American Academy of Child & Adolescent Psychiatry

CPT CODE TRAINING MODULE

WORKING DRAFT--Last updated October 2004

NOT FOR DISTRIBUTION OR CITATION
(CPT changes so rapidly that by the time
this module is printed, it may be outdated.)

MAINTAINED BY THE COMMITTEE ON HEALTHCARE ACCESS AND
ECONOMICS

Michael Houston, M.D., Chair
Alan Axelton, M.D
Sherry Barron-Seabrook, M.D.
David Berland, M.D.
Martin Glasser, M.D.
Anthony Jackson, M.D.
Joel V. Oberstar, M.D.
Lisa Ponfick, M.D.
Barry Sarvet, M.D.
Robert Schreter, M.D.
Benjamin Shain, M.D., Ph.D.
Harsh Trevedi, M.D.
Melinda Young, M.D.

PRIMARY AUTHORS
David Berland, M.D.
Karl Stevenson, M.D.

AACAP STAFF
Kristin Kroeger Ptakowski, Director of Clinical Affairs

For More Assistance with CPT Codes, call the Academy’s
Managed Care Complaint Service of the Clinical Affairs Department
1-800-333-7636 and clinical@aacap.org
TABLE OF CONTENTS

HISTORY AND CONTEXT OF CPT
- Back Ground
- Fraud and Abuse
- Code Categories

Part I: DOCUMENTATION
  - What E/M is, When and How to Use These Codes
    - History
    - Examination
    - Medical Decision-Making
    - The “Head” System
    - Counseling and Coordination of Care

PART II: PATIENT DEFINITIONS AND RELATED SPECIFIC CODES

REFERENCES

GLOSSARY
INTRODUCTION
HISTORY AND CONTEXT OF CPT

BACKGROUND

In the beginning, there was fee for service, whether barter or cash. During World War II, Congress imposed price and wage freezes. Orders for manufactured goods (material for the war effort) were increasing and companies were short on labor. They needed to recruit. Without ability to raise wages to attract workers, what was to be done?

Business came up with the idea of BENEFITS. Benefits included vacation, pension and agreement to help pay for medical expenses *(health insurance)*. Companies could offer improved benefit packages and workers would come to work for them. The concept of employer’s paying for medical insurance grew rapidly.

Twenty years later, Medicare was enacted (1965) and implemented 1967. Healthcare expenses rose. So did employer’s cost of paying for health insurance and healthcare expenditure nationally. While other developed countries devoted no more than 5% of their Gross Domestic Product to health care, the United States was spending no less than 10% on its healthcare. By the 1970’s, health benefits added $500 to the cost of every automobile made in this country.

Congress’s solution

The Health Care Finance Administration (HCFA) was established within the Department of Health and Human Services of the Federal government to rein in the spiraling costs of administering Medicare (established 1966). HCFA’s charge was to:

- Control expenses.
- Guarantee that the services billed and paid for are the ones that were delivered. For example, if HCFA paid for an adolescent in an acute psychiatric bed, the adolescent must have received documented acute care, as opposed to residential or custodial care. Or, if HCFA pays for a comprehensive outpatient examination, the examination must have been truly comprehensive, with documented evidence that it was different from a less thorough examination.
- Adopt procedure codes to accurately describe medical procedures. HCFA choose the Current Procedural Terminology (CPT) codes developed by CPT Editorial Board of the American Medical Association. In 1992 many private insurance companies began using them as well and their use has increased.
- Assign reimbursement values for each CPT code, based on interpretation of Congressional mandates. To assist them in the process, Congress
authorized development of The Resource-based Relative-value Scale (RBRVS) (Hsiao, 1987). Currently, Medicare payment is based on modifications of the RBRVS as well as public comment to determine how much to reimburse physicians for specific procedures.

In the 1970’s, Congress also wanted to encourage insurance companies to offer health insurance programs and pension plans (Employee Benefit Plans) to companies. President Ford signed the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provided:

- Federal, not state control of pension funds
- Exemption of insurance companies from lawsuit
- Assign feduciary responsibility to funds administrator, even if it is the insurance company.

Because of the feduciary’s need to maintain pension fund’s solvency and because healthcare cost had an increasing impact on the company’s bottom line, fund administrators had increasing impact on purchasing health care coverage. Through ERISA, companies had the authority to determine what health care services, packages and limitations their employees could receive, without risk of lawsuit against them or the insurance company.

Before ERISA, insurance companies had to make good faith effort to settle claims or face lawsuit. ERISA inserted the standard of “arbitrary and capricious” in place of “bad faith” liability. Even if this higher standard were met, no punitive damages could be awarded. Before filing a claim, the claimant must first exhaust all administrative appeals (internal) to obtain a settlement. The settlement cannot exceed what the insurance company would have to pay if the claim had originally been approved (no punitive damage). The settlement does not include attorney fees for this administrative process.

Going into the 1992 Presidential elections, healthcare “reform” was a major issue for both Bush I and Clinton. The Jackson Hole Group advised both candidates. Systems of managing care were recommended. Since then, managed care imposed restrictions have increased and are now decreasing. Of note is that Congress has failed to pass any major health care legislation during the Bush I, Clinton and Bush II Presidencies except for the Medicare Drug Bill. The Patient Bill of Rights introduced in 1997 still has not been passed.

Politics aside, since the early 1980’s, physicians have been paid by procedure, whether office visit or surgical. Instead of basing payments to physicians on charges, HCFA (name changed to CMS in 2001) paid according to a standardized payment schedule based on the resource costs needed to provide each service. The cost of providing a service was determined by three components:
• physician work
• practice expense
• professional liability insurance expense

The resultant relative value unit (RVU) would then be multiplied by a conversion factor (a monetary figure determined by HCFA - CMS) and adjusted for geographical variability to arrive at the payment.

Relative value units (RVU’s) are assigned to CPT codes by CMS after receiving recommendations from the Relative-value Update Committee (RUC) of the AMA. The RUC’s recommendations are based on the specialty society’s presentation to the 28 member RUC. These physicians, along with a representative from allied medical fields, arrive at specific work and practice expense values that are then sent to CMS for review and publication in the Federal Register.

What was the impact over first 12 years? Healthcare expenditures increased to 15% of the GDP. It had increased at a slower rate during the 1990’s, but no longer. Health care expense as per cent of GDP has risen from 5% in 1960 to 15% in 2003. (Be comparison, Germany spends less than 8% of its GDP on healthcare.)

<table>
<thead>
<tr>
<th></th>
<th>1990 (Sbillions)</th>
<th>2002 (Sbillions)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medicare</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital cost</td>
<td>68.5</td>
<td>149.2</td>
</tr>
<tr>
<td>Physician cost</td>
<td>45.5</td>
<td>68.8</td>
</tr>
<tr>
<td><strong>Medicaid</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital cost</td>
<td>46.8</td>
<td>83.1</td>
</tr>
<tr>
<td>Physician cost:</td>
<td>29.2</td>
<td>24.5</td>
</tr>
<tr>
<td><strong>Private insurance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital cost</td>
<td>89.4</td>
<td>165.0</td>
</tr>
<tr>
<td>Physician cost</td>
<td>58.2</td>
<td>166.9</td>
</tr>
<tr>
<td><strong>Mental health--All ages</strong></td>
<td>10.5%</td>
<td>unavailable</td>
</tr>
</tbody>
</table>


In 1995, the RUC elected David Berland, MD to sit in its 2-year non-internal medicine rotating seat. He completed his term in May, 1999. Sherry Barron-Seabrook, M.D. is the current RUC Adviser. In addition, the Academy participates in surveys of its members to determine the most realistic figures for physician work and practice expense for each service. In 1997, the Academy administered a survey for the 908X A series of codes adopted by HCFA on January 1 1997, as G codes. Working with the American
Psychiatric Association, American Nurses Association, American Psychological Association, and the National Association of Social Workers, the AACAP helped forge a consensus recommendation for these codes which were recommended by the RUC for HCFA’s adoption. HCFA published its decision in the *Federal Register Final Rule* in November 1998. On June 14, 2001, HCFA’s name was changed to the more descriptive Center for Medicare- Medicaid Service (CMS). CMS will be used throughout the remainder of the module.

**Physician Work**

The physician work component accounts, on average, for 54% of the total relative value for each service. The factors used to determine physician work include:

- the amount of physician time involved
- the technical skill and physical effort required
- the mental effort and judgment required
- the stress to the physician resulting from potential risk to the patient from the procedure

**Practice Expense**

The RUC has completed assigning Practice Expense (PE) RVU’s to extant codes. Practice expense RVU’s accounts for an average of 41% of the total value for each service. The RUC established a Practice Expense Advisory Committee (PEAC) in February 1999. Along with the American Psychiatric Association. Sherry Barron-Seabrook, M.D. presented PE data from the AACAP to the PEAC in August, 2001. These PE values reflected office costs like play equipment, rent, utilities, billing expenses, etc. Any new or revised code presented to the RUC will include both work and PE values. The RUC will then recommend a specific value for each to CMS.

**Professional Liability Cost**

The professional liability cost component is derived from a formula. Of all specialty societies psychiatry has the lowest malpractice cost. Consequently, it will be used as the denominator in the formula.

**Scope of CPT and RUC**

CPT codes and the reimbursement values assigned to them are, strictly speaking, applicable only to services billed to Medicare through any of its regional carriers. Private payers choose whether to use the codes and reimbursement values adopted by CMS for the procedures they reimburse. Academy members must ask each insurance carrier directly regarding the extent to which it adheres to the CMS values for each CPT code.
The only legal way to be paid for a service is to bill using the correct CPT code. You also must document that the level of service claimed was delivered. Failure to do so may be fraud, not sloppy record keeping. In 1996, the standard of “intent to knowingly and willingly deceive” was adopted.

FRAUD AND ABUSE

False Claims – Billing for services not provided.

Up coding
Examples: Coding a 90805 when seeing a patient for 20 minutes (or coding 90805 for 3 visits in an hour).
Coding 90214 while documentation supports a lower level of service.

