E&M Coding for Behavioral Health Providers: Avoiding Common Documentation Mistakes
by Derek Jansen-Jones, PhD
5/2/2013
It’s in the details........
Key Points -

• Most Important - **One size does not fit all** – **One size fits one size**

• Coding rules, payment mechanisms and benefits
  – Coding rules = ways to describe the services rendered – CPT, HCPCS L-II and ICD-9/DSM;
  • Vary only slightly from payer to payer – Fed rule, including Medicaid
Key Points

• Payment mechanisms and benefits
  – Payment mechanisms = FFS, APGs, DRGs, capitated, episode of care, rates (and rate codes)
    • These can vary widely from payer to payer
  – Benefits = What’s covered/not, utilization thresholds, credential issues (who can do what to whom), payment amounts/service, co-pay and deductible amounts and variance, in and out of network, place of service, etc
    • In spite of “parity,” these can be all over the map.
Key Points

• Multi-payer coverage (dually eligible) numbers are going to increase;

• Very important:
  – Primary payer first
  – Codes may change from primary to secondary in order to code the most accurate –
Key Advice

• Suspect behavior:
  – Coding advice from the software company, including phrases such as “we can’t” being understood as “you shouldn’t”;  
  – “I checked with John over at the Hospital of Perpetual Obligation and they’ve been billing this way for years...”;
  – “We bill all our medical services as (fill in the blank)...”
Key Advice

• Good behavior:
  – Billing accesses resources, too.
  – “I am more than my user group..”
  – We cross train, by choice.
  – Quality of care in our place includes using the client’s benefits wisely.
  – Compliance (following the rules) is an item on everyone’s performance review, including mine.
Why coding changes?

• 90862
  – Written over 20 years ago
• Mainly: The limited ability to describe the typical medical services required for current psychiatric patients.
• DX codes
• Ind Psy Tx
  – Payment for Psy Tx + E/M
• Interactive
• Evaluations
Uh-huh
New Framework

• Psychiatric Diagnostic Procedures
  – Two new codes: with and without medical services
• Psychotherapy
  – Stand-alone codes
• Add-on codes to be used with E/M
• New add-on code for interactive complexity (other interactive deleted)
New Framework

• Two new codes for Psychotherapy for Crisis
• Allows all codes to be reported in all settings (deleted codes based on site of service)
• New times for psychotherapy codes
• Changes result in increased use of E/M codes by psychiatrists
New Framework: E/M continued

- Acknowledgement that these are medical services.
  - Removed 90862, the “Med Management” code most often used by MDs
  - Removed 90805, 90807, the Psychotherapy + E/M codes most often used by NP
- Emphasis on Evaluation and Management of the patient, rather than the medication.
  - With combos, instructions to “Pick E/M first, then add the minutes if psychotherapy.” This is a correction, not a new direction.
- Reluctance or fear of the documentation guidelines are no longer issues for medical providers: They have no choice! But, there’s good news . . .
New Rules: Reporting E/M and Psychiatry Services

• Some services may be reported with E/M or other services
  + psychotherapy; + interactive; + prolonged service

• E/M services may be reported for treatment of psychiatric conditions rather than using Psychiatry Services codes
  – A very important change
New Rules: Psychotherapy: 90832-90838

• If patient receives medical E/M service and psychotherapy service on the same day by the same provider, report:
  – E/M code at the appropriate level AND Psychotherapy add-on code (90833, 90836, 90838)

• If two services: must be significant and separately identifiable, though a separate diagnosis is not required
This slide is to convince you that using the combo codes is still not a great idea:

- Reporting both E/M and psychotherapy codes
- Type and level of E/M is selected first based on the key components (history, exam, MDM)
- **Time may not be used as basis of E/M code selection**
- Psychotherapy service code based on time providing psychotherapy
- **Time providing E/M activities is not considered in selection of time-based psychotherapy code**
E/M Learning Tips

• Recognize that there *is* a lot of information and it is likely not something you can learn without effort

• Go through this presentation and others first with an eye to learning the system rather than remembering details

• Later, “cheat sheets” and templates may be helpful.

