Billing, Coding, Auditing, Revenue Cycle Training by BCA

Tough Topics in FQHC 10: Behavioral Health Overview

OBJECTIVES

Psychiatric Diagnostic Evaluations

- Purpose
- Documentation Requirements

Treatment Plans

Psychotherapy

- Individual
- Interactive Complexity
- Psychotherapy for Crisis

Health and Behavior Assessments and Interventions

BCA Behavioral Health Non-Prescriber Recipe Card

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)*

B Psychotherapy Encounter *See CPT definition (right)*		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.	

C 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

D Psychotherapy w/patient and/or family			Time
90846	Family therapy, patient not present	*Note those present, themes, observations, etc.*	50 min.
90847	Family and patient present		50 min.

E Health Behavior Assessment & Intervention (HBAI)	
Review CPT. Focus of service is not 'mental health' - 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

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."

Review full coding detail in CPT Code Book

F Interactive Complexity (during visit) *Add-on code*	
+90785	Need to manage maladaptive comm Play therapy to overcome comm barrier Evidence/disclosure of sentinel event

G Virtual Communication Code FQHCs/RHCs	
G0071	Virtual Communication 5 or> minutes ***NO*** if r/t billable visit past 7 days, or shall be seen within 24 hrs or a next available appt. **Review current Medicare info before using**

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.
H0046	MN service, not specified
H0032	MH plan development
90899	Unlisted psychiatric service

BCA Behavioral Health Non-Prescriber Recipe Card (Back)

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

I Collaboration / Care Management Codes: ***Services are directed by, and billed by, the managing PCP - MD, DO, NP, PA, CNM***

Detailed Coding and Documentation Requirements Must be Reviewed (Expect Changes)

CPT Codes for Care Management for Behavioral Health (Read CPT)	
99484	Clinical staff management facilitation, coordinating & communicating details of patient care (20 min/month)

FQHC/RHC Gen. Care Mgt/BH Integration (BHI Care Mngt.)	
G0511	Clinical staff management facilitation, coordinating & communicating details of patient care (20 min/month)

CPT Codes for Psychiatric Collaborative Care Management (PCCM)	
99492	Initial PCCM Assmt./coordination - 1st month, 1st 70 min.
99493	PCCM duties during follow-up months, 1st 60 min./month
+99494	Add-on to 99492/99493 for each additional 30 min./month

FQHC/RHC Psychiatric Collaborative Care Model Mngt. [CoCM]	
G0512	Clinical staff management [collaboration, facilitation, communication, in consultation w/psychiatric consultant] (60 minutes or more, per calendar month)

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
8. **Assessment A/P** [Diagnosis/Diagnoses]
   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..."
7. **Assessment** Diagnosis/Diagnoses *to the greatest code detail*
   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

Psychiatric Diagnostic Evaluation (PDE)

Components, CPT Documentation, See also CPT and Payer Policy

Comprehensive history

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
8. **Assessment A/P** [Diagnosis/Diagnoses]
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

- **One-visit service code**

State when incomplete and more time needed...

- **No coding time guidelines**
- **Culminates in Treatment Plan & Recommendations**

.Past psychiatric history includes meds and treatments

.Medical history

.Family history

.Personal history (traumas, developmental issues, etc.)

Psychiatric Diagnostic Evaluation (PDE)

CPT Documentation, See also CPT and Payer Policy Continued

Mental status examination
(and observations)

Data PHQ, GAD, etc. – with your interpretation

Disposition

Special record reviews
(as needed)

Assessment - Diagnoses

Ordering/interpretation of Dx/other lab studies

Collaboration with others

Treatment Plan, Recommendations and Goals

Common Audit Findings

PDE reported when diagnoses are well-established

No plan for care documented

Simply refers to next encounter plans

PDE takes more than one visit – why?

- Ran out of time
- Multiple informants
- Treatment plan development
  - Psychoeducation?
  - Teaching coping skills?

Many Payers Allow PDE's Annually

Purpose is to assess whether additional factors influence current diagnostic picture

- New trauma?
- New life circumstances?
- New medical concerns influencing behavioral health?
- Assessing need for ongoing care/care types?