Code edits
Billing codes that do not belong together (Correct Coding Initiative – CCI)
Examples: Coding 2 services when one of the codes billed includes the other service – coding 90805 AND 90862 for the same visit.
Violating AdminiStar software program – most edits involve surgical procedures like separate billing for amputation of digits and foot when performing a below the knee amputation. Currently, there are over 250 000 edits.
(http://cms.hhs.gov/physician/cciedits/default.asp)

Kennedy-Kassebaum (1996): Added “knowingly and willingly” standard to false claims legislation. Before 1996, physicians could be accused of violating the law if they simply made a mistake. Now, the standard is “knowingly and willingly,” BUT that does NOT exempt ignorance of coding rules.
Specifically, the standard can be met if it is proven that the physician’s office or billing service has a reckless disregard for the rules by repeating the same mistake(s) without procedures in place to catch and correct the error(s). “Reckless disregard” is the most common basis for conducting audits.

Made “falsifying” a private claim a federal offense like falsifying a Medicare/Medicaid claim.

Added 700 investigators to the Inspector General’s office at CMS.
Fines collected support the salaries of the investigators.

Example: Instructing one’s billing agent to code 90805 for any brief visit is a knowing and willing action that could place the
physician at risk if the level of service does not meet 90805 criteria – 20 to 30 minutes with additional time for the e/m component.

Physician is responsible (and liable) for all coding done in that physician’s name.

Consequences

Pay damages up to 3 times the amount of the claim

Mandatory penalties of $5 000 to $10 000 per claim, regardless of the size of the claim.

The Investigator General’s office receives a return of about $20 for each $1 used to fund an investigation. That return is used to support the salary of the investigators.

Whistle-blowers act in the name of the government and may seek the same damages. The Department of Justice may intercede and the realtor could still receive 15 to 25% of the claim. Realtor may proceed alone and keep of the 30% of the final recovery.

**CODE CATEGORIES**

The Health Insurance Portability and Accountability Act (HIPPA, 1996) required CMS to issue a request for proposals for alternative coding systems. The AMA realized that CPT needed to be changed and initiated the CPT 5 project to develop necessary modifications. In August, 2000, CMS announced that it would continue to use CPT as the coding system for medical procedures for Medicare patients. Two additional code categories (see below) debuted in CPT 2002.

Category I: these are the current procedure codes. All of the E/M and psychiatry codes are included in Category I.

Category II: These are OPTIONAL codes designed for physicians and/or auditors to track certain services that various agencies (e.g. HCQA) have determined contribute to quality care and good outcomes. They may be include diabetic foot exam or the initiation of an anti-arrhythmia drug after a heart attack. While there are NO category II codes for psychiatry, Health-Plan Employer Data and Information Set (HEDIS) measures are being developed for treatment of depression, ADD, and other illnesses. The AACAP wants its members to be informed of this new category because it seems likely that some carriers may begin audits for quality and use HEDIS measures.

For ADD, frequency of face to face patient-physician visits is one possible measure.
For Depression, possible measures include
  3 follow up visits in the acute (first 12 weeks) of treatment
  Continuous trial of antidepressants for the entire acute phase
  Continuous trial of medication throughout the continuous phase of treatment
  (6 months)

Other HEDIS measures:
  Immunizations by age 2
  Immunization completed by age 3
  Mammography within 2 years for ages 52 – 69
  First trimester prenatal care
  Post partum check ups
  Eye exams for diabetics within 1 year
  Outpatient follow up within 30 days after hospitalization for mental disorder

  May use –28 modifier if not appropriate; e.g. diabetic foot exam for amputee

These are 5 digit codes with an "F" occupying the fifth digit slot e.g. 1234F

Category III: These are TEMPORARY codes for new and emerging technologies. They may be covered by given carriers if you personally arrange for that. They are not covered by Medicare. The rTMS procedure will likely be assigned a category III code. If these codes are not assigned a category I code within 5 years, they will be retired. These codes are 5 digits with a "T" occupying the fifth digit slot - e.g. 1234T.

To summarize: “Regular” CPT codes are grouped as CATEGORY I codes in this edition of CPT. Two other code categories are also included in the book. Category II codes are used to track performance measures like eye exam or foot exam, which may be part of another general examination. They rely heavily on HEDIS measures. OPTIONAL. Category III codes are used to track new and emerging technologies. You must negotiate directly with the insurance carrier for payment. They are not part of the Medicare payment system.
PART I: DOCUMENTATION

It is important to note that no service has been provided unless it has been documented. If a service is not documented, it might as well never have been performed from the point of view of any third party reviewers who are providing payment. The government has increased financial support for “watchdogs” who investigate providers. These investigators from CMS’s Inspector General’s office look for fraud and abuse in billing by examining documentation of medical services (your patient’s charts).

### PRINCIPLES OF DOCUMENTATION FOR CPT

- The medical record should be complete and legible.
- The documentation of each patient encounter should include: reason for the encounter and relevant history, physical examination findings and prior diagnostic tests; assessment, clinical impression or diagnosis; plan for care; and date and legible identity of the observer.
- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
- Past and present diagnoses should be accessible to the treating and/or consulting physician.
- Appropriate health risk factors should be identified.
- The patient’s progress, response to and changes in treatment, and revision of diagnosis should be documented.
- The CPT and ICD-9 codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

*Source: CMS and AMA publication BPO-B12, May 1997*

With input from the AMA and Specialty Societies, CMS is revising the E/M (Evaluation/Management) documentation requirements. Until the new requirements are adopted, physicians may use either the 1994 (general multi-system examination) or 1997 (single system examination) guidelines. We discuss the 1997 guidelines below. Ben Shain, MD represents the Academy in this process. Please see the end of Section 1.

### EVALUATION AND MANAGEMENT SERVICES

Evaluation and Management (E/M) services constitute nearly one-third of all services reported by physicians (Udell, et al., 1996). E/M codes describe office, hospital, consultative, nursing home, and related “visit” services. The exact codes are determined by the combination of different levels of history taking, examination, and medical decision making performed by a physician **when a specific procedure is not performed.**
If a specific procedure is performed on the same day as an E/M service, the appropriate bundled code (procedure code plus E/M) should be used (for example, 20-30 minutes of insight oriented psychotherapy with E/M, #90805).

The following components are used to determine the level of E/M service:

- History
- Examination
- Medical Decision Making
- Counseling
- Coordination of Care
- Nature of Presenting Problem
- Time

Of these, the first three (history, examination, and medical decision making) are the key components in selecting the level of E/M services. In the case of visits that consist predominantly of counseling or coordination of care, time is the key or controlling factor to qualify for a particular level of E/M service.

Because the level of initial E/M service is dependent on all three key components, and follow-up E/M service depends on two of three key components, performance and documentation of one component (i.e., examination) at the highest level does not necessarily mean that the encounter in its entirety qualifies for the highest level of E/M service.

Each of the seven components of E/M services is described in detail in the sections that follow.

**HISTORY**

The levels of E/M services are based on four levels of history (Problem-focused, Expanded Problem-focused, Detailed, and Comprehensive.) Each type of history includes some or all of the following elements:

- Chief complaint (CC);
- History of present illness (HPI);
- Review of systems (ROS); and
- Past, family, and/or social history (PFSH).

History may be gathered from the patient, the patient’s parents, and other sources (e.g. school, court referral source, and social services agencies). Parent and patient questionnaires and standardized interviews are acceptable. The work-ups of residents or physician extenders also are acceptable, but the physician must certify their authenticity and/or record changes and differences of opinion.
The extent of history of present illness, review of systems, and past, family, and/or social history that is obtained and documented is dependent on clinical judgment and the nature of the presenting problem(s).

Levels Of History

All levels of history include the chief complaint. The completeness of the other three components of history-taking determines the overall level of History.

<table>
<thead>
<tr>
<th>COMPONENTS OF HISTORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of history</td>
</tr>
<tr>
<td>Problem-focused Brief</td>
</tr>
<tr>
<td>Expanded problem-focused Brief</td>
</tr>
<tr>
<td>Detailed</td>
</tr>
<tr>
<td>Comprehensive</td>
</tr>
</tbody>
</table>

Chief Complaint

The chief complaint is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter, usually stated in the patient’s words. The medical record should clearly reflect the chief complaint.

History Of Present Illness

The history of present illness (HPI) is a chronological description of the development of the patient’s present illness from the first sign and/or symptom or from the previous encounter to the present. It includes the following elements:

- location
- quality
- severity
- duration,
- timing,
- context,
- modifying factors, and
- associated signs and symptoms.

A brief HPI consists of 1 to 3 elements of the complete HPI.

An extended HPI consists of at least 4 elements of the complete HPI, or the status of at least 3 chronic or inactive conditions.

The medical record should describe the appropriate number of elements of the HPI.
Review Of Systems

The review of systems (ROS) is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced. For the purposes of CPT, the following systems are recognized (CPT, 2002):

- Constitutional symptoms (fever, weight loss)
- Eyes
- Ears, nose, mouth, and throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/lymphatic
- Allergic/immunologic

ROS can be performed at three levels, from least to most comprehensive.

<table>
<thead>
<tr>
<th>Least Comprehensive</th>
<th>Most Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem-pertinent</td>
<td>Extended problem-pertinent</td>
</tr>
<tr>
<td></td>
<td>Complete</td>
</tr>
</tbody>
</table>

**Problem-pertinent system review**

The review covers:

- The (one) system directly related to problem identified in the history of present illness (HPI).

The patient’s positive responses and pertinent negatives for the system related to the problem should be documented.

**Extended problem-pertinent system review**

The review covers:

- Two to 9 systems, including the system related to the problem identified in the HPI and a limited number of additional systems.

The patient’s positive responses and pertinent negatives for two to nine systems should be documented.
**Complete system review**

The review covers:

- At least **10** systems, including the system related to the problem identified in the HPI plus all additional body systems.

Those systems with positive responses and pertinent negatives must be individually documented. For the remaining systems, a notation indicating “all other systems are negative” is permissible. In the absence of such a notation, at least 10 systems must be individually documented.

Physicians can add to or accept data from another physician by noting changes in the ROS, and the date and location of earlier ROS.

