Coding and Payment Guide for Behavioral Health Services

An essential coding, billing and reimbursement resource for psychiatrists, psychologists and clinical social workers
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HCPCS Level II Codes

HCPCS Level II codes are commonly referred to as national codes or simply by the acronym HCPCS (Healthcare Common Procedure Coding System, pronounced hik piks). HCPCS codes are used to bill Medicare and Medicaid patients and are also used by some third-party payers.

HCPCS Level II codes, updated and published by CMS, are intended to supplement the CPT coding system by including codes for nonphysician services, durable medical equipment (DME), and office supplies. These Level II codes consist of one alphanumeric character (A through V) followed by four numbers. Non-Medicare acceptance of HCPCS Level II codes is idiiosyncratic. Providers should check with the payer before billing these codes. A complete list of the HCPCS Level II codes and the quarterly updates to this code set may be found at http://www.cms.gov/HCPCSReleaseCodeSets/02_HCPCS_Quarterly_Update.asp.

Claim Forms

Institutional (facility) providers use the UB-04 claim form, also known as the CMS-1450 or the electronic 837P format, to file a Medicare Part A claim to Medicare contractors.

Noninstitutional providers and suppliers (private practice or other health care provider’s offices) use the CMS-1500 form or the 837P electronic format to submit claims to Medicare contractors for Medicare Part B covered services. Medicare Part A coverage includes inpatient hospital, skilled nursing facilities (SNF), hospice, and home health. Medicare Part B coverage provides payment for medical supplies, physician, and outpatient services.

Not all services rendered by a facility are inpatient services. Providers working in facilities routinely render services on an outpatient basis. Outpatient services are provided in settings that include rehabilitation centers, certified outpatient rehabilitation facilities, SNFs, and hospitals. Outpatient and partial hospitalization facility claims might be submitted on either a CMS-1500 or UB-04, depending on the payer.

For professional component billing, most claims are filed using ICD-9-CM diagnosis codes to indicate the reason for the service, CPT codes to identify the service provided, and HCPCS Level II codes to report supplies on the CMS-1500 paper claim or the 837P electronic format.

A step-by-step guide for completing the CMS-1500 and UB-04 claim forms and an explanation of the claims filing process can be found in the claims processing section.

Contents and Format of This Guide

The three chapters following this introduction provide information regarding the reimbursement process, documentation, and claim completion, respectively.

The fifth chapter, “Procedure Codes,” contains a numeric listing of procedure codes. Each page identifies the information associated with that procedure including an explanation of the service, coding tips, and associated diagnoses. Please note that this list of associated ICD-9-CM codes is not all inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported. The procedure code page also contains related terms and the CMS Manual System references that designate the official references to the service, which is identified by the procedure code and found in the online manual system. The full excerpt from the online CMS Manual System pertaining to the reference is provided in the Medicare official regulatory information appendix. The full text of all of the Internet-Only Manuals (IOM) may be found at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html. The procedure code pages also have a list of codes from the official Centers for Medicare and Medicaid Services National Correct Coding Policy Manual for Part B Medicare Contractors that are considered to be an integral part of the comprehensive or mutually exclusive coding system and should not be reported separately. Please note that the CCI edits will be updated quarterly and posted on Optum’s website at www.optumcoding.com/cci-edits. Finally, all relative value information relevant to the code is listed at the bottom of the page.

Following this chapter are a procedure code index, a diagnosis code for behavioral health index, HCPCS Level II definitions and guidelines, an appendix that contains Medicare official regulatory information, and a glossary.

How to Use This Guide

The chapters: “The Reimbursement Process,” “Documentation—An Overview,” and “Claims Processing” may be read in their entirety and/or used as references. When using this Coding and Payment Guide for code assignment, follow these important steps to improve accuracy and experience fewer overlooked diagnoses and services:

- **Step 1.** Carefully read the medical record documentation that describes the patient’s diagnosis and the service provided. Remember, more than one diagnosis or service may be documented.
- **Step 2.** Locate the main term for the procedure or service documented in the CPT index. This will identify the procedure code that may be used to report this service.
- **Step 3.** Locate the procedure code in the chapter titled “Procedure Codes.” Read the explanation and determine if that is the procedure performed and supported by the medical record documentation. The Terms to Know section may be used to ensure appropriate code assignment.
- **Step 4.** At this time review the additional CPT coding information found in the coding tips, IOM references, and CCI sections or the Medicare physician fee schedule references.
- **Step 5.** Peruse the list of ICD-9-CM codes to determine if the condition documented in the medical record is listed and the code identified. If the condition is not listed refer to the ICD-9-CM index or ICD-9-CM manual to locate the appropriate code.
- **Step 6.** Determine if any Medicare regulatory information is associated with this code and if so, an excerpt of this information may be found in the appendix titled, “Medicare Official Regulatory Information.”
- **Step 7.** Finally, review the HCPCS Level II section to determine if there are applicable HCPCS Level II codes that may be reported. This section also includes HCPCS Level II modifiers as well as coding tips.
90875-90876

