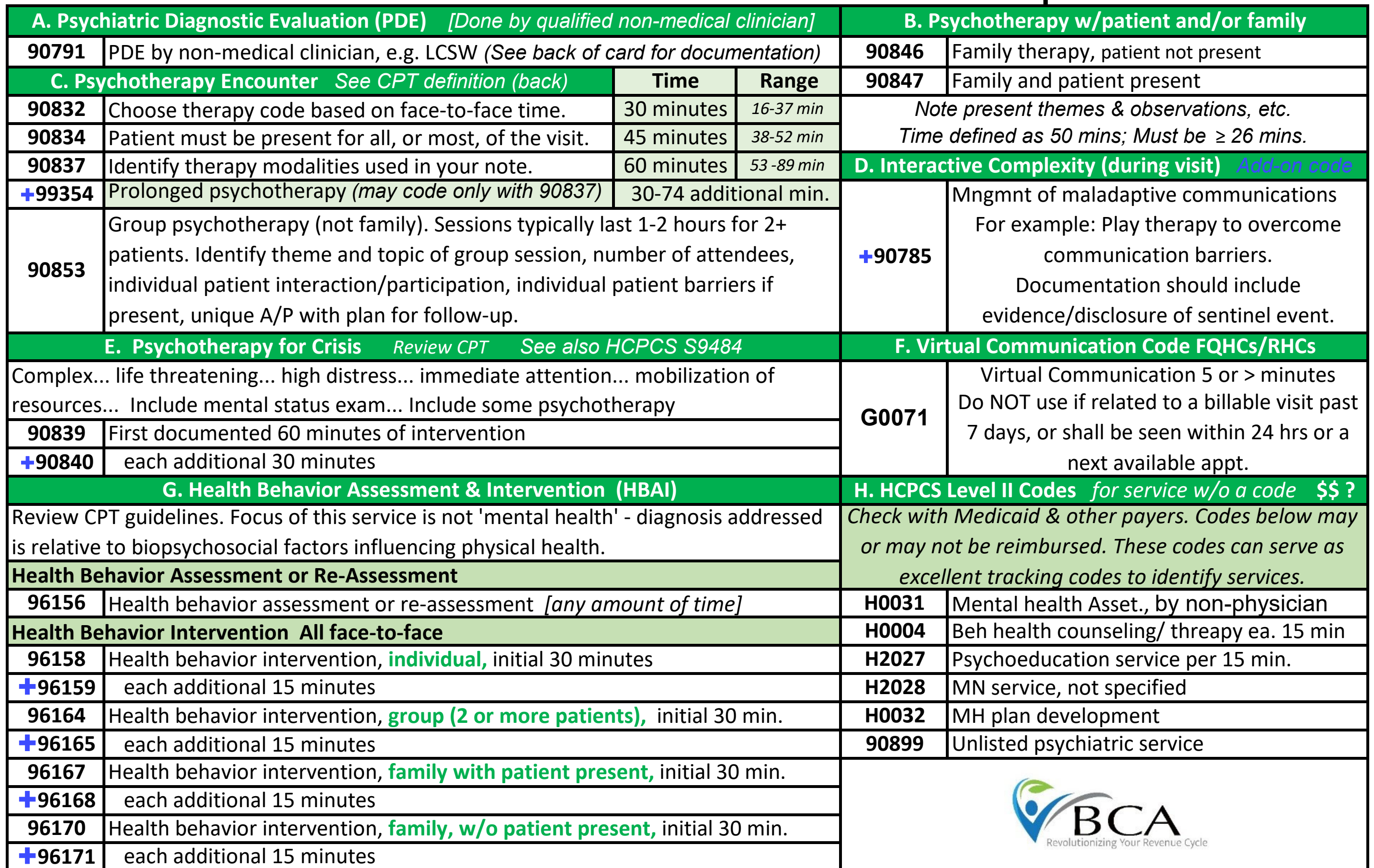
BCA's Behavioral Health Non-Prescriber Visit Code Recipe Card



A. Psychiatric Diagnostic Evaluation (PDE) *[Done by qualified non-medical clinician]*

Code	Description
90791	PDE by non-medical clinician, e.g. LCSW *(See back of card for documentation)*

C. Psychotherapy Encounter *See CPT definition (back)*

Code	Description	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.		

B. Psychotherapy w/patient and/or family

Code	Description
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*

Code	Description
+90785	Mngmnt of maladaptive communications For example: Play therapy to overcome communication barriers. Documentation should include evidence/disclosure of sentinel event.

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

Code	Description
90839	First documented 60 minutes of intervention
+90840	each additional 30 minutes

F. Virtual Communication Code FQHCs/RHCs

Code	Description
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.

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

Code	Description
96156	Health behavior assessment or re-assessment *[any amount of time]*

Health Behavior Intervention All face-to-face

Code	Description
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

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.

Code	Description
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

BCA
Revolutionizing Your Revenue Cycle

© BCA, Inc. 2009-2022 kerri@codinghelp.com Revised May 2022

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)

1. **Title Note** "Psychiatric Diagnostic Evaluation"
2. **Reason For Visit** "Requested by PCP XXXXXX because..."
3. **History** Full psychiatric/behavioral history,
   Social history, Family history, Medical history as appropriate
4. **Examination** (MSE)/Your observations today
5. **Data** Such as PHQ9, GAD-7 etc.
6. **Outside Record Review** (list and summarized)
7. **Current Med List** (as applicable) Identify prescriber
   Assign diagnoses with greatest detail level appropriate
   List 1st the most significant diagnosis today
   If multiple psychiatric diagnoses, so indicate/list
   List other Dx not managed by you, affect your care, e.g. substance
   If you are not treating Dx, indicate "as managed by..."
9. **Plan** Note any need for other evaluation
10. ***Best Practice*** **" Collaboration/Management"** *("Plan" subsection)*
    Communicate with your new "Care Managers" resources
11. **Treatment Plan Developed Today**
    Best Practice Indicate patient acceptance (or not) of plan

Basic Elements of a Psychotherapy Visit

1. **Title Note** "Psychotherapy Visit"
2. **Reason for visit** "FU for... Urgent concern... New problem..."
3. **HPI** (Hx Present Illness) - ***How are*** *problems, from the patient's point of view, since the last visit?*
4. **Observations/Exam** MSE (as appropriate)
5. **Data** PHQ9, GAD-7, Other records (as appropriate)
6. **Psychotherapy** Document your evidence of therapy provided
   Best Practice *name therapy modality, "CBT utilized today..."*
   Best Practice Include current status of Dx *stable/improved/worse*
   Best Practice Note reason for Dx change (DSM, PHQ *your reason)*
8. **Plan** Your plan for continued care, homework, pt. activities...
   Best Practice Indicate patient willingness and their plan...
9. ***Best Practice*** **"Collaboration/Management" - *Plan*** subsection
   Consider making this a subsection in the "Plan" section of note.
   Communicate with your "Care Managers."
10. **Treatment Plan update**
11. **Today's Actual Time** - not pre-published in EMR w/code

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.

© BCA, Inc. 2009-2022 kerri@codinghelp.com Revised May 2022