**PAST, FAMILY, AND/OR SOCIAL HISTORY**

The Past, Family, and/or Social history (PFSH) consists of three areas:

- Past history (the patient’s past medical experiences)
  - major illnesses and injuries
  - hospitalizations
  - surgeries
  - current medications
  - allergies
  - immunization status
  - dietary status

- Family history (a review of medical events in the patient’s family, including diseases that may be hereditary or place the patient at risk); health status or cause of death of parents, siblings

- Social history (an age-appropriate review of past and current activities)
  - school behavior and academic achievement
  - living arrangements
  - parental separation, divorce
  - foster or adoptive status
  - current living arrangement
  - sexual history
  - trauma history
  - substance use history
For certain categories of E/M services that include only an interval history, it is not necessary to record information about the PFSH. Those categories are subsequent hospital care, follow-up inpatient consultations, and subsequent nursing facility care.

Past, family, and social history are defined by two levels, pertinent and complete.

**Pertinent past, family, and social history**

A pertinent PFSH is a review of the history area(s) directly related to the problem(s) identified in the HPI.

At least one specific item from any of the three histories (past, family, social) must be documented.

**Complete past, family, and social history**

A complete PFSH is a review of either 2 or all 3 of the PFSH history areas, depending on the category of E/M service. A review of all 3 history areas is required for services that by their nature include a comprehensive assessment or reassessment of the patient. A review of 2 of the 3 history areas is sufficient for other services.

At least one specific item from 2 of the 3 history areas must be documented for a complete PFSH for the following categories of E/M services:
- emergency department
- office or other outpatient services, established patient
- domiciliary care, established patient
- home care, established patient

At least one specific item from each of the 3 history areas must be documented for a complete PFSH for the following categories of E/M services:
- office or other outpatient services, new patient
- hospital observation services
- hospital inpatient services, initial care
- consultations
- comprehensive nursing facility assessments
- domiciliary care, new patient
- home care, new patient

**Problem-focused history**
- chief complaint
- brief history of present illness or problem

**Example:** While interviewing a 17-year-old girl, the clinician obtains statements from her that she feels depressed and has felt that way since she broke up with her boyfriend six weeks ago.
Expanded problem-focused history
• chief complaint
• brief history of present illness or problem
• problem-pertinent system review

Example: While interviewing the same patient, the clinician obtains the above statements from her, and that she has had a sleep disturbance for three weeks, appetite loss for 10 days, and that the fun has disappeared from life for the past several days.

Detailed history
• chief complaint
• brief history of present illness or problem
• problem-pertinent system review extended to include a review of a limited number of additional systems
• pertinent past, family, and/or social history directly related to the patient’s problems

Example: While interviewing the same patient, the clinician obtains the above statements from her, and that she felt depressed three years ago, but it resolved without intervention; that her mother had a post-partum depression and required ECT eleven years ago; that her concentration has deteriorated with a decline in her grades. The system review includes nausea, constipation, decreased energy, and slowed movement. The impact of the presenting problem on the patient, as well as prior interventions, should be included.

Comprehensive history
• chief complaint
• extended history of present illness or problem
• problem-pertinent system review extended to include a review of systems that are directly related to the problem(s) identified in the history of the present illness, plus a review of all additional body systems
• complete past, family, and/or social history

Example: While interviewing the same patient, the clinician obtains the above statements from her, and also inquires in greater depth about her school functioning, social functioning, developmental history, and family history. The clinician asks and records a complete review of systems; inquiring about fever, weight loss, energy, vision, hearing, mouth, teeth, heart, dizziness, swelling, shortness of breath, skin lesions, menstrual history, pain/burning on urination, etc... These requirements are probably less rigorous than a moderately complete case study without the mental status examination (discussed below).
EXAMINATION

A general multi-system examination or a single organ system examination may be performed by any physician regardless of specialty. The type (general multi-system or single organ system) and content of the examination are selected by the examining physician and are based on clinical judgment, the patient’s history, and the nature of the presenting problem (AMA & HCFA, 1997).

A review and acceptance of examinations performed by competent others can suffice for documented portions of examinations not performed by the physician (AMA & HCFA, 1997), but attending physicians must repeat and document key elements of the examination.

Examination can be either general multi-system, or single-system for the following organ systems:

- cardiovascular: ears, nose, mouth, and throat
- eyes
- genitourinary
- hematologic/lymphatic/immunologic
- musculoskeletal
- neurological
- psychiatric
- respiratory
- skin

General multi-system or single organ system examination can be performed at any of four levels.

- problem-focused
- expanded problem focused
- detailed
- comprehensive.

General Multi-System Examination

The General Multi-System Examination (1994 documentation standard) will not be discussed in this Module. See the current CPT for description.

Single-system Examination-Psychiatric - 1997

Each of the organ systems has its own “single system examination.” Only the psychiatric single-system examination is presented here. Details of the other single-system examinations are available from the AMA (AMA & HCFA, 1997).
## Single System Examination – Psychiatric

<table>
<thead>
<tr>
<th>System/Body Area</th>
<th>Elements of Examination</th>
</tr>
</thead>
</table>
| **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 (e.g. development, nutrition, body habitus, deformities, attention to grooming) |
| **Head and Face**         |                                                                                                                                                          |
| Eyes                      |                                                                                                                                                          |
| Ears, Nose, Mouth and Throat |                                                                                                                                                    |
| Neck                      |                                                                                                                                                          |
| Respiratory               |                                                                                                                                                          |
| **Cardiovascular**        |                                                                                                                                                          |
| Chest                     |                                                                                                                                                          |
| Gastrointestinal (abdomen)|                                                                                                                                                         |
| Genitourinary             |                                                                                                                                                          |
| Lymphatic                 |                                                                                                                                                          |
| **Musculoskeletal**       | • Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements  
  • Examination of gait and station |
| Extremities               |                                                                                                                                                          |
| Skin                      |                                                                                                                                                          |
| **Neurological**          | • Description of speech, including: rate; volume; articulation; coherence; and spontaneity with notation of abnormalities (e.g., perservation, paucity of language)  
  • Description of thought processes, including: rate of thoughts; content of thoughts (e.g., logical vs. illogical, tangential); abstract reasoning; and computation  
  • Description of association (e.g. 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 judgement (e.g., concerning everyday activities and social situations) and insight (e.g., concerning psychiatric condition) Complete mental status examination, including  
  • Orientation to time, place and person  
  • Recent and remote memory |
- Attention span and concentration
- Language (e.g. naming objects, repeating phrases)
- Fund of knowledge (e.g., awareness of current events, past history, vocabulary)
- Mood and affect (e.g., depression, anxiety, agitation, hypomania, lability)

**Problem-focused examination**

Problem-focused examination includes performance and documentation of 1 to 5 elements identified by a bullet, whether in a box with a shaded or unshaded border.

**Example:** In evaluating a patient with depression, the clinician would address mood and affect (psychiatric organ system). “The patient is depressed as manifested by depressed mood, crying, and irritability.”

**Example:** In evaluating a patient with mental retardation, the clinician would address cognitive ability. “The patient is mentally retarded as manifest by an IQ score that is two standard deviations below the mean on a standardized test.”

**Expanded problem-focused examination**

Expanded problem-focused examination includes performance and documentation of at least 6 elements identified by a bullet, whether in a box with a shaded or unshaded border.

**Example:** In evaluating a patient with depression, the clinician would address at least six areas affected by the condition. “The patient is depressed. Attention and concentration are impaired. She can only report 3 digits forward. Speech is slow, sparse, and diminished volume. The patient appears sad, but is appropriately dressed. Thinking is slowed, but abstract reasoning and computation are in tact. Suicidal ideation present with no plan.

**Example:** In evaluating a patient with mental retardation, the clinician would address at least six areas affected by the condition. “The patient is mentally retarded and examination of abstract reasoning and fund of knowledge reveals findings well below age-expected developmental level. Mood and affect are somewhat labile. The patient is oriented x3, recent and remote memory are in tact. Judgment is impaired - patient does not understand nuance of social interaction.”

**Detailed examination**

Detailed examination includes the performance and documentation of at least nine elements identified by a bullet, whether in a box with a shaded or unshaded border.
Example: In evaluating a patient with depression, the clinician would examine and comment on at least nine aspects of the patient’s mental status. In addition to appearance, mood, attention and concentration, speech, abnormal thoughts and thought processes, the clinician also examines memory, orientation, and associations: “With prompts and encouragement, he is able to recall three of three items after five minutes. He repeats five digits forward and four backward before giving up. He is oriented x4. There is no evidence of loose, tangential, or circumstantial associations.”

Example: In evaluating a patient with mental retardation, the physician should examine and comment on at least nine aspects of the patient’s mental status. In addition to abstract reasoning, fund of knowledge, memory, judgment, orientation, and moods, the clinician also examines attention span and concentration, abnormal thoughts, and language: “The child can repeat only three digits forward and two backward. With encouragement and numerous repetitions, he recalled two of three items after five minutes. He is easily distracted, but attends well when given individual attention. He is not suicidal, homicidal or hallucinating. Language is simple, but he can name objects and repeat phrases.”

Comprehensive examination

Comprehensive examination includes performance of all elements identified by a bullet, whether in a box with a shaded or unshaded border. Documentation of every element in a box with a shaded border, and at least 1 element in a box with an unshaded border is expected.

Example: In evaluating a patient with depression, the physician must examine and comment on every area of the Single System Examination. Constitutional, orientation, memory, attention span and concentration, language, associations, mood and affect, speech, thought processes, abnormal thoughts, judgment and insight, fund of knowledge, and musculoskeletal need comment. “P-88, R-14, BP-110/70. The patient was preoccupied with sad stories regarding separation and loss. While language was normal, he spoke slowly and said his thoughts came slowly. He felt like life was not worth living and he had thoughts of ending his life. He had no specific plan. His judgment was impaired; he felt that no one liked him in spite of his being invited to peers’ homes frequently. His fund of knowledge was age-appropriate. His motor activity was slowed. He slouched when he walked, and associated arm movements were diminished. He had some insight into his condition as he stated he knew something was wrong with him and he wanted to feel better. He added he thought he would feel better if his parents stopped fighting and moved back in together. His recent and remote memory were normal. He was orientated to time, person, and place. His attention span and concentration were impaired as he was unable to perform serial 3's from 20 or spell ‘cake’ backward; and he ‘forgot’ what he was saying several times during the interview. His mood was depressed. Hallucinations, delusions, frank
homicidal thoughts, and pre-occupation with violence were not present. There was no paranoid ideation or obsessive-compulsive thought.”

