# Documenting Brief Interventions

Earl Sutherland, Ph.D., ABMP

# The Big Deal

- 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
- Make past and present diagnoses accessible for the treating and consulting physicians
- Sign all services furnished or ordered

# 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

# 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 | Type | Definition | Explanation | Documentation/ Requirements/Approx. 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 |

# 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 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.

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.

# 90791

- **Does CPT Code 90791 Pay More Than A Standard Outpatient Session? - Usually**
- **Time Requirements For Using CPT Code 90791** at least 45 minutes and not more than 90 minutes in the designated session time, with 60-minutes being the typical standard.
- **What Are The CPT Code 90791 Coding Requirements?**
  - **A thorough mental status examination is performed**
  - **The patient's ability and capacity to respond to treatment is evaluated**
  - **A complete medical and psychiatric history is collected and included**
  - **The recommendations in the initial treatment plan**
  - **The evaluation is part of a face to face meeting between the new patient and the provider**

# Comparison 90832 to 90791

**90832**

1. Record start and stop times

2. Reason for encounter and relevant history, previous diagnoses

3. Document the patient's progress, response to changes in treatment, and diagnosis revision

4. Document any assessment, clinical impression, and diagnosis

5. Plan of care –active goal(s)

**90791**

- 1 through 5 plus

6. A thorough mental status examination is performed

7. The patient's ability and capacity to respond to treatment is evaluated

8. A complete medical and psychiatric history is collected and included

9. The recommendations in the initial treatment plan

10. The evaluation is part of a face to face meeting between the new patient and the provider