• Memorize portions related to the small number of codes you use every day
Documentation

General Principles
Documentation, general principles

Facilitates:

• The ability to evaluate and plan the patient's immediate treatment and to monitor his/her health care over time

• Communication and continuity of care among health care professionals

• Appropriate utilization review and quality of care evaluations

• Collection of data that may be useful for research and education

• Accurate and timely claims review and payment
Documentation, general principles

Complete and legible

• Include:
  – Reason for the encounter and relevant history, physical examination findings and prior diagnostic test results
  – Assessment, clinical impression or diagnosis
  – Plan for care
  – Date and legible identity of the observer
Documentation, general principles

• Rationale for ordering ancillary services should be easily inferred
• Past and present diagnoses should be accessible
• Appropriate health risk factors should be identified
• Document the patient's response to, changes in treatment, and revision of diagnosis
• The CPT and ICD-9-CM codes reported should be supported
Better E/M Documentation in support of high level MDM

• High risk for morbidity: e.g. bipolar, depression, substance use
• Laboratory or other diagnostic tests requiring review
• Extensive differential dx. to consider

• Proper documentation of the visit is the cornerstone of justifying the use of any specific E/M code.
General Audit Issues

- Upcoding
- Downcoding
- Meet E/M criteria
- Medical necessity
- Red flags
  - High use of highest level code
  - Exclusive use of one level code
E/M Coding Structure
Most E/M codes are part of “families”
  – New
  – Established

Most families have multiple levels
– Denoted by the 5th digit of the code
– 3 or 5 levels are commonly used
– We will now focus on choosing and documenting the appropriate level
E/M components

- **“Key” Elements (Components)**
  - K1. History
  - K2. Examination
  - K3. Medical decision making

- **Time - Based**
  - T1. Counseling
  - T2. Coordination of care

- **Nature of presenting problem**
Key Components

- **K1. History**
  - Chief complaint
  - History of present illness (HPI)
    - Elements
    - Chronic or inactive problems
  - Past, family, social history (PFSH)
    - Past history
    - Family history
    - Social history
  - Review of systems (ROS)
    - 14 organ systems (Possibly. This is history, after all.)
    - “All other systems reviewed and are negative” is permissible
Key Components

• K2. Exam

• PSYCHIATRY is recognized as one of the SINGLE ORGAN SYSTEM EXAMINATIONS

• Comprehensive Examination – should include performance of all elements identified by a bullet (•), whether in a shaded or unshaded box. Documentation of every element in each box with a shaded border and at least one element in a box with an unshaded border is expected.
  – Constitutional
  – Psychiatric (mental status)
  – Musculoskeletal
Single Organ System

• PSYCHIATRY is recognized as one of the SINGLE ORGAN SYSTEM EXAMINATIONS.

• Comprehensive Examination – should include performance of all elements identified by a bullet (•), whether in a shaded or unshaded box. Documentation of every element in each box with a shaded border and at least one element in a box with an unshaded border is expected.
| Constitutional | • Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff)  
• General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming) |
| Musculoskeletal | • Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements  
• Examination of gait and station |
| Psychiatric | • Description of speech including: rate; volume; articulation; coherence; and spontaneity with notation of abnormalities (eg, perseveration, paucity of language)  
• Description of thought processes including: rate of thoughts; content of thoughts (eg, logical vs. illogical, tangential); abstract reasoning; and computation  
• Description of associations (eg, loose, tangential, circumstantial, intact)  
• Description of abnormal or psychotic thoughts including: hallucinations; delusions; preoccupation with violence; homicidal or suicidal ideation; and obsessions  
• Description of the patient’s judgment (eg, concerning everyday activities and social situations) and insight (eg, concerning psychiatric condition)  

**Complete mental status examination including**  
• Orientation to time, place and person  
• Recent and remote memory  
• Attention span and concentration  
• Language (eg, naming objects, repeating phrases)  
• Fund of knowledge (eg, awareness of current events, past history, vocabulary)  
• Mood and affect (eg, depression, anxiety, agitation, hypomania, lability)
Key Components

- K3. Medical Decision Making
- Number of diagnoses or management options
- Amount and/or complexity of data to be reviewed
- Risk of complications and/or morbidity or mortality, related to
  - presenting problem,
  - diagnostic procedure, or
  - management option
Office visit for a 27-year-old female, established patient, with stable depression and anxiety. Intermittent moderate stress.

27-year-old female seen for follow up visit for depression and anxiety. Visit attended by patient.

Difficulty at work but coping has been good. Minimal (severity) situational sadness (quality) and anxiety when stressed (context).