**NOTE:** Additional examples would flesh out this description. This case is ONLY an example, it is NOT a model or standard. Alternatively, a checklist could be used to document the Single System Examination.

**Example:** In evaluating a patient with mental retardation, the physician must examine and comment on every area of the Single System Examination. Constitutional, orientation, memory, attention span and concentration, language, associations, mood and affect, speech, thought processes, abnormal thoughts, judgment and insight, fund of knowledge, and musculoskeletal need comment. “Ht- 4’8”, wt- 110#, T- 98.4. The patient responded well to the examiner's questions and requests. He engaged in the interview to the best of his ability. He was neatly dressed. His ears appeared low set, he had wide-spaced eyes and a prominent forehead. His speech was understandable but articulation problems were present: w for r, dark l and voiceless th. His thought content was impoverished, but there was no hallucination, delusion, or suicidal, homicidal, or paranoid thought. Thought flow and associations were normal. The patient’s judgment was limited. He did not understand several age-appropriate questions and looked to his mother for help. He lacked insight into his delays. His gait was awkward and clumsy. His posture appeared rigid. Mother reported he was obsessed with buttons and he played repeatedly with them during the interview (compulsion). With support and prompts, he was able to recall 3 of 3 items immediately and after 5 minutes. He was oriented x3. His fund of knowledge was diminished. He could repeat 3 digits forward and 2 digits backward.”

**NOTE:** Additional examples would flesh out this description. This case is ONLY an example, NOT a model or standard. Alternatively, a checklist could be used to document the Single System Examination.

**MEDICAL DECISION-MAKING**

The complexity of decision-making is one of the three key determinants of the level of E/M service. There are four levels of decision-making (CPT, 2002, p. 7). Medical decision-making refers to the complexity of establishing a diagnosis and/or selecting a management option, as measured by:

- the number of possible diagnoses and/or the number of management options that must be considered;
- the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and
- the risk of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient’s presenting problem(s), the diagnostic procedure(s) and/or the possible management options (AMA & CMS, 1997).
LEVELS OF DECISION-MAKING

<table>
<thead>
<tr>
<th>Type of Decision-Making</th>
<th>Number of Diagnoses or Management Options</th>
<th>Amount or Complexity of Data Reviewed</th>
<th>Risk of Complication, Morbidity, or Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straight-forward</td>
<td>Minimal</td>
<td>Minimal or none</td>
<td>Minimal</td>
</tr>
<tr>
<td>Low Complexity</td>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
</tr>
<tr>
<td>Moderate Complexity</td>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>High Complexity</td>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
</tr>
</tbody>
</table>

Number of Diagnoses or Management Options

The number of possible diagnoses and/or the number of management options that must be considered is based on the number and types of problems addressed during the encounter, the complexity of establishing a diagnosis, and the management decisions that are made by the physician.

Generally, decision-making with respect to a diagnosed problem is easier than that for an identified but undiagnosed problem. The number and type of diagnostic tests employed may be an indicator of the number of possible diagnoses. Problems that are improving or resolving are less complex than those that are worsening or failing to change as expected. The need to seek advice from others is another indicator of complexity of diagnostic or management problems.

For each encounter, an assessment, clinical impression or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.

For a presenting problem with an established diagnosis, the record should reflect whether the problem is:

- improved, well-controlled, resolving, or resolved;
- inadequately controlled, worsening, or failing to change as expected.

For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of differential diagnoses or as a “possible,” “probable,” or “rule out” (R/O) diagnosis.

The initiation of, or changes in, treatment should be documented. Treatment includes a wide range of management options including patient instructions, nursing instructions, therapies, and medications.
If referrals are made, consultations requested, or advice sought, the record should indicate to whom or where the referral or consultation was made or from whom the advice was requested (AMA & CMS, 1997).

**Amount and/or Complexity of Data to Be Reviewed**

The amount and complexity of data to be reviewed is based on the types of diagnostic testing ordered or reviewed. A decision to obtain and review old medical records and/or obtain history from sources other than the patient (e.g., school, parent, therapist, pediatrician) increases the amount and complexity of data to be reviewed.

Discussion of contradictory or unexpected test results with the physician who performed or interpreted the test is an indication of the complexity of data being reviewed. On occasion the physician who ordered a test may personally review the image, tracing, or specimen to supplement information from the physician who prepared the test report or interpretation; this is another indication of the complexity of data being reviewed.

If a diagnostic service (test or procedure) is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service, e.g. rating scale, lab, or x-ray, should be documented.

The review of rating scales, lab, radiology, and/or other diagnostic tests should be documented. A simple notation such as “WBC elevated,” or “chest x-ray unremarkable,” is acceptable. Alternatively, the review may be documented by initialing and dating the report containing the test results.

A decision to obtain old records or additional history from the family, caregiver, or other source to supplement that obtained from the patient should be documented.

Relevant findings from the review of old records, and/or the receipt of additional history from the family, caregiver, or other source to supplement that obtained from the patient should be documented.

**Medical decision making of low complexity**

Low complexity decision making also may not exist in child and adolescent psychiatry. Example: mother states Johnny, age 7, stole a pack of gum and wants to know what to do. The physician makes NO further inquiries into Johnny's biopsychosocial functioning and tells her to have him return it to the store.

**Medical decision making of moderate complexity**

While the physician does NOT need to document every option considered, he or she could state: "Decision making was moderately complex and I considered medication (antidepressants or stimulants) and family therapy (Structural or Bowen). The child was
already engaged in behavior management program for his ADHD. I added stimulant medication."

**Medical decision making of high complexity**
As above, but one could state "High complexity. I considered individual psychotherapy (cognitive or psychoanalytic), group therapy, pharmacology (serotonin reuptake inhibitor, tricyclic, or atypical) and school intervention, separately and in combination, to treat the depression." Unless the patient is severely psychotic, violent, homicidal, or suicidal, decision making is unlikely to be of "high complexity."

**THE “HEAD” SYSTEM FOR DOCUMENTING E/M SERVICES**
Karl Stevenson, M.D., has designed a variation of the S (subjective), O (objective), A (assessment), P (Plan) organization, of record keeping for CPT. His system is identified by the acronym HEAD:

- **H** (History)
- **E** (Examination)
- **A** (Assessment)
- **D** (Decision-making)

Time______ (record number of minutes in service)

**The Audit**

**Step 1. Describe History**

History is described according to the parameters described in the table below.

<table>
<thead>
<tr>
<th>HPI</th>
<th>Brief</th>
<th>Brief</th>
<th>Brief</th>
<th>Extended</th>
<th>Extended</th>
</tr>
</thead>
<tbody>
<tr>
<td>SR</td>
<td>None</td>
<td>None</td>
<td>Problem pertinent</td>
<td>Extended</td>
<td>Complete</td>
</tr>
<tr>
<td>P, F, SH</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>Pertinent</td>
<td>Complete</td>
</tr>
<tr>
<td><strong>Problem Focused</strong></td>
<td>Problem Focused</td>
<td><strong>Expanded Problem Focused</strong></td>
<td>Detailed</td>
<td>Comprehensive</td>
<td></td>
</tr>
</tbody>
</table>

The reviewer will circle:
- HPI type
- SR - what is documented?
- P,F,SH - what is documented?

The reviewer then will draw a vertical line through the circles and read the history type below.
**RULE:** Value as far to left as possible. For example, if there is a "none" under SR, that history is Problem Focused or the lowest level, e.g. 99201 or 99211, etc., regardless of the HPI or P,F,SH entries. But see end of step 4.

For example:

<table>
<thead>
<tr>
<th>HPI</th>
<th>Brief</th>
<th><strong>Extended</strong></th>
<th>Extended</th>
</tr>
</thead>
<tbody>
<tr>
<td>SR</td>
<td>Problem Pertinent</td>
<td>Extended</td>
<td>Complete</td>
</tr>
<tr>
<td>P, F, SH</td>
<td>None</td>
<td><strong>Pertinent</strong></td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Expanded Problem Focused</td>
<td>Detailed</td>
<td>Comprehensive</td>
</tr>
</tbody>
</table>

**Step 2. Describe Examination**

The reviewer will count the organ systems examined or elements examined from a Single System Examination (SSE) and determine whether the examination is

- Problem-focused (1-5 elements of the SSE)
- Expanded problem-focused (6+ elements)
- Detailed (6+elements with 2+sub-elements)
- Comprehensive (9+elements)

Note: “all other systems negative” counts for ALL OTHER SYSTEMS and qualifies for comprehensive examination. “Abnormal” counts for nothing unless the abnormality is described.

**Step 3. Describe Assessment**

A list of diagnoses is sufficient.

**Step 4. Describe Medical Decision Making**

(A) The reviewer assigns points for the level of intensity of the first two of the three components of medical decision making:

- Number of diagnoses or management options
- Amount/Complexity of data to be reviewed according to the following scoring system:

  **Diagnoses/problem categories**

  - 1 point for self-limited problems, e.g. insect bite, cold.
  - 2 points for a single problem that is worsening, e.g. tics, increasing in number
  - 3 points for a new problem
  - 4 points for a new problem requiring additional work-up
Amount/Complexity of data to be reviewed

1 point for:
- review and order of lab tests
- review and order of radiological tests
- review and order of EEG, EKG, psychological testing, etc.
- discussion of tests with preforming physician
- independent review of images
- decision to obtain old records

2 points for review and summary of old records, or obtaining history from collateral sources.

(B) Next, the reviewer determines risk of complication, morbidity, or mortality from the following Table of Risk.

