FAQs from CPT Changes 2013 Webinars

The following questions/answers are taken from the recent webinars regarding changes to CPT codes that took effect on January 1, 2013. They are organized under topical headings. (Some answers have been used, in whole or part, from material provided by the National Council for Community Behavioral Health Care)

If you have additional questions regarding these changes, or other quality management related issues, direct them to QIMatters.hhsa@sdcounty.ca.gov

CPT Codes

Q: What is an "add-on" code? What is an "interactive" code?

A: Add-on codes identify procedures that are carried out in addition to a primary procedure. They only apply to services or procedures performed by the same health care professional. Add-on codes should only be reported along with a primary procedure, and must never be reported alone as a stand-alone code.

Examples of add-on codes are:

- Add-on codes for psychotherapy: 90833 (30 min.), 90836 (45 min.), 90838 (60 min.)
- Add-on code for interactive complexity: 90785

An example for use of an add-on code:

Evaluation and Management service plus 30 minute psychotherapy session by a psychiatrist: *Code as*: 99211 (or other appropriate level of E/M code) and 90833 (30 min

Interative codes refer to the "interactive complexity" of a service. Interactive complexity is a new term in CPT for 2013. It refers to specific factors that complicate the delivery of a psychiatric procedure, such as needing to involve third parties like probation officers, interpreters, other legal guardians, etc.

Interactive complexity is an add-on code and should not be reported as a standalone service; the code is 90785.

Interactive complexity can be used with:

- Initial evaluation codes (90791 and 90792)
- Psychotherapy codes
- Non-family group psychotherapy codes
- E/M codes when used in conjunction with psychotherapy services. E&M code alone without psychotherapy may not include the interactive add-on code.

Q: For "add on" codes, do we enter 2 different codes on 2 separate progress notes in Anasazi?

A: No. In the progress note you would use the appropriate Anasazi code in the service entry portion of the note and you would include the **total time** of all services in the service entry portion of the note.

In the narrative of the note, you would document the appopriate CPT code and Add-On code(s) and the time spent for each. The time for each of these codes **must add up** to the total time you've entered in the service entry portion of the progress note.

Q: What is the difference between 90839 and 90840?

A: 90839 is the actual CPT code for Crisis Psychotherapy. 90840 is the Add-on code for each additional 30 minutes spent with client for crisis psychotherapy.

Q: What is an "Established Patient"? Does someone need to be seen by someone of the same discipline in order to be established?

A: A patient is considered established if he or she has received a professional service by the physician or another physician in group of the same specialty (and sub-specialty) within the past three years.

Q: There seems to be a contradiction in the written information about CPT code 90785 and using it with E/M codes – in one place it says we can use 90785 with E/M codes, but in another it says we cannot. Can you clarify?

A: You may use the interactive add-on code with E/M codes only when used in conjunction with psychotherapy services. E&M code alone without psychotherapy may not include the interactive add-on code.

Q: If I do an EM or diagnositic evaluation as the pasychiatist and then later in the day am called to see the patient for possible hospitalization, what code do I use for the second visit?

A: For Medicare, if the doctor provides a psychiatric evaluation, he/she may not bill for an E&M code or psychotherapy code on the same day.

Anasazi Service Codes

Q: Is there a crosswalk that includes the Anasazi Service Codes?

A. One has been developed and is in the final stages of review. It will be distributed to the System of Care as soon as it becomes available.

Q: Can you bill phone calls to a patient as a 25 or 26?

A: Medicare Part B (Medical Insurance) covers outpatient mental health services in an office setting, clinic, or hospital outpatient setting. The services must be provided by a doctor, clinical psychologist, clinical social worker, nurse practitioner, clinical nurse specialist, or physician assistant. Telephone calls to a patient are not covered by Medicare.

Q: Are the new service codes now in Anaszi?

A: Yes, they have been activated and ready for use since 1/1/13.

Q: Have the old codes been disabled in Anasazi so that the doctors can't pick them accidentally?

A. Not yet. For programs that may need to make corrections or changes to services from December, the old codes need to remain in Anasazi for a period of time.

Q: Approximately when will service code 22 be disabled?

A: SC 22 will be inactived mid February 2013.

Q: What code would a nurse use when giving an injection in the field?

A. The nurse in this example would continue to use Service Code 20.

Q: Will there be any changes to code 20?

A. No, there are no changes to service code 20.

Q: Our facility uses SC34 for Rehab. Are we able to continue to use this code?

A: Yes. There has been no change to Service Code 34.

Q: If a therpist does the BHA under a code 10, then refers to psychiatiry for evaluation, would that be a service code 11 or the new E/M CPT Code?

A: The doctor would be fine to code SC 11 for the psychiatric evaluation, but the doctor also have the option of choosing the appropriate E&M code as well based on the nature of the problem, level of examination and medical decision making.

Q: In the past, service codes 10 and 11 are cross-referenced in Anasazi with CPT code 90801. Is that still the case?

A. 90801 has been deleted as a CPT code, so this is no longer the case.

Q: For no shows, in the past, we would bill the intended service and use service indicator 5 to indicate the "no show." Is that still the way it should be done?