HPI scoring: 3 elements = Brief

N/A

Psychiatric: no sadness, anxiety, irritability

ROS scoring: 1 system = Problem-pertinent

Appearance: appropriate dress, appears stated age

N/A

Speech: normal rate and tone; Thought content: no SI/HI or psychotic symptoms; Associations: intact; Orientation: x 3; Mood and affect: euthymic and full and appropriate; Judgment and insight: good

Examination scoring: 7 elements = Expanded problem-focused

Problem 1: Depression
Comment: Stable
Plan: Renew SSRI script at the same dose; Return visit in 3 months

Problem 2: Anxiety
Comment: Stable
Plan: Same dose of SSRI

Problem scoring: 2 established problems, stable (1 for each = 2), total of 2 = Limited

Data scoring: None = Minimal

Risk scoring: Two stable chronic illnesses; and Prescription drug management = Moderate
Office visit for a 70-year-old male, established patient, with stable depression and recent mild forgetfulness.

70-year-old male seen for follow up visit for depression. Visit attended by patient and daughter, history obtained from both.

Patient and daughter report increasing distress related to finding that he has repeatedly lost small objects (e.g., keys, bills, items of clothing) over the past 2-3 months (duration). Patient notices intermittent (timing), mild (severity) forgetfulness (quality) of people’s names and what he is about to say in a conversation. There are no particular stressors (modifying factors) and little sadness (associated signs and symptoms).

HPI scoring: 6 elements = Extended
Less attention to hobbies
PFSH scoring: 1 element, social = Pertinent
Psychiatric: no problems with sleep or anger;
Neurological: no headaches, dizziness, or weakness
ROS scoring: 2 systems = Extended

Appearance: appropriate dress, appears stated age
Muscle strength and tone: normal
Speech: normal rate and tone; Thought process: logical; Associations: intact; Thought content: no SI/HI or psychotic symptoms; Orientation: x 3; Attention and concentration: unable to focus on serial 7s; Mood and affect: euthymic and full and appropriate, Recent and remote memory: mild struggle with telling history and remembered 1/3 objects

Examination scoring: 10 elements = Detailed

| Problem 1: Depresison | Comment: Stable; few symptoms | Plan: Continue same dose of SSRI; write script | Return visit in 1 month |
| Problem 2: Forgetfulness | Comment: New; mildly impaired attention and memory | Plan: Brain MRI; consider referral to a neurologist if persists |