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Minimal</strong></td>
<td>One self-limited or minor problem, e.g., cold, insect bite, tinea corporis</td>
<td>Laboratory tests requiring venipuncture, Chest x-rays, EKG/EEG, Urinalysis, Ultrasound, KOH prep</td>
<td>Rest, Gargles, Elastic bandages, Superficial dressings</td>
</tr>
<tr>
<td><strong>Low</strong></td>
<td>Two or more self-limited or minor problems</td>
<td>Physiologic tests not under stress, Pulmonary function tests, Non-cardiovascular imaging studies with contrast, Urinalysis, Superficial needle biopsies, IV fluids without additives</td>
<td>Over-the-counter drugs, Minor surgery with no identified risk factors, Physical therapy, Occupational therapy, IV fluids without additives</td>
</tr>
</tbody>
</table>

Moderate
- One or more chronic illness or injury, e.g., allergy, simple sprain
- Physiologic tests requiring arterial puncture, Skin biopsies
- Major surgery with

- Over-the-counter drugs
- Minor surgery with no identified risk factors
- Physical therapy
- Occupational therapy
- IV fluids without additives
ILLNESSES WITH MILD EXACERBATION, PROGRESSION, OR SIDE EFFECTS OF TREATMENT
- Two or more stable chronic illnesses
- Undiagnosed new problems with uncertain prognosis, e.g., lump in breast
- Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis
- Acute complicated injury, e.g., head injury with brief loss of consciousness

<table>
<thead>
<tr>
<th>Under Stress, E.g., Cardiac Stress Test, Fetal Contraction Stress Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic Endoscopies with No Identified Risk Factors</td>
</tr>
<tr>
<td>Deep Needle or Incisional Biopsy</td>
</tr>
<tr>
<td>Cardiovascular Imaging Studies with Contrast and No Identified Risk Factors, E.g., Arteriogram, Cardiac Catheterization</td>
</tr>
<tr>
<td>Obtain Fluid from Body Cavity, E.g., Lumbar Puncture, Thoracentesis, Culdocentesis</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Identified Risk Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective Major Surgery (Open Percutaneous or Endoscopic) with No Identified Risk Factors</td>
</tr>
<tr>
<td>Prescription Drug Management</td>
</tr>
<tr>
<td>Therapeutic Nuclear Medicine</td>
</tr>
<tr>
<td>IV Fluids with Additives</td>
</tr>
<tr>
<td>Closed Treatment of Fracture or Dislocation Without Manipulation</td>
</tr>
</tbody>
</table>

**High**
- One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment
- Acute or chronic illnesses or injuries that pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure. An abrupt change in neurologic status, e.g., seizure, TIA, weakness, sensory loss

<table>
<thead>
<tr>
<th>Cardiovascular Imaging Studies with Contrast with Identified Risk Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac Electrophysiologic Tests</td>
</tr>
<tr>
<td>Diagnostic Endoscopies with Identified Risk Factors</td>
</tr>
<tr>
<td>Discography</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Identified Risk Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective Major Surgery (Open, Percutaneous or Endoscopic) with Identified Risk Factors</td>
</tr>
<tr>
<td>Emergency Major Surgery (Open, Percutaneous or Endoscopic)</td>
</tr>
<tr>
<td>Parenteral Controlled Substances</td>
</tr>
<tr>
<td>Drug Therapy Requiring Intensive Monitoring for Toxicity</td>
</tr>
<tr>
<td>Decision Not to Resuscitate or De-escalate Care Because of Poor Prognosis</td>
</tr>
<tr>
<td>Suicidal/Homicidal Ideation</td>
</tr>
</tbody>
</table>

(C) Finally, the reviewer determines level of complexity of decision making using the following table.
Level of Complexity

<table>
<thead>
<tr>
<th>Number of dx or Management Options</th>
<th>Data to be Reviewed</th>
<th>Risk of complication, morbidity, mortality</th>
<th>Type of Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Minimal or none</td>
<td>Minimal</td>
<td>Straight-forward</td>
</tr>
<tr>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
<td>Low Complexity</td>
</tr>
<tr>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate Complexity</td>
</tr>
<tr>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
<td>High Complexity</td>
</tr>
</tbody>
</table>


CMS has indicated it will change the rule of valuing as far to the left as possible for decision making. Its reviewers will be instructed to value toward the right as indicated by two of the three categories above (number of diagnostic/management options; data to be reviewed, risks). Again, Academy members should stay tuned and check the module updates for implementation dates for these possible changes.

Step 5. TIME: ____ (FILL IN THE NUMBER OF MINUTES INVOLVED)

COUNSELING AND COORDINATION OF CARE

Add up the total time spent in interpretation/coordination of care and/or patient counseling.

COUNSELING/COORDINATION TOTAL TIME: _________

Example: "I discussed with staff the medication side effects, mother's resistance to psychological intervention...." etc.

TOTAL TIME = HEAD + Counseling and Coordination of Care

If “HEAD” is less than 50% of total time, total time determines the appropriate CPT code. (CPT, 2002, p. 7)

FUTURE POSSIBILITY: As of October 2004, CMS continues to review documentation requirements. CMS is considering doing away with single system examinations in favor of requiring documentation of a certain number of elements taken from all the examinations - general and specialty single system. We are working to have enough elements in the psychiatry examination to be able to qualify for the comprehensive level of service. Stay tuned. At this time, one can use the single system examination (1997 standard) or general multi-system examination (1994 standard). CMS had hoped to have the new documentation requirements developed in 1999 for implementation late in 1999. They did not make it.

The following ideas are proposals. They are not accepted, nor will CMS use them as standards for documentation requirements.
The CPT editorial board is working out a new way to determine levels of E/M codes. They are based on clinical examples contained in Appendix D of the CPT manual. The physician will assign a level of service based on these examples. If the patient is more complex than the example, the level of service would be higher than the example. If the patient is less complex, the level assigned should be lower. Some examples include:

**Outpatient Office Visit**

99211- Office visit for prescription refill for a 35 y/o female established patient, with schizophrenia who is stable but has run out of her medicine and is scheduled to be seen in a week.

99215- Office visit for a 28 y/o female, established patient, who is abstinent from previous cocaine dependence, but reports progressive panic attacks and chest pains.

Continue to check this CPT manual for information regarding the implementation date and details.
PART II: PATIENT DEFINITIONS
AND
RELATED SPECIFIC CODES

Part II describes commonly used CPT codes in the major service categories used by child and adolescent psychiatrists. The reader is referred to the Physicians’ Current Procedural Terminology (CPT, 2003) for further information on these codes and their use.

The categories of codes covered in this section include:
- Evaluation and management codes
- Psychiatric diagnostic interview codes
- Psychotherapy codes
- Prolonged services codes
- Physician standby services codes
- Care plan oversight codes
- Hospital observation services codes
- Polysomnography codes

This section also describes the modifier codes and their appropriate uses.

OUTPATIENT

New patient (not seen by you or office-mate in your specialty in past three years)

99201 (10 minutes)
Problem focused history
Problem focused examination
Straightforward medical decision making

99202 (20 minutes)
An expanded problem focused history
Expanded problem focused examination
Straightforward medical decision making

99203 (30 minutes)
A detailed history
A detailed examination
Medical decision making of low complexity

99204 (45 minutes)
A comprehensive history
A comprehensive examination
Medical decision making of moderate complexity

99205 (60 minutes)
A comprehensive history
A comprehensive examination
Medical decision making of high complexity

(For prolonged services, see separate section below.)

Established patient (seen within past three years)

Two of three components (history, examination, medical decision making) determine the level of service.

99211   (5 minutes, may or may not require a physician)

99212   (10 minutes)
A problem focused history
A problem focused examination
Straight forward decision making

99213   (15 minutes)
An expanded problem focused history
An expanded problem focused examination
Medical decision making of low complexity

99214   (25 minutes)
A detailed history
A detailed history
Medical decision making of moderate complexity

99215   (40 minutes)
A comprehensive history
A comprehensive examination
Medical decision making of high complexity

HOSPITAL INPATIENT

Initial care -- new or established patient

99221   (30 minutes)
A comprehensive history
A comprehensive examination
Straight forward medical decision making

99222   (50 minutes)
A comprehensive history
A comprehensive examination
Medical decision making of moderate complexity
99223  (70 minutes)
A comprehensive history
A comprehensive examination
Medical decision making of high complexity

(For prolonged services, see separate section below.)

**Subsequent care**

Two of three components (history, examination, decision making) determine the level of service.

99231  (15 minutes)
A problem focused interval history
A problem focused examination
Medical decision making that is straightforward or of low complexity

99232  (25 minutes)
An expanded problem focused interval history
An expanded problem focused examination
Medical decision making of moderate complexity

99233  (35 minutes)
A detailed interval history
A detailed examination
Medical decision making of high complexity

**NURSING FACILITY/RESIDENTIAL TREATMENT CENTER**

**New or established patient** -- initial consultation

The "HEAD + TIME system" may be especially useful to keep track of counseling and coordination of care.

99301  (30 minutes)
A detailed interval history
A comprehensive examination
Straight forward medical decision making

99302  (40 minutes)
A detailed interval history
A comprehensive examination
Medical decision making of moderate to high complexity
99303  (50 minutes)
A comprehensive history
A comprehensive examination
Medical decision making of moderate to high complexity

Subsequent care

Codes are used to report services for patients who do not require a comprehensive assessment and/or have not had a major, permanent change of status.

99311  (15 minutes)
A problem focused interval history
A problem focused examination
Straight forward medical decision making

99312  (25 minutes)
An expanded problem focused interval history
An expanded problem focused examination
Medical decision making of moderate complexity

99313  (35 minutes)
A detailed interval history
A detailed examination
Medical decision making of moderate to high complexity

CONSULTATIONS

All reports must include a heading "requested by __________" and must conclude with "recommendations."

New or established patient-- in office

99241  (15 minutes)
A problem focused history
A problem focused examination
Straight forward medical decision making

99242  (30 minutes)
An expanded problem focused history
An expanded problem focused examination
Straight forward medical decision making

99243  (40 minutes)
A detailed history
A detailed examination
Medical decision making of low complexity

99244  (60 minutes)
A comprehensive history
A comprehensive examination
Medical examination making of moderate complexity

99245  (80 minutes)
A comprehensive history
A comprehensive examination
Medical decision making of high complexity

(For prolonged services, see separate section below.)

New or established patient-- initial inpatient consultation.