90875 Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); 30 minutes

90876 45 minutes

Explanation

The treating clinician gives individual psychophysiological therapy by utilizing biofeedback training together with psychotherapy to modify behavior. The clinician prepares the patient with sensors that read and display skin temperature, blood pressure, muscle tension, or brain wave activity. The patient is taught how certain thought processes, stimuli, and actions affect these physiological responses. The treating clinician works with the patient to learn to recognize and manipulate these responses, to control maladapted physiological functions, through relaxation and awareness techniques. Psychotherapy is also rendered using supportive interactions, suggestion, persuasion, reality discussions, re-education, behavior modification techniques, reassurance, and the occasional aid of medication. Individual psychophysiological therapy is performed face to face with the patient. Report 90875 for sessions of 30 minutes and 90876 for sessions of 45 minutes.

Coding Tips

These codes have been revised for 2013 in the official CPT description. These procedures may be performed by a physician or other qualified healthcare professional. Check with the specific payer to determine coverage. Most third-party payers, including Medicare, do not provide coverage of biofeedback therapy when used to treat psychiatric conditions. Schizophrenia is not diagnosed unless there is characteristic disturbance of at least two of these areas: thought, perception, mood, conduct, and personality. The first axis of coding schizophrenia is to identify the type (e.g., simple, disordered, paranoid, latent, residual, etc.). Identify the course of illness with a fifth digit, as follows: 0 Unspecified, 1 Subchronic state: continuous for more than six months but less than two years, 2 Chronic state: continuous for more than two years, 3 Subchronic with acute exacerbation: continuous for more than six months but less than two years but psychotic features have resurfaced in patient who has been in residual phase, 4 Chronic with acute exacerbation: continuous for more than two years but psychotic features have resurfaced in patient who has been in residual phase, and 5 In remission: history of schizophrenia but free from symptoms, regardless of whether patient is currently on medication. For category 296, while subcategories identify the type (e.g., manic or major depressive, bipolar, etc.) and episodic nature (e.g., single, recurrent, etc.) of the disorder, the fifth-digit assignment identifies severity of the episode: 0 Unspecified, 1 Mild, 2 Moderate, 3 Severe, without mention of psychotic behavior, 4 Severe, specified as with psychotic behavior, and 5 In partial or unspecified remission. Subcategory 302.5 Transsexualism may be assigned to report a patient’s sex reassignment surgery status, with the appropriate fourth-digit subclassification to specify sexual history, if known. For patients with gender identity disorder (302.85), an additional code should be reported to identify sex reassignment surgery status (302.5X), with the appropriate fourth-digit sexual history designation. Codes in categories 303 Alcohol dependence syndrome, 304 Drug dependence, and 305 Nondependent use of drugs, are reported using fifth-digit subclassifications that more specifically describe the episode of abuse. These are: 0 Unspecified, 1 Continuous, 2 Episodic, and 3 In remission. Physiological malfunction arising from mental factors includes functional disturbances or interruptions due to mental or psychological causes. There is no tissue damage sustained in these conditions. If there is tissue damage, see category 306. Also excluded from this category are dissociative conversion, and factitious disorders (300.11–300.19) and specific nonpsychotic mental disorders following organic brain damage (310.0–310.9). Subcategories are organized by organ system involvement: Musculoskeletal (306.0), Respiratory (306.1), Cardiovascular (306.2), Skin (306.3), Gastrointestinal (306.4), Genitourinary (306.5), Endocrine (306.6), Organs of special sense (306.7), Other specified psychophysiological malfunction, unspecified (306.8), Unspecified psychophysiological malfunction (306.9). For subcategory 306.5, one of the following fifth-digit subclassifications must be assigned: 306.50 Psychogenic genitourinary malfunction, unspecified; 306.51 Psychogenic vaginismus; 306.52 Psychogenic dysmenorrhea; 306.53 Psychogenic dysuria; 306.59 Other. Category 307 is intended for use if the psychopathology is manifested by a single specific symptom or a group of symptoms, which are not part of an organic illness or other mental disorder classifiable elsewhere. Included in this category are the following subcategories: Stuttering (307.0), Anorexia nervosa (307.1), Tic (307.2), Stereotypic movement disorder (307.3), Specific disorders of sleep of nonorganic origin (307.4), Other and unspecified disorders of eating (307.5), Enuresis (307.6), Encopresis (307.7), Pain disorders related to psychological factors (307.8), Other and unspecified special symptoms or syndromes (307.9). Some sleep disorders are not due to a substance or known physiological or pathological condition. These disorders are classified as having a psychophysiological origin, disturbance in sleep environment, paradoxical conditions that exhibit seemingly contradictory aspects and/or idiopathic conditions that are self-originated or on unknown etiology.