Problem scoring: 1 established problem, stable (1), 1 new problem with additional workup (4), total of 5 = Extensive
Data scoring: Order of test in the radiology section of CPT (1), Obtain history from other (2), total of 3 = Multiple
Risk scoring: Undiagnosed new problem with uncertain prognosis, and Prescription drug management = Moderate
<table>
<thead>
<tr>
<th>Office visit for an established adolescent patient with a history of bipolar disorder treated with lithium; seen on urgent basis at family's request because of severe depressive symptoms.</th>
<th>Office visit for a 25-year-old male, established patient with a history of schizophrenia, who has been seen bi-monthly but is complaining of auditory hallucinations.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CC</strong> 17-year-old male seen for urgent visit for depression. Visit attended by patient and parents; history obtained from all 3.</td>
<td>25-year-old male seen for follow up visit for schizophrenia. Visit attended by patient.</td>
</tr>
<tr>
<td><strong>HPI</strong> Patient doing well until 2 days ago (timing) when, for no apparent reason (context), he refused to leave his bed and appeared extremely (severity) and continuously depressed (quality); he is sleeping more and eating little (associated signs and symptoms).</td>
<td>The patient reports doing well until 1 week ago (duration) when he stayed up all night to finish a term paper (context). He has slept poorly (severity) since (timing) and, 2 days ago, began hearing fairly continuous voices (quality) telling him that people plan to shoot him. Attention and organization were good up until this past week (associated signs and symptoms).</td>
</tr>
<tr>
<td><strong>HPI scoring</strong>: 5 elements = Extended</td>
<td><strong>HPI scoring</strong>: 6 elements = Extended</td>
</tr>
<tr>
<td><strong>PFSH</strong> Stopped attending school; family history of suicide is noted from patient's initial evaluation.</td>
<td>Doing well in third year of graduate school. Chart notes no family psychiatric history.</td>
</tr>
<tr>
<td><strong>PFSH scoring</strong>: Family and social (2 elements) = Complete</td>
<td><strong>PFSH scoring</strong>: Family and social (2 elements) = Complete</td>
</tr>
<tr>
<td><strong>ROS</strong> Psychiatric: no problems with anxiety or anger; Neurological: no headaches; All other systems reviewed and are negative.</td>
<td>Psychiatric: denies symptoms of depression or mania; Neurological: no headaches; All other systems reviewed and are negative.</td>
</tr>
<tr>
<td><strong>ROS scoring</strong>: All systems = Complete</td>
<td><strong>ROS scoring</strong>: All systems = Complete</td>
</tr>
<tr>
<td><strong>Const</strong> VS: BP (sitting) 120/70, P 90 and regular, R 20; Appearance: appropriate dress, appears stated age.</td>
<td>VS: BP (sitting) 115/70, P 86 and regular, Ht 5'10&quot;, Wt 180 lbs; Appearance: appropriate dress, appears stated age.</td>
</tr>
<tr>
<td><strong>MS</strong> Gait and station: normal.</td>
<td>Gait and station: normal.</td>
</tr>
<tr>
<td><strong>Psych</strong> Speech: sparse and slow; Thought process: logical; Associations: intact; Thought content: hopelessness, thinks of suicide, no HI or psychotic symptoms; Orientation: X 3; Attention and concentration: impaired; Mood and affect: depressed and constricted; Judgment and insight: poor; Fund of knowledge: good; Recent and remote memory: good; Language: able to repeat phrases.</td>
<td>Speech: normal rate and tone; Thought process: logical; Associations: intact; Thought content: auditory hallucinations and paranoid ideation, no SUHI; Orientation: X 3; Attention and concentration: impaired; Mood and affect: euthymic and full and appropriate; Judgment and insight: good; Fund of knowledge: good; Recent and remote memory: good; Language: able to repeat phrases.</td>
</tr>
<tr>
<td><strong>Examination scoring</strong>: All elements of constitutional and psychiatric and 1 element of musculoskeletal = Comprehensive</td>
<td>Examination scoring: All elements of constitutional and psychiatric and 1 element of musculoskeletal = Comprehensive</td>
</tr>
<tr>
<td><strong>Problem 1</strong>: Bipolar disorder</td>
<td><strong>Problem 1</strong>: Psychosis</td>
</tr>
<tr>
<td><strong>Comment</strong>: Major relapse</td>
<td><strong>Comment</strong>: Major relapse</td>
</tr>
<tr>
<td><strong>Plan</strong>: Continue current dose of Lithium for the moment</td>
<td><strong>Plan</strong>: Increase dose of antipsychotic; write script; hold off on hospital admission as patient historically very adherent; return for visit in 1 day</td>
</tr>
<tr>
<td><strong>Problem 2</strong>: Suicidality</td>
<td><strong>Problem 2</strong>: Insomnia</td>
</tr>
<tr>
<td><strong>Comment</strong>: New</td>
<td><strong>Comment</strong>: Sleep deprivation may have triggered the psychosis relapse</td>
</tr>
<tr>
<td><strong>Plan</strong>: Refer to hospital; confer with hospitalist once patient is admitted</td>
<td><strong>Plan</strong>: Change to a more powerful hypnotic; write script</td>
</tr>
<tr>
<td><strong>Problem 3</strong>: ADHD</td>
<td><strong>Problem 3</strong>: ADHD</td>
</tr>
<tr>
<td><strong>Comment</strong>: Appears stable</td>
<td><strong>Comment</strong>: Appears stable</td>
</tr>
<tr>
<td><strong>Plan</strong>: Continue same dose of non-stimulant medication</td>
<td><strong>Plan</strong>: Continue same dose of non-stimulant medication</td>
</tr>
<tr>
<td><strong>Prob Data Risk</strong> Problem scoring: 1 established problem, worsening (2), 1 new problem (3), total of 5 = Extensive</td>
<td>Problem scoring: 1 established problem, stable (1), 2 established problems, worsening (2 for each problem = 4), total of 5 = Extensive</td>
</tr>
<tr>
<td>Data scoring: None = Minimal</td>
<td>Data scoring: None = Minimal</td>
</tr>
<tr>
<td>Risk scoring: Chronic illness with severe exacerbation, and illness that poses a threat to life = High</td>
<td>Risk scoring: Chronic illness with severe exacerbation = High</td>
</tr>
</tbody>
</table>
Using Time to Determine E/M Levels

• Time may be the key factor for the selection of the level of service when counseling and/or coordination of care dominates the encounter (more than 50%)
D. DOCUMENTATION OF AN ENCOUNTER DOMINATED BY COUNSELING OR COORDINATION OF CARE

In the case where counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (face-to-face time in the office or other or outpatient setting, floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E/M services.