99251  (20 minutes)
A problem focused history
A problem focused examination
Straight forward medical decision making

99252  (40 minutes)
An expanded problem focused history
An expanded problem focused examination
Straight forward medical decision making

99253  (55 minutes)
A detailed history
A detailed examination
Medical decision making of low complexity

99254  (80 minutes)
A comprehensive history
A comprehensive examination
Medical examination making of moderate complexity

99255  (110 minutes)
A comprehensive history
A comprehensive examination
Medical decision making of high complexity

(For prolonged services, see separate section below.)
Follow-up inpatient consultation

As with the initial inpatient consultation, the "HEAD + TIME system" may be especially useful to keep track of counseling and coordination of care.

99261 (10 minutes)
A problem focused interval history
A problem focused examination
Straight forward medical decision making

99262 (20 minutes)
An expanded problem focused interval history
An expanded problem focused examination
Medical decision making of moderate complexity

99263 (30 minutes)
A detailed interval history
A detailed examination
Medical decision making of high complexity

CPT CODES FOR SPECIFIC PROCEDURES USED BY PSYCHIATRISTS

NOTE: Documentation standards are being developed for these codes.

Documentation Recommendations

- Legible Medical Record
- Date and Type of Service Rendered
- If family session – who was present
- Mental Status of Patient
- Types of Interventions (e.g. insight, cognitive behavioral, anger management, etc)
- E/M
- Diagnosis

Diagnostic interview procedures

90801 Psychiatric diagnostic interview examination including history, mental status or disposition. This code may include communication with the family and other sources and ordering and medical interpretation of laboratory or other medical diagnostic studies. In certain circumstances, other informants will be seen in lieu of the patient.

90802 Interactive medical psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other
mechanisms of communication. This code is typically furnished to children and may involve the use of physical aides and non-verbal communication to overcome barriers to therapeutic interaction between the clinician and the patient who has not yet developed, or has lost either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the clinician if he/she were to use ordinary adult language for communication.

(This code replaced 90820)

96100 Psychological testing (includes psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, e.g., by WAIS-R, Rorschach MMPI) with interpretation and report per hour. This code is used primarily by psychologists. Psychiatrists are not usually reimbursed for this procedure.

(Note: 90831 has been deleted. To report, use 99371-99373.)

- 96110 Developmental testing: limited (e.g. Developmental Screening Test II, Early Language Milestone Screen) with interpretation and report
  - Physician work is not required

- 96111 Developmental testing extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments, (e.g. Bayley Scales of Infant Development) with interpretation and report, per hour

**Psychotherapy codes**

The individual psychotherapy codes listed below (90841-44, 90855) may still be honored by a few third party payers, but do not exist in CPT- since 1997.

1. 90841: time unspecified
2. 90842: 75-80 minutes
3. 90843: 20-30 minutes
4. 90844: 45-50 minutes
5. 90855: Interactive individual medical psychotherapy - uses interaction beyond words, i.e. art, play during the therapy

For Medicare billing, however, use only those codes that bundle psychotherapy and E/M services (see below).
Bundled E/M - psychotherapy codes

As a result of administrative pressures, CMS introduced bundled codes in the November, 1996 Final Rule (Department of Health & Human Services, 1996).

- They replaced the five codes listed above for Medicare patients effective January 1, 1997.
- Other insurance companies are adopting the bundled codes. If a claim is electronically submitted to Medicare, Medicare will crosswalk that claim and submit it to any Medigap secondary insurance. The provider will have to submit that claim if filing is not done electronically with Medicare.
- The bundled codes reflect the greater physician work documented in the five-year review process completed by the Relative-Value Update Committee (RUC) in 1996.
- The bundled codes are based on:
  1. Site of service (office vs. inpatient, partial, residential facility)
  2. Face-to-face time with patient
  3. Type of therapy: insight, supportive, cognitive behavioral vs. interactive
  4. Presence or absence of medical evaluation and management services (billed only by primary care providers - M.D., D.O., R.N., Physician Assistant).

- Facility-based patients require more provider work and are reimbursed more than outpatient or office patient visits.

- More face-to-face time requires more work.

- Interactive (play) therapy requires more work than other therapies.

- Additional medical evaluation and management requires more work and reimburses more.

- As a result, there are now 24 codes for individual psychotherapy, 2 codes for group therapy, 3 codes for family therapy and 1 code for pharmacological management.

How to select the correct code

In order to select the correct code, consider the following:

ORIENTATION X 3

- Procedure - What are you doing, and does it include medical evaluation/management services
• Place - Where are you doing it

• Time - How long does it take

**Psychotherapy Procedures**

- Type of Psychotherapy
  - Individual, Insight oriented, Supportive, Cognitive behavioral
  - Interactive
  - Family
  - Group (insight oriented, problem focus, support or interactive)
  - E/M – Evaluation and Medical Management Services
    - Time is **IN ADDITION** to psychotherapy service
    - Billed only by MD, DO, RN, PA

**What is E/M? (Evaluation and Management)**

Evaluation and management consists of the following procedures:

- Medical diagnostic evaluation including diagnosis of co-morbid medical disorders
- Drug management
- Physician orders
- Interpretation of lab or other medical diagnostic tests
- Physical examination

Evaluation and management may be provided as a part of the bundled individual psychotherapy procedures or may be provided strictly as pharmacologic management services without psychotherapy.

**Place (site of service)**

<table>
<thead>
<tr>
<th>Office</th>
<th>Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Office</td>
</tr>
<tr>
<td></td>
<td>Hospital</td>
</tr>
<tr>
<td></td>
<td>Residential Treatment Setting</td>
</tr>
<tr>
<td></td>
<td>Nursing Home</td>
</tr>
</tbody>
</table>

**Time**

- 20 – 30 minutes (**face-to-face** with patient)
- 45 - 50 minutes (**face-to-face** with patient)
- 75 – 80 minutes (**face-to-face** with patient)
### Decision Tree for Psychotherapy

<table>
<thead>
<tr>
<th>With E/M</th>
<th>No E/M</th>
<th>Interactive</th>
<th>No E/M</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>office</strong></td>
<td><strong>facility</strong></td>
<td><strong>office</strong></td>
<td><strong>facility</strong></td>
</tr>
<tr>
<td><strong>Time</strong></td>
<td><strong>20-30 min</strong></td>
<td><strong>20-30 min</strong></td>
<td><strong>20-30 min</strong></td>
</tr>
<tr>
<td><strong>Insight, support</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Interactive</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>With E/M</strong></td>
<td><strong>No E/M</strong></td>
<td><strong>With E/M</strong></td>
<td><strong>No E/M</strong></td>
</tr>
<tr>
<td><strong>20-30 min</strong></td>
<td><strong>90804</strong></td>
<td><strong>90805</strong></td>
<td><strong>90810</strong></td>
</tr>
<tr>
<td><strong>45-50 min</strong></td>
<td><strong>90806</strong></td>
<td><strong>90807</strong></td>
<td><strong>90812</strong></td>
</tr>
<tr>
<td><strong>75-80 min</strong></td>
<td><strong>90808</strong></td>
<td><strong>90809</strong></td>
<td><strong>90814</strong></td>
</tr>
</tbody>
</table>

### Codes for Office-based Psychotherapy

<table>
<thead>
<tr>
<th>Insight, support</th>
<th>Interactive</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No E/M</strong></td>
<td><strong>With E/M</strong></td>
</tr>
<tr>
<td><strong>Time</strong></td>
<td><strong>Time</strong></td>
</tr>
<tr>
<td><strong>20-30 min</strong></td>
<td><strong>20-30 min</strong></td>
</tr>
<tr>
<td><strong>45-50 min</strong></td>
<td><strong>45-50 min</strong></td>
</tr>
<tr>
<td><strong>75-80 min</strong></td>
<td><strong>75-80 min</strong></td>
</tr>
<tr>
<td><strong>90804</strong></td>
<td><strong>90805</strong></td>
</tr>
<tr>
<td><strong>90806</strong></td>
<td><strong>90807</strong></td>
</tr>
<tr>
<td><strong>90808</strong></td>
<td><strong>90809</strong></td>
</tr>
</tbody>
</table>

### Codes for Facility-based Psychotherapy

<table>
<thead>
<tr>
<th>Insight, support</th>
<th>Interactive</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No E/M</strong></td>
<td><strong>With E/M</strong></td>
</tr>
<tr>
<td><strong>Time</strong></td>
<td><strong>Time</strong></td>
</tr>
<tr>
<td><strong>20-30 min</strong></td>
<td><strong>20-30 min</strong></td>
</tr>
<tr>
<td><strong>45-50 min</strong></td>
<td><strong>45-50 min</strong></td>
</tr>
<tr>
<td><strong>75-80 min</strong></td>
<td><strong>75-80 min</strong></td>
</tr>
<tr>
<td><strong>90816</strong></td>
<td><strong>90817</strong></td>
</tr>
<tr>
<td><strong>90818</strong></td>
<td><strong>90819</strong></td>
</tr>
<tr>
<td><strong>90821</strong></td>
<td><strong>90822</strong></td>
</tr>
</tbody>
</table>
**Codes for Family Therapy**

<table>
<thead>
<tr>
<th></th>
<th>Family Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Without Patient</td>
<td>90846</td>
</tr>
<tr>
<td>With Patient</td>
<td>90847</td>
</tr>
<tr>
<td>Multi-family group</td>
<td>90849</td>
</tr>
</tbody>
</table>

**Codes for Group Therapy**

<table>
<thead>
<tr>
<th></th>
<th>Group Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal</td>
<td>90853</td>
</tr>
<tr>
<td>Interactive</td>
<td>90857</td>
</tr>
</tbody>
</table>

**Codes for Pharmacological Management**

- 90862 – pharmacologic management, including prescription, use and review of medication with no more than MINIMAL psychotherapy

E/M codes – choose code based on complexity of the medical management
- 99211
- 99212
- 99213
- 99214
- 99215

**What is this code worth?**
Each code is assigned an RVU (relative value unit)
The RVU is multiplied by a “conversion factor” determined yearly by CMS. The conversion factor for 2004 is $37.3374/RVU. In order to calculate the dollar value of a code, multiply the conversion factor by the total RVU. For 90805, $71.31 or for 90807, $103.80.