A. Yes. There has been no change to coding and documentation for a "no show."

Q: Since we can't predict who is coming in with what level of complexity, won't be be losing money if all appointms are 30 minutes but we bill 24 instead of 27?

A. You should not attempt to pick one code and bill all services to that code. For the integrity of documentaion and appropriate reimbursement, you cannot "under code" or "over code." Your medical staff must be aware of the differences in the requirements for each of the five new service codes and claim/document according to the level of service they provide at the time.

Q: Can a nurse practitioner bill for the same codes as the doctor?

A. Yes, a nurse practitioner can bill for the same codes as a doctor.

Q: Each of the new service codes has a "typical" time mentioned. Are those times set in stone or is there some flexibility?

A. Service code selection is determined by the complexity of the client's needs and the medical decision making required to meet those needs at the time of the service, not by a timeframe.

The "typical times" mentioned are averages that are listed as examples. They are not "set in stone" and you should claim the actual time spent in providing the service. For example, Anasazi Service Code 25 ("Meds E/M Minor Problem") has a typical time of 10 minutes. If the complexity of the client's needs and the medical decision making required to meet those needs indicate that this is the appropriate code to use, and you actually spend 20 minutes providing the service, you would claim for 20 minutes and not the "typical" time of 10 minutes.

Medicare Billing

Q: For service codes 24 – 28, can we bill Medicare for telepsychiatry services?

A: Medicare reimburses for telesychiatry at the same rate as face-to-face. Medicare also reimburses $18 per session for the staff person presenting with the client (Telehealth originating site facility fee - CPT code Q3014). Medicare imposes three restrictions on the use of telepsychiatry/telehealth:

1. Geographic - The consumer must be located in a non-metropolitan statistical area (see map).
2. Facility - The consumer must be located in a qualifying facility and accompanied by a qualified staff person.
3. Procedure - Must be an approved procedure for telehealth

Services conducted via telehealth and reimbursed by Medicaid and Medicare use the same billing codes as face-to-face (with a "GT" modifier). These services include:

1. Consultations (CPT codes **99241-99275**)
2. Office or other outpatient visits (CPT codes **99201 - 99215**)
3. Individual psychotherapy (CPT codes **90804 - 90809**) Replaced by time-specific codes in 2013: 90832 (30 minutes) 90834 (45 minutes) 90837 (60 minutes)
4. Pharmacologic management (CPT code **90862**) Replaced with Evaluation/Management coding (99xxx). For example, use 99213 for outpatient, use 99212 for refills, use 99214 for complex situations.
5. Psychiatric diagnostic interview examination (CPT code **90801**) Replaced by 90791 and 90792 in 2013.

Q: Since billing staff do not have access to progress notes will we need to develop an individual service record that can document both codes (for "add on" or "interactive" code usage), including the time for the primary and the add on code?

A. Each program will determine the process and workflow of billing Medicare. Your idea is a good one.

Q: It seems admin staff will need access to progress notes when biling Medicare to know whether or not there is an add-on code. Is thise correct?

A. No. Each program will determine the process and workflow of billing Medicare, such as the development of a service record as mentioned in the above question. Admin staff will not have access to progress notes.

Client Plans/Progress Notes

Q: For existing patients with existing client plans, how shall we enter the new service codes? (i.e., do we need to revise existing client plans?)

A. The client plans will need to be revised to add the new codes **no later than six months from now.** In the meantime, you can enter the service as an "unplanned service."

Q: Do we need new signatures on the client plans if we're only adding the new codes?

A. If you are only adding the new codes and there are no clinical changes to the plan (adding additional services due to a change in the client's needs), you do NOT need to get a new signature on the client plan.

Q: When we are prompted by Anasazi for client signature, what should we enter?

A. You have an two options: one is to indicate that the client's signature has been obtained on hard copy. This is true if you are not making any clinical changes to the plan and are simply adding the new codes for administrative purposes. You would use the date the client signed the hard copy on the most recent plan as the date the signature was obtained.

The second option is to select the "client refused to sign" option, which currently in our System of Care means both refusal and "unable to sign." You would then be prompted to enter the reason for the refusal, and you would document that an "administrative only" change was made to the plan in order to add new service codes generated by the change in CPT codes for 2013.

Q: Can my staff bill for the time they spend making the changes to the new codes on the client plan?

A. No. Standards have not changed in this regard and you cannot bill for documentation outside of a face-to-face service.

Q: How do we do a progress note for the new codes if we haven't updated the client plan yet?

A. If the new codes have not been added to the client plan, you will select the option for "unplanned service" and complete the progress note.

Q: There are new documentation standards for each new service code. How can we help to make sure our doctors and nurses meet these standards in their progress notes?

A. The Quality Management Unit is working to create new progress note templates for each of the new service codes that will help medical staff meet the documentation requirements. These should be in Anasazi shortly. In the meantime, you can provide your medical staff with the attached copies of the documentation elements for each service code to assist in their documentation.