The Treatment Plan

Minimal Fundamental Elements: Employ Internal Policy and Procedure

Based on assessment [e.g. Psychiatric Diagnostic Evaluation, PDE] goals, treatment priorities & milestones

Geared toward the individual's needs

Includes long-term goals

Includes measurable goals

Signed consent that patient/guardian agrees to Treatment Plan Includes estimated time frames and treatment frequency

Includes identification of collaborative care team

Is reviewed and updated on a regular basis

Lack of updated Treatment Plan can be the source of third-party payer audit liability

Sample Requirements from Payers

01 The treatment plan must be geared towards the individual member's needs and include treatment goals in the member's own words.

02 There must be documentation that the member or legal guardian has agreed to the treatment plan. Member and, when applicable, family involvement in treatment must be documented.

03 The treatment plan must be consistent with the diagnosis, member strengths and functional needs, as well as include objective and measurable short and long-term goals with time frames for goal attainment. The plan must also include an initial discharge plan.

04 Treatment plan updates occur when goals are achieved, or new problems are identified.

Psychotherapy, CPT Definition

"Psychotherapy is the treatment for 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." (CPT 2022)

1. Specify therapy time
2. Identify therapy modality
3. Illustrate therapy modality
4. Note expected outcome, homework, reinforce FU, work with other team members

B	Psychotherapy Encounter *See CPT definition (right)*	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.	

BCA Psychotherapy 12-Step Documentation Program

01 Clearly label notes "Psychotherapy"

02 Chief Complaint/Reason for visit, initial or follow-up (If new, who referred and why)

03 Your observations and/or exam (MSE)

04 Major themes of therapy today [modalities such as CBT]

05 Skills used to produce therapeutic change

06 Patient's interpersonal/intraverbal changes

07 Functional status (Impairment, severity/complexity of illness)

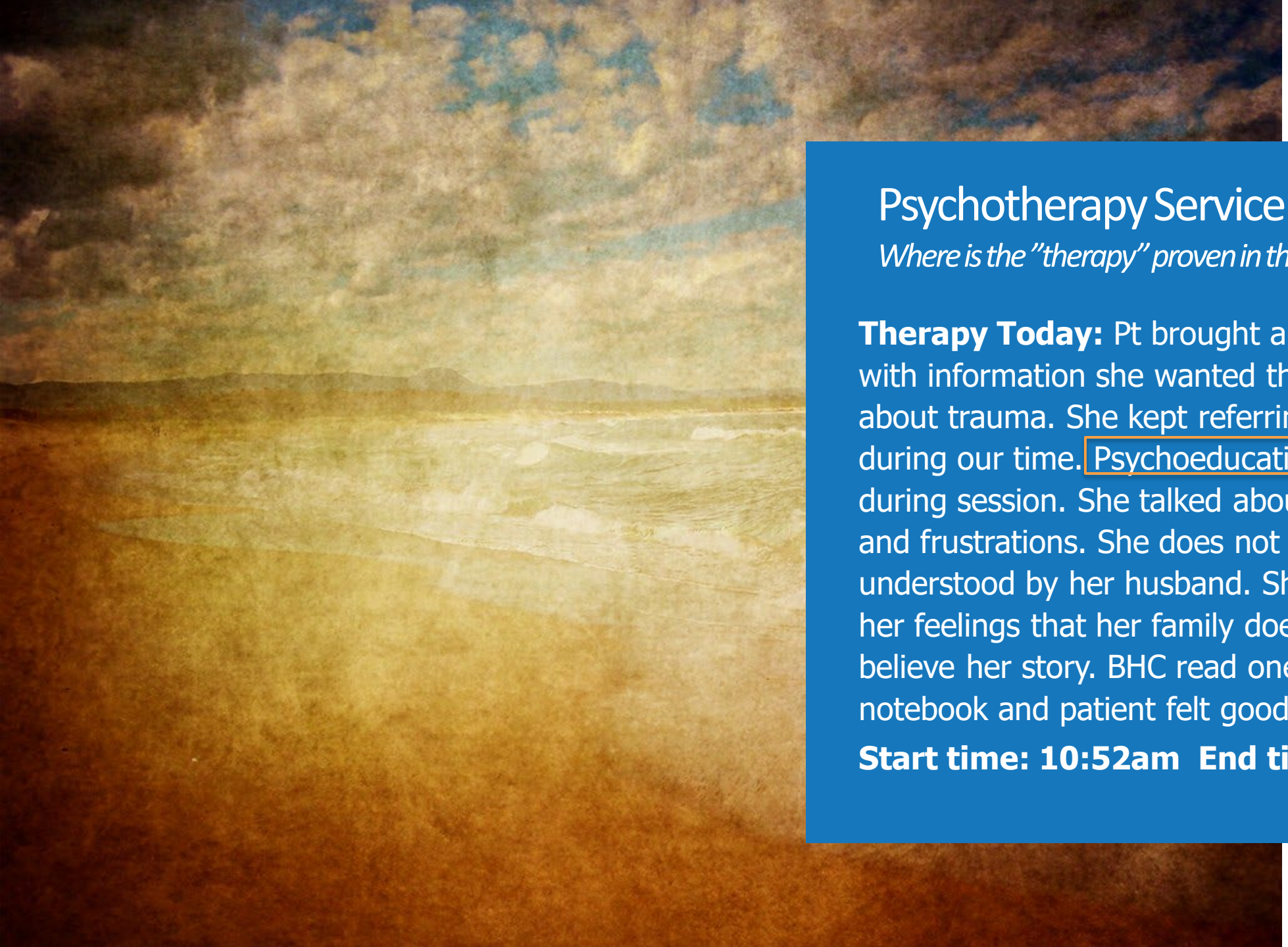
08 Assessment w/Dx treated today [improved, worsening?] Include also diagnoses that affect your care today

09 Progress toward goals

Homework and other expected self-care

11 Compliance with treatment plan

12 Actual time face-to-face (length of session) –Some payers want start/stop time

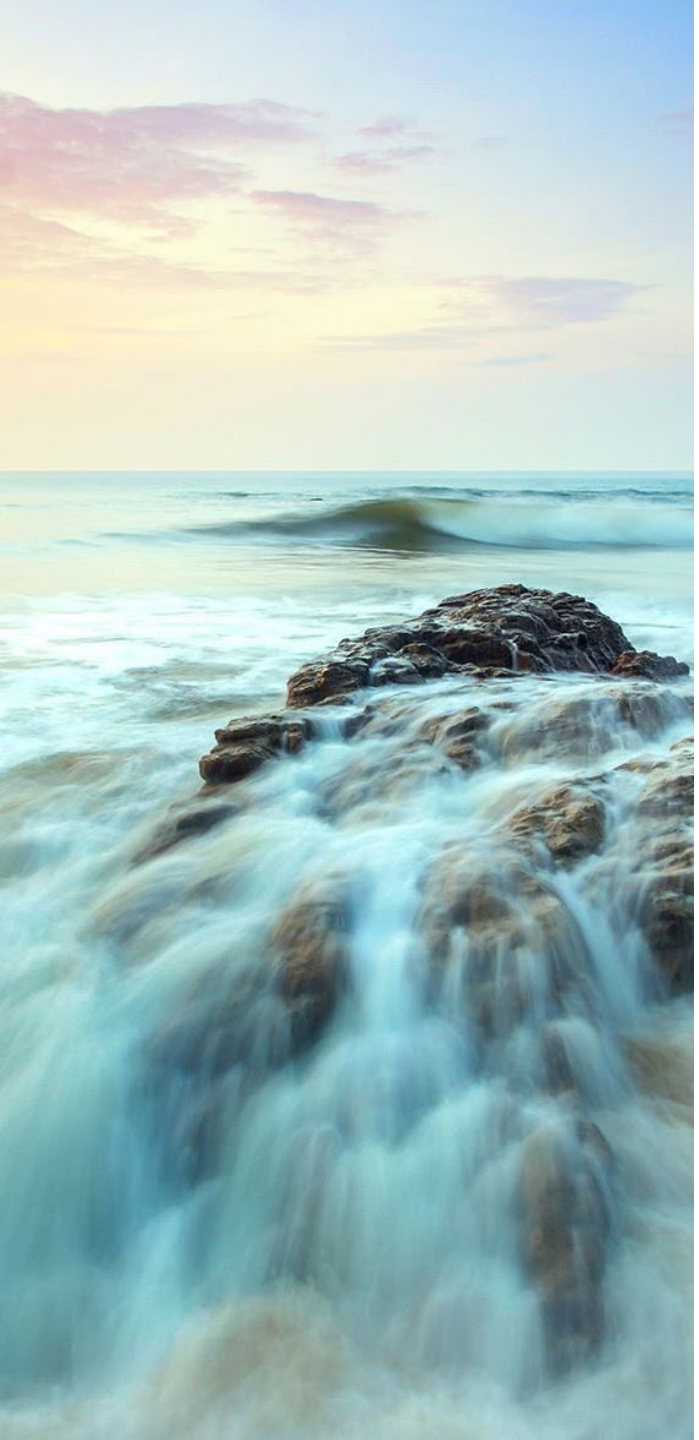


Psychotherapy Service

Where is the "therapy" proven in the note below?

Therapy Today: Pt brought a notebook filled with information she wanted the BHC to read about trauma. She kept referring to pages during our time. Psychoeducation and CBT during session. She talked about her stressors and frustrations. She does not think she is understood by her husband. She talked about her feelings that her family does not fully believe her story. BHC read one page of notebook and patient felt good about that.

Start time: 10:52am End time: 11:35am



Psychotherapy Service

Identify the documented FTF time and evidence of therapy

Therapy Today: Pt brought a notebook filled with information she wanted the BHC to read about recent trauma. BHC provided psychoeducation related to re-traumatization and trauma treatment course. Using CBT, facilitated processing of psychosocial stressors. We discussed her frustration at not feeling understood or that she can talk about recent assault. BHC encouraged her to discuss trauma when she is in WOT *[window of tolerance]* and she can process.
We discussed and processed feelings and thoughts related to above. BHC read one page of notebook and discussed her thoughts/feelings about sharing experience.
Start time: 10:52am End time: 11:35am

Action **Terms Give "Life".. to "Modality" Terms**

- **BHC *provided* PE, r/t.. Re-traumatization**
- ***Facilitated* process…**
- **BHC *encouraged*…**
- **BHC *discussed*…**

Common Audit Findings

Diagnosis(es) being treated today is unclear

Time isn't clearly captured

Modality is suggested, but not named

Application of modality isn't clear

Plan for follow-up isn't identified

Treatment plan hasn't been referenced in several months

Treatment plan cannot be found in EMR

General Behavioral Health Medical Record Documentation Requirements

Behavioral Health services must meet specific requirements for reimbursement. Documented services must:

To the extent required under State law, reflect medical necessity and justify the treatment and clinical rationale (remember, each State adopts its own medical necessity definition);

To the extent required under State law, reflect active treatment;

Be legible, signed, and dated;

Be maintained and available for review;

Be complete, concise, and accurate, including the face-to-face time spent with the patient (for example, the time spent to complete a psychosocial assessment, a treatment plan, or a discharge plan);

Be coded correctly for billing purposes.

Meet that State's Medicaid program rules;