**RVU Values for Psychotherapy Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Time (Minutes)</th>
<th>E/M</th>
<th>Physician Work</th>
<th>Total RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>90804</td>
<td>20-30</td>
<td>NONE</td>
<td>1.21</td>
<td>1.74</td>
</tr>
<tr>
<td>90805</td>
<td>20-30</td>
<td>YES*</td>
<td>1.37</td>
<td>1.91</td>
</tr>
<tr>
<td>90806</td>
<td>45-50</td>
<td>NONE</td>
<td>1.86</td>
<td>2.61</td>
</tr>
<tr>
<td>90807</td>
<td>45-50</td>
<td>YES*</td>
<td>2.02</td>
<td>2.78</td>
</tr>
<tr>
<td>90808</td>
<td>75-80</td>
<td>NONE</td>
<td>2.79</td>
<td>3.90</td>
</tr>
<tr>
<td>90809</td>
<td>75-80</td>
<td>YES*</td>
<td>2.95</td>
<td>4.03</td>
</tr>
</tbody>
</table>

*Presence of E/M requires additional time and documentation. It cannot be “worked into” the face-to-face therapy time. Time must be added to the minimal face-to-face therapy time.
### OFFICE, INTERACTICE PSYCHOTHERAPY CODES

<table>
<thead>
<tr>
<th>Code</th>
<th>Time (Minutes)</th>
<th>E/M</th>
<th>Physician Work</th>
<th>Total RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>90810</td>
<td>20-30</td>
<td>NO</td>
<td>1.32</td>
<td>1.86</td>
</tr>
<tr>
<td>90811</td>
<td>20-30</td>
<td>YES*</td>
<td>1.48</td>
<td>2.09</td>
</tr>
<tr>
<td>90812</td>
<td>45-50</td>
<td>NO</td>
<td>1.97</td>
<td>2.82</td>
</tr>
<tr>
<td>90813</td>
<td>45-50</td>
<td>YES*</td>
<td>2.13</td>
<td>2.96</td>
</tr>
<tr>
<td>90814</td>
<td>75-80</td>
<td>NO</td>
<td>2.90</td>
<td>4.09</td>
</tr>
<tr>
<td>90815</td>
<td>75-80</td>
<td>YES*</td>
<td>3.06</td>
<td>4.19</td>
</tr>
</tbody>
</table>

*Presence of E/M requires additional time and documentation. It cannot be “worked into” the face-to-face therapy time. Time must be added to the minimal face-to-face therapy time.

### FACILITY, NON- INTERACTICE PSYCHOTHERAPY CODES

<table>
<thead>
<tr>
<th>Code</th>
<th>Time (Minutes)</th>
<th>E/M</th>
<th>Physician Work</th>
<th>Total RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>90816</td>
<td>20-30</td>
<td>None</td>
<td>1.25</td>
<td>1.75</td>
</tr>
<tr>
<td>90817</td>
<td>20-30</td>
<td>YES*</td>
<td>1.41</td>
<td>1.90</td>
</tr>
<tr>
<td>90818</td>
<td>45-50</td>
<td>NONE</td>
<td>1.89</td>
<td>2.63</td>
</tr>
<tr>
<td>90819</td>
<td>45-50</td>
<td>YES*</td>
<td>2.05</td>
<td>2.76</td>
</tr>
<tr>
<td>90821</td>
<td>75-80</td>
<td>NONE</td>
<td>2.83</td>
<td>3.91</td>
</tr>
<tr>
<td>90822</td>
<td>75-80</td>
<td>YES*</td>
<td>2.99</td>
<td>4.02</td>
</tr>
</tbody>
</table>

*Presence of E/M requires additional time and documentation. It cannot be “worked into” the face-to-face therapy time. Time must be added to the minimal face-to-face therapy time.

### FACILITY, INTERACTICE PSYCHOTHERAPY CODES

<table>
<thead>
<tr>
<th>Code</th>
<th>Time (Minutes)</th>
<th>E/M</th>
<th>Physician Work</th>
<th>Total RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>90823</td>
<td>20-30</td>
<td>NONE</td>
<td>1.36</td>
<td>1.88</td>
</tr>
<tr>
<td>90824</td>
<td>20-30</td>
<td>YES*</td>
<td>1.52</td>
<td>2.05</td>
</tr>
<tr>
<td>90826</td>
<td>45-50</td>
<td>NONE</td>
<td>2.01</td>
<td>2.79</td>
</tr>
<tr>
<td>90827</td>
<td>45-50</td>
<td>YES*</td>
<td>2.16</td>
<td>2.91</td>
</tr>
<tr>
<td>90828</td>
<td>75-80</td>
<td>NONE</td>
<td>2.94</td>
<td>4.09</td>
</tr>
<tr>
<td>90829</td>
<td>75-80</td>
<td>YES*</td>
<td>3.10</td>
<td>4.17</td>
</tr>
</tbody>
</table>

*Presence of E/M requires additional time and documentation. It cannot be “worked into” the face-to-face therapy time. Time must be added to the minimal face-to-face therapy time.

If the therapist is a primary care provider (M.D., D.O., R.N., or P.A.), that person may add an E/M component to the therapy and bill the appropriate bundled code above. That provider must document the E/M service provided. Possible examples include:

- Medical diagnostic evaluation including co-morbid medical diagnoses
- Drug management
The bundled codes were surveyed by the Academy, the American Psychiatric Association, the American Psychological Association, the National Association of Social Workers, and the American Nurses Association for RVU’s, and the RUC accepted the survey recommendations.

**FAMILY PSYCHOTHERAPY CODES**

<table>
<thead>
<tr>
<th>Code</th>
<th>Time</th>
<th>E/M</th>
<th>Physician Work</th>
<th>Total RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>90846</td>
<td>Unspecified</td>
<td>N/A</td>
<td>1.83</td>
<td>2.53</td>
</tr>
<tr>
<td>90847</td>
<td>Unspecified</td>
<td>N/A</td>
<td>2.21</td>
<td>3.09</td>
</tr>
<tr>
<td>90849</td>
<td>Unspecified</td>
<td>N/A</td>
<td>0.59</td>
<td>0.87</td>
</tr>
</tbody>
</table>

**GROUP THERAPY CODES**

<table>
<thead>
<tr>
<th>Code</th>
<th>Time</th>
<th>E/M</th>
<th>Physician Work</th>
<th>Total RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>90853</td>
<td>Unspecified</td>
<td>N/A</td>
<td>0.59</td>
<td>0.85</td>
</tr>
<tr>
<td>90857</td>
<td>Unspecified</td>
<td>N/A</td>
<td>0.63</td>
<td>0.95</td>
</tr>
</tbody>
</table>

**PHARMACOLOGICAL MANAGEMENT CODES**

<table>
<thead>
<tr>
<th>Code</th>
<th>Time</th>
<th>Physician Work</th>
<th>Total RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>90862</td>
<td>Unspecified</td>
<td>0.95</td>
<td>1.37</td>
</tr>
<tr>
<td>99211</td>
<td>No face-to-face</td>
<td>0.17</td>
<td>0.57</td>
</tr>
<tr>
<td>99212</td>
<td>~5 minutes</td>
<td>0.45</td>
<td>0.57</td>
</tr>
<tr>
<td>99213</td>
<td>~10 minutes</td>
<td>0.67</td>
<td>0.1.41</td>
</tr>
<tr>
<td>99214</td>
<td>~15 minutes</td>
<td>1.1</td>
<td>2.2</td>
</tr>
<tr>
<td>99215</td>
<td>~40 minutes</td>
<td>1.77</td>
<td>3.19</td>
</tr>
</tbody>
</table>

**MISCELLANEOUS CODES**

<table>
<thead>
<tr>
<th>Code</th>
<th>Time</th>
<th>Physician Work</th>
<th>Total RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>90845</td>
<td>Psychoanalysis</td>
<td>1.79</td>
<td>2.42</td>
</tr>
<tr>
<td>90865</td>
<td>Narcosynthesis</td>
<td>2.84</td>
<td>4.51</td>
</tr>
<tr>
<td>90870</td>
<td>ECT-single seizure</td>
<td>1.88</td>
<td>2.72</td>
</tr>
<tr>
<td>90871</td>
<td>Unspecified</td>
<td>2.72</td>
<td>3.86</td>
</tr>
</tbody>
</table>
| Code      | Description                                      | Time Range   | Work 
|-----------|--------------------------------------------------|--------------|--------
| 90875     | Biofeedback                                      | 20-30 minutes| 1.2    |
| 90876     | Biofeedback                                      | 45-50 minutes| 1.9    |
| 90880     | Hypnotherapy                                     | Unspecified  | 2.19   |
| 90882     | Environmental Intervention                       | Unspecified  | 0      |
| 90855     | Psychiatric evaluation of records                | Unspecified  | 0.97   |
| 90887     | Consultation with family                         | Unspecified  | 1.48   |
| 90889     | Preparation of report                            | Unspecified  | 0      |
| 90899     | Unspecified psychiatric service                 | Unspecified  | 0      |

**Additional Codes**

- Psychological testing 96100
- Assessment of Aphasia 96105
- Developmental test, limited 96110
- Developmental test, extended 96111
- Neurobehavioral status exam 96115
- Neuropsychological test battery 96117

These codes are primarily used by psychologists, speech therapists and developmental pediatricians.

**CARE PLAN OVERSIGHT**

Code 99374 is used for 15 to 29 minutes per month of physician supervision of patients under the care of home health agencies, who require complex treatment and regular physician attention to care plans, review of patient status reports and tests, communication with other health care professionals, and integration of new information into the medical treatment plan and/or adjustment of medical therapy. 99375 is used for services beyond 30 minutes. The time is cumulative delivered over a 30 day period.

Code 99377 is used to 15 to 29 minutes for a hospice care patient. Code 99378 is used for services beyond 30 minutes. Code 99379 is for 15 to 29 minutes for a nursing facility patient. 99380 is used for services beyond 30 minutes.
HOSPITAL OBSERVATION SERVICES
Code 99217 has been added for observation care discharge day management, and it may be used to report services on any day other than the day of admission. Services include final examination, discussion of the hospital stay, instruction of continuing care, and preparation of discharge records. 99238, hospital discharge management, has been retained and modified to exclude the observation portion.

