.apaservices.org/practice/reimbursement/health-codes/testing/bill-multiple-days-providers?_ga=2.151240698.297531184.1668710567-966990224.1668710567
- https://www.apaservices.org/practice/reimbursement/health-codes/health-behavior/webinar
- https://www.apaservices.org/practice/reimbursement/health-codes/health-behavior/webinar
- https://www.bcbsmt.com/static/mt/provider/pdf/mt_telehealth_faq.pdf

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