**DG:** If the physician elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter (face-to-face or floor time, as appropriate) should be documented and the record should describe the counseling and/or activities to coordinate care.
Measuring Time

- **Outpatient**: Time spent by the provider face-to-face with the patient and/or family

- **Inpatient**: Time spent both with the patient and on the patient’s unit or floor

- Report using the code with the closest actual time
Typical Times for Outpatient E/M Services

• Outpatient - New
  • Codes: 99201  99202  99203  99204  99205
  • Times: 10 min   20 min   30 min   45 min   60 min.

• Outpatient - Established
  • Codes: 99211  99212  99213  99214  99215
  • Times:  5 min   10 min   15 min   25 min   40 min
• The total length of time of the encounter should be documented and the record should describe the counseling and/or activities to coordinate care
  • The medical record must reflect the extent of counseling and/or coordination of care
  • Resident/NP/PA face to face time can not be included (except under specialty specific Medicaid contracts)
  • It is a good idea to document in a separate paragraph what documentation is supporting the counseling/coordination of care. This will make it easy to justify the time spent.
E/M Components

• **T1. Counseling**
• Discussion of:
  • – Diagnostic results
  • – Impressions
  • – Recommended diagnostic studies
  • – Prognosis
  • – Risks and benefits of management options
  • – Instructions for management and/or follow-up
  • – Importance of compliance with chosen management options
  • – Risk factor reduction
  • – Patient and family education
E/M Components

- T2. Coordination of Care
- **Coordination of Care** (Must be “with client present” and involve coordination of care with staff “outside” of your office)
- Coordination with (i.e.):
  - _____ Family ___Caregiver
  - _____ PCP/Outside Medical Staff
  - _____School Staff ____Probation
  - _____ Other: (include name, phone # of person with whom coordinating care if not in session)
E/M COUNSELING/ CARE COORDINATION (Circle the code and time ≤ the total time spent face to face with the patient)

Outpatient - New
Codes: 99201 99202 99203 99204 99205
Times: 10 min. 20 min. 30 min. 45 min. 60 min.

Outpatient - Established
Codes: 99211 99212 99213 99214 99215
Times: 5 min. 10 min. 15 min. 25 min. 40 min.

Total time face-to-face with patient

Greater than 50% of face time spent providing counseling and/or care coordination

Cannot be checked without areas noted in section below along with response

Counseling Provided to Client/Family
- Diagnostic results/impressions and or recommended studies
- Risk and benefits of treatment options
- Instruction for management/treatment and/or follow-up
- Importance of adherence with chosen treatment
- Risk factor reduction
- Client/Family/Caregiver education
- Prognosis
- Other

Client/Family Member Response to Intervention(s) (This section must be completed)

Coordination of Care (Must be “with client present” and involve coordination of care with staff “outside” of our Agency)
- None provided

Coordination with:
- Family
- Caregiver
- PCP/Outside Medical Staff
- School Staff
- Probation
- Other: (include name, phone # of person with whom coordinating care if not in session)

Response/Outcome/Special Instructions (must be answered if any above checked)

Next appointment timeframe
Time Documentation Examples

Bad
• – “I spent 25 minutes talking with the patient about her diagnosis”
• Why? Fails to show whether more than half the time of the visit was dedicated to counseling

Good
• – “I spent 40 minutes total time and 25 minutes was spent in counseling and coordination of care with the patient.”
• – “I spent 40 minutes total time and more than 50% of the visit was spent in counseling and coordination of care with the patient.”
• Assume elaboration in documentation of what was discussed with the patient.
Summary

• Codes are still time based or based on Key Elements, so the vignettes are only guidelines.
• Codes were effective January 1, 2013 and must be accepted by MMC in NYS
• Knowledge of E/M coding will be necessary to ensure that psychiatrists and other qualified professionals receive appropriate reimbursement
Other time factors

“Joyce, how much do I charge people when I don’t know what’s wrong with them?”