Code 99218 is used for initial observation care, per day, for the evaluation and management of a patient who requires a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity. Usually the problem(s) requiring admission to "observation status" are of low severity.

Code 99219 is used for initial observation care, per day, when the medical decision making is of moderate complexity. Usually the problem(s) requiring admission are of high severity.

Code 99220 is used for initial observation care, per day when the medical decision making is of high complexity. Usually the problem(s) requiring admission are of high severity.

MODIFIER CODES
Modifier codes are used to document a procedure or service that has been altered in some way due to a specific circumstance, however its definition or code has not been charged.

Specific Modifier Codes

-21 Prolonged E/M service
When face to face or floor time is longer than the highest level of E/M, add this -21 modifier or a separate modifier code 09921. A report may be appropriate.

-22 Unusual Procedural Services
When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier ‘-22’ to the usual procedure number or by use of the separate five digit modifier code 09922. A report may also be appropriate.

-25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Day of a Procedure
The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the usual pre-procedure and post procedure care associated with the procedure
that was performed. This circumstance may be reported by adding the modifier '-25' to the appropriate level of E/M service, or the separate five digit modifier 09925 may be used.

-32 Mandated Services

Services related to mandated consultation and/or related services (e.g., PRO, third party payer) may be identified by adding the modifier '-32' to the basic procedure or the service may be reported by use of the five digit modifier 09932.

-51 Multiple Procedures

When multiple procedures are performed on the same day or at the same session, the major procedure or service may be reported as listed. The secondary additional, or lesser procedure(s) or service(s) may be identified by adding the modifier '-51' to the secondary procedure or service code(s) or by use of the separate five digit modifier code 09951. This modifier may be used to report multiple medical procedures performed at the same session, as well as a combination of medical and surgical procedures, or several surgical procedure performed at the same operative session.

-52 Reduced services

At times the clinician may elect to partially reduce or eliminate parts of a procedure. Use the modifier -52 to report the reduced service. Modifier code 09952 may also be used.

-90 Reference (Outside) Laboratory

When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding the modifier '-90' to the usual procedure number or by use of the separate five digit modifier code 09990.

-99 Multiple Modifiers

Under certain circumstances two or more modifiers may be necessary to completely delineate a service. In such situations modifier '-99' should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service. Modifiers code 09999 may be used as an alternative to modifier '-99'.
PHYSICIAN STAND-BY SERVICES
Code 99360 is used to report each 30 minutes of physician standby services requested by another physician. It involves prolonged attendance without face to face contact, but the physician may not provide care to other patients during this time.

POLYSOMNOGRAPHY
These codes cover the continuous monitoring of various physiological and pathophysiological parameters of sleep for six or more hours, including review, interpretation and report. This monitoring is used to diagnose a variety of sleep disorders and evaluate patient response to therapies such as nasal continuous positive airway pressure (CPAP). For a study to be coded as polysomnography, sleep must be recorded and staged.

Code 95828, which had previously been used to report polysomnography, has been deleted.

Code 95807 should be used for studies that involve 3 or more parameters of sleep other than sleep staging. 95808 is used for studies involving an additional 1 to 3 parameters of sleep, and 95810 is used for studies that include an additional 4 or more parameters of sleep.

PROLONGED SERVICES WITH FACE-TO-FACE CONTACT
New CPT codes for prolonged, face-to-face services have been instituted to replace 99150 and 99151, which have been deleted.

The code series 99354-99357 should be used when a physician provides direct patient contact greater than 30 minutes beyond the usual service. Each of these codes may be reported in addition to other physician services, including evaluation and management services. The series enables physicians to report the total duration of face to face time on a given date, even if the time spent is not continuous. (Use -22 modifier for 0-29 minutes beyond usual service.)

Code 99354 (for outpatient) or 99356 (for inpatient) is used for the first hour of prolonged service on a given date. Either code may also be used to report a total duration of prolonged service of 30-60 minutes on a give date. Either of these codes may be used only once per date.

Code 99355 (for outpatient) or 99357 (for inpatient) is used to report each additional 30 minutes beyond the first hour. Either code may also be used to report the final 15 to 30 minutes of prolonged service on a given date.

PROLONGED SERVICES WITHOUT FACE-TO-FACE CONTACT
Codes 99358 AND 99259 are used when a physician provides prolonged services that do not involve face to face contact, and can only be used when another physician service has been provided, including evaluation and management codes.
Code 99358 is used for the first 30 to 60 minutes of prolonged evaluation and management before and/or after face to face patient contact. Services might include review of extensive records and tests, communication with other professionals, or communication with the family. 99359 is used for each additional 30 minutes.

TEAM MEETINGS
Code 99361(approximately 30 minutes), 99362 (approximately 60 minutes) can be used to code team meetings. Sadly, no carriers pay for this code.

TELEPHONE CALLS
CPT has 3 codes for telephone calls to patient or other health care professionals to co-ordinate care. 99371 is brief. 99372 is intermediate. 99373 is complex or lengthy. No times are specified.

CODING OPTIONS

Pharmacological Management

<table>
<thead>
<tr>
<th>CODE</th>
<th>RVU</th>
<th>MEDICARE $</th>
</tr>
</thead>
<tbody>
<tr>
<td>90862</td>
<td>1.37</td>
<td>$ 51.15</td>
</tr>
<tr>
<td>99213</td>
<td>1.41</td>
<td>52.65</td>
</tr>
<tr>
<td>99214</td>
<td>2.2</td>
<td>82.14</td>
</tr>
<tr>
<td>90805</td>
<td>1.91</td>
<td>71.31</td>
</tr>
<tr>
<td>90807.52</td>
<td>2.78</td>
<td>103.80</td>
</tr>
<tr>
<td>90847</td>
<td>3.09</td>
<td>115.37</td>
</tr>
</tbody>
</table>

Initial Diagnostic Evaluation

<table>
<thead>
<tr>
<th>CODE</th>
<th>RVU</th>
<th>MEDICARE $</th>
</tr>
</thead>
<tbody>
<tr>
<td>90801</td>
<td>4.06</td>
<td>$ 149.35</td>
</tr>
<tr>
<td>90802</td>
<td>4.31</td>
<td>158.55</td>
</tr>
<tr>
<td>99205</td>
<td>4.62</td>
<td>172.50</td>
</tr>
<tr>
<td>99244</td>
<td>4.56</td>
<td>170.26</td>
</tr>
<tr>
<td>99245</td>
<td>5.89</td>
<td>219.92</td>
</tr>
</tbody>
</table>

OTHER SECTIONS OF THE CPT MANUAL

Any physician may utilize, as appropriate, any code from the CPT manual to describe services provided. In particular, child and adolescent psychiatrists may want to review the neurology, consultation, emergency department, domiciliary, preventive medicine and miscellaneous services of the manual for procedures that they may be providing but not currently coding, and therefore not being reimbursed. Child and adolescent psychiatrists may want to pay particular attention to the codes that follow.
REFERENCES


American Medical Association (1992), *The CPT Process* (Booklet)

American Medical Association and Health Care Financing Administration (1997) Documentation Guidelines for Evaluation and Management Services (Approved Draft)


Health Insurance Association of America (1991), *Source Book of Health Insurance Data*


National Advisory Mental Health Council (1993), *Healthcare Reform for Americans with Severe Mental Illnesses*


NOTE

Many of these publications can be ordered from AMA at 1-800-621-8335

http://www.ama-assn.org
PARTIAL GLOSSARY


PHYSICIAN CURRENT PROCEDURAL TERMINOLOGY (CPT) “a list of descriptive terms and identifying codes for reporting medical services and procedures that physicians perform. The purpose of CPT is to provide a uniform language that accurately describes medical, surgical, and diagnostic services, thereby serving as an effective means for reliable nationwide communication among physicians, patients, and third parties” (AMA, 1992).

PHYSICIAN PAYMENT REVIEW COMMISSION (PPRC). A federal advisory body created in 1986 by Congress to design reasonable and rational payments to physicians by Medicare. After three years of study and consultation, the commission recommended that the work of William Hsiao and his colleagues at Harvard University in developing the resource-based relative-value scale be adopted as the method used to revamp the Medicare fee schedule.

RELATIVE-VALUE UPDATE COMMITTEE (RUC) Formed in 1991 to make recommendations to CMS (HCFA) on the relative values to be assigned to new or revised codes in the CPT. It is composed of 28 members; an AACAP member served from 1996-1999 in the non-internal medicine rotating seat. In 1999, the RUC established the PEAC (Practice Expense Advisory Committee) to recommend Practice Expense (PE) Relative Value Units (RVU) for each CPT code to the RUC.

RELATIVE VALUE UNIT (RVU) A unit of measure designed to permit comparison of the amounts of resources required to perform various provider services by assigning weight to such factors as personnel time, level of skill, and sophistication of equipment required to render service.

RESOURCE-BASED RELATIVE VALUE (RBRV) The actual figure or value arrived at in relative, nonmonetary work units (relative value units) that can later be converted into dollar amounts as a means for determining reimbursement for provider (such as physicians and hospital) services. The formula for RBRV for a given service is: RBRV=(TW) (1+RPC) (1+AST), in which TW represents total work input by the provider; PRC is an index of relative specially practice cost; and AST is an index of amortized value for the opportunity cost of specialized training. Total work input is defined by four attributes: time, mental effort and judgment, technical skill and physical effort, and psychological stress.
RESOURCE-BASED RELATIVE-VALUE SCALE (RBRVS) A method of reimbursement under Medicare that attempts to base physician reimbursement on the amount of resources, including cognitive and evaluative skills, required to diagnose and treat conditions. The approach weights what resources, such as practice costs and the cost of specialty training, have gone into the “manufacture” of a service or procedure. Since the 1930's physicians have been paid according to the “customary, prevailing and reasonable” fee for a region of the country, and fee schedules reimbursed disproportionately for procedural services.

FOR MORE INFORMATION: