BCA's Behavioral Health Non-Prescriber Visit Code Recipe Card

A. Psychiatric Diagnostic Evaluation (PDE) *[Done by qualified non-medical clinician]*	
90791	PDE by non-medical clinician, e.g. LCSW *(See back of card for documentation)*

C. Psychotherapy Encounter *See CPT definition (back)*		Time	Range
90832	Choose therapy code based on face-to-face time.	30 minutes	*16-37 min*
90834	Patient must be present for all, or most, of the visit.	45 minutes	*38-52 min*
90837	Identify therapy modalities used in your note.	60 minutes	*53 -89 min*
+99354	Prolonged psychotherapy *(may code only with 90837)*	30-74 additional min.	
90853	Group psychotherapy (not family). Sessions typically last 1-2 hours for 2+ patients. Identify theme and topic of group session, number of attendees, individual patient interaction/participation, individual patient barriers if present, unique A/P with plan for follow-up.		

E. Psychotherapy for Crisis *Review CPT* *See also HCPCS S9484*	
Complex... life threatening... high distress... immediate attention... mobilization of resources... Include mental status exam... Include some psychotherapy	
90839	First documented 60 minutes of intervention
+90840	each additional 30 minutes

G. Health Behavior Assessment & Intervention (HBAI)	
Review CPT guidelines. Focus of this service is not 'mental health' - diagnosis addressed is relative to biopsychosocial factors influencing physical health.	
Health Behavior Assessment or Re-Assessment	
96156	Health behavior assessment or re-assessment *[any amount of time]*
Health Behavior Intervention All face-to-face	
96158	Health behavior intervention, **individual,** initial 30 minutes
+96159	each additional 15 minutes
96164	Health behavior intervention, **group (2 or more patients),** initial 30 min.
+96165	each additional 15 minutes
96167	Health behavior intervention, **family with patient present,** initial 30 min.
+96168	each additional 15 minutes
96170	Health behavior intervention, **family, w/o patient present,** initial 30 min.
+96171	each additional 15 minutes

B. Psychotherapy w/patient and/or family	
90846	Family therapy, patient not present
90847	Family and patient present
Note present themes & observations, etc. *Time defined as 50 mins; Must be ≥ 26 mins.*	

D. Interactive Complexity (during visit) *Add-on code*	
+90785	Mngmnt of maladaptive communications For example: Play therapy to overcome communication barriers. Documentation should include evidence/disclosure of sentinel event.

F. Virtual Communication Code FQHCs/RHCs	
G0071	Virtual Communication 5 or > minutes Do NOT use if related to a billable visit past 7 days, or shall be seen within 24 hrs or a next available appt.

H. HCPCS Level II Codes *for service w/o a code* **$$?**	
Check with Medicaid & other payers. Codes below may or may not be reimbursed. These codes can serve as excellent tracking codes to identify services.	
H0031	Mental health Asset., by non-physician
H0004	Beh health counseling/ threapy ea. 15 min
H2027	Psychoeducation service per 15 min.
H2028	MN service, not specified
H0032	MH plan development
90899	Unlisted psychiatric service

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BCA's Behavioral Health Non-Prescriber Visit Code Recipe Card (Back)

CPT Definition for "Psychotherapy"

"Psychotherapy is the treatment of mental illness and behavioral disturbances in which the physician or other qualified health care professional, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development."

Basic Elements of a Psychiatric Diagnostic Evaluation (PDE)	Basic Elements of a Psychotherapy Visit
1. **Title Note** "Psychiatric Diagnostic Evaluation"	1. **Title Note** "Psychotherapy Visit"
2. **Reason For Visit** "Requested by PCP XXXXXX because..."	2. **Reason for visit** "FU for... Urgent concern... New problem..."
3. **History** Full psychiatric/behavioral history, Social history, Family history, Medical history as appropriate	3. **HPI** (Hx Present Illness) - ***How are*** *problems, from the patient's point of view, since the last visit?*
4. **Examination** (MSE)/Your observations today	4. **Observations/Exam** MSE (as appropriate)
5. **Data** Such as PHQ9, GAD-7 etc. & Outside Record Review w/summa	5. **Data** PHQ9, GAD-7, Other records (as appropriate)
6. **Current Med List** (as applicable) Identify prescriber	6. **Psychotherapy** Document your evidence of therapy provided
7. **Assessment A/P** [Diagnosis/Diagnoses]	***Best Practice*** *name therapy modality, "CBT utilized today..."*
List 1st the most significant diagnosis today	***Best Practice*** Include current status of Dx *stable/improved/worse*
If multiple psychiatric diagnoses, so indicate/list	***Best Practice*** Note reason for Dx change (DSM, PHQ *your reason)*
List other Dx not managed by you, affect your care, e.g. substance	7. **Plan** Your plan for continued care, homework, pt. activities...
If you are not treating Dx, indicate "as managed by..."	***Best Practice*** Indicate patient willingness and their plan...
*Note any rule-out conditions, but assign only signs/symptom cod	***8. Best Practice*** **"Collaboration/Management" - *Plan*** subsection
8. **Plan** Note any need for other evaluation	*Consider making this a subsection in the "Plan" section of note.*
9. ***Best Practice*** **" Collaboration/Management"** *("Plan" subsection)*	*Communicate with your "Care Managers."*
Communicate with your new "Care Managers" resources	9. **Treatment Plan update**
10. **Treatment Plan Developed Today**	10. **Today's Actual Time** - not pre-published in EMR w/code
Best Practice Indicate patient acceptance (or not) of plan	***Best Practice*** *Document as Start/Stop Time*

Coding and Documentation Reminders/tips

Tip#1: Each note should tell a clear story: Why is the patient here today (f/u on depression)? How have they been since last visit? What occurred during the encounter? How did the clinician engage? Clinical impression of todays presentation? What is the plan moving forward?

Tip#2: Document evidence of improvement, or lack thereof, to support communication/collaboration and ongoing therapy.

Tip #3: The patients problem list should contain the most accurate and specified definitive chronic conditions. Update PRN.