Terms To Know

Psychophysiological disorders. Various physical symptoms or types of physiological malfunctions of mental origin, usually manifested in the autonomic nervous system.

ICD-9-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

OMI References

100-1,3,30; 100-1,3,30.1; 100-1,3,30.2; 100-1,3,30.3; 100-2,15,160; 100-2,15,170; 100-4,12,150; 100-4,12,160; 100-4,12,160.1; 100-4,12,170; 100-4,12,170.1; 100-4,12,210

CCI Version 18.3

No CCI Edits apply to this code.

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This section provides an overview of evaluation and management (E/M) services, tables that identify the documentation elements associated with each code, and the federal documentation guidelines with emphasis on the 1997 exam guidelines. This set of guidelines represents the most complete discussion of the elements of the currently accepted versions. The 1997 version identifies both general multi-system physical examinations and single-system examinations, but providers may also use the original 1995 version of the E/M guidelines; both are currently supported by the Centers for Medicare and Medicaid Services (CMS) for audit purposes.

Although some of the most commonly used codes by physicians of all specialties, the E/M service codes are among the least understood. These codes, introduced in the 1992 CPT® manual, were designed to increase accuracy and consistency of use in the reporting of levels of non-procedural encounters. This was accomplished by defining the E/M codes based on the degree that certain common elements are addressed or performed and reflected in the medical documentation.

The Office of the Inspector General (OIG) Work Plan for physicians consistently lists these codes as an area of continued investigative review. This is primarily because Medicare payments for these services total approximately $32 billion per year and are responsible for close to half of Medicare payments for physician services.

The levels of E/M services define the wide variations in skill, effort, and time and are required for preventing and/or diagnosing and treating illness or injury, and promoting optimal health. These codes are intended to represent physician work, and because much of this work involves the amount of training, experience, expertise, and knowledge that a provider may bring to bear on a given patient presentation, the true indications of the level of this work may be difficult to recognize without some explanation.

At first glance, selecting an E/M code may appear to be difficult, but the system of coding clinical visits may be mastered once the requirements for code selection are learned and used.

**Providers**

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, the service or procedure itself is not limited to use only by that specialty group (see paragraphs 2 and 3 under “Instructions for Use of the CPT Codebook” on page x of the CPT book). Additionally, the procedures and services listed throughout the book are for use by any qualified physician or other qualified health care professional or entity (e.g., hospitals, laboratories, or home health agencies).

The use of the phrase “physician or other qualified health care professional” (OQHCP) was adopted to identify a health care provider other than a physician. This type of provider is further described in the CPT code book as an individual “qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable)” State licensure guidelines determine the scope of practice and a qualified health care professional must practice within these guidelines, even if more restrictive than the CPT guidelines. The qualified health care professional may report services independently or under incident-to-guidelines. The professionals within this definition are separate from “clinical staff” and are able to practice independently. The CPT code book defines clinical staff as “a person who works under the supervision of a physician or other qualified health care professional and who is allowed, by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service.” Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

**Types of E/M Services**

When approaching E/M, the first choice that a provider must make is what type of code to use. The following tables outline the E/M codes for different levels of care for:

- Office or other outpatient services—new patient
- Office or other outpatient services—established patient
- Hospital observation services—initial care, subsequent, and discharge
- Hospital inpatient services—initial care, subsequent, and discharge
- Observation or inpatient care (including admission and discharge services)
- Consultations—office or other outpatient
- Consultations—inpatient

The specifics of the code components that determine code selection are listed in the table and discussed in the next section. Before a level of service is decided upon, the correct type of service is identified.

Office or other outpatient services are E/M services provided in the physician or other qualified health care provider’s office, the outpatient area, or other ambulatory facility. Until the patient is admitted to a health care facility, he/she is considered to be an outpatient.

A new patient is a patient who has not received any face-to-face professional services from the physician or other qualified health care provider within the past three years. An established patient is a patient who has received face-to-face professional services from the physician or other qualified health care provider within the past three years. In the case of group practices, if a physician or other qualified health care provider of the exact same specialty or subspecialty has seen the patient within three years, the patient is considered established.

If a physician or other qualified health care provider is on call or covering for another physician or other qualified health care provider, the patient’s encounter is classified as it would have been by the physician or other qualified health care provider who is not available. Thus, a locum tenens physician or other qualified health care provider who sees a patient on behalf of the patient’s attending physician or other qualified health care provider may not bill a new patient code unless the attending physician or other qualified health care provider is responsible for close to half of Medicare payments for physician services.