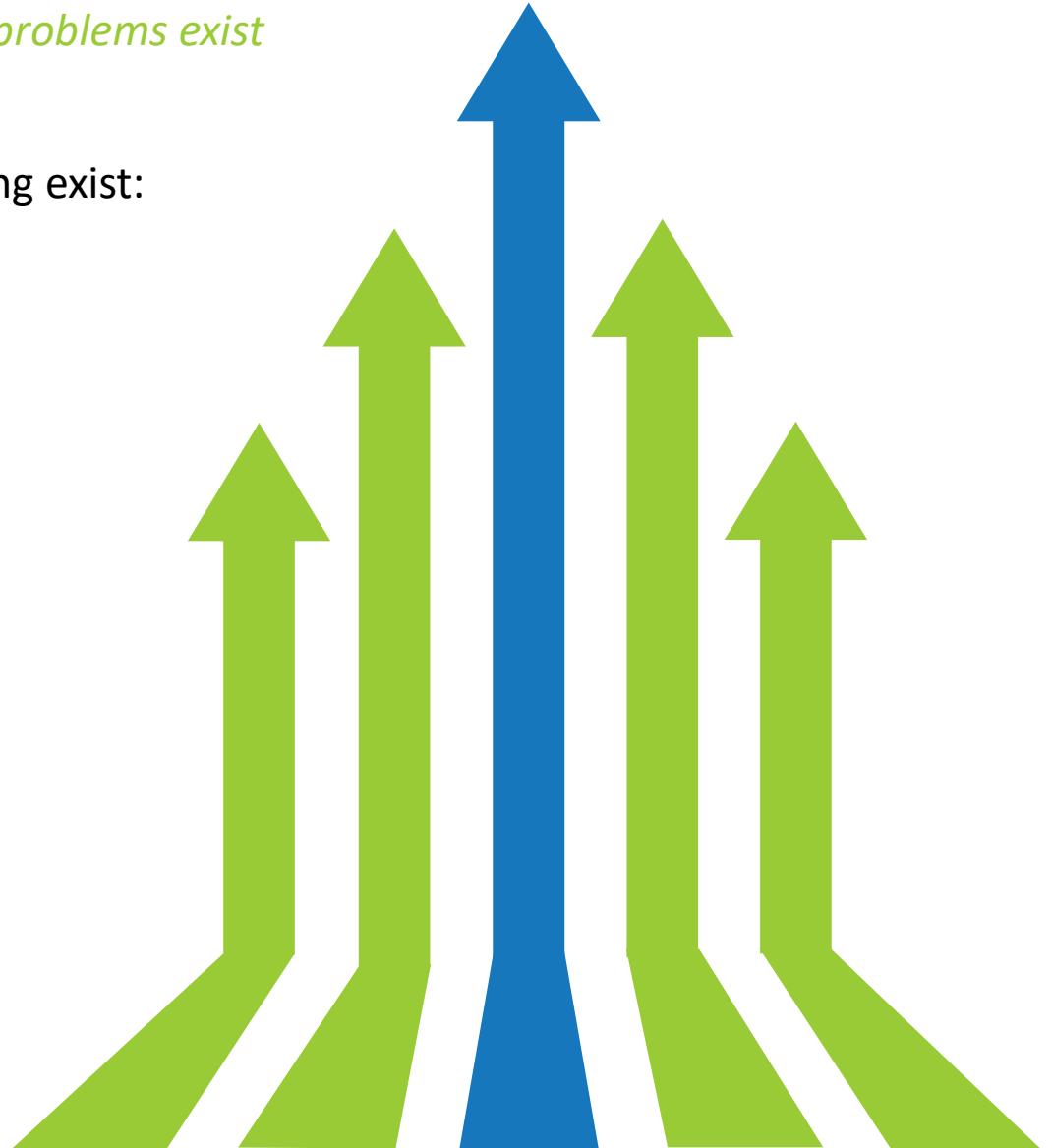
Interactive Complexity +90785

Add-on code, do not report this code alone. Reimbursement problems exist

Report with other psychiatric codes when one of the following exist:

- Use of play equipment, other physical devices, therapeutic or diagnostic interaction between the clinician and a patient who: Has not 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 typical language for communication…

F Interactive Complexity (during visit) *Add-on code*	
+90785	Need to manage maladaptive comm Play therapy to overcome comm barrier Evidence/disclosure of sentinel event



Interactive Complexity +90785

...continued

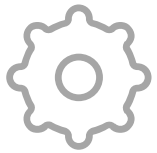
The need to manage maladaptive communication (related to, e.g. high anxiety, high reactivity, repeated questions or disagreement) among participants that complicate delivery of care.

Caregiver emotions or behavior interfering with caregiver's understanding/ability to assist in implementation of treatment plan.

Evidence or disclosure of sentinel event and mandated report to third party (e.g. abuse/neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.

Interactive Complexity is Used in Conjunction With

The following psychiatric "primary procedures":



90791, 90792

Psychiatric diagnostic evaluation

90832, 90834, 90837

Psychotherapy

When performed with psychotherapy, the interactive complexity component (90785) relates only to the increased work intensity of the psychotherapy service and does not change the time for the psychotherapy service.

90833, 90836, 90838

Psychotherapy add-on codes when reported with E/M

90853

Group psychotherapy

Psychotherapy for Crisis 90839

Problem is typically life-threatening or complex

Patient is in high distress

Minimum of 30 minutes

Requires immediate attention

Clinician provides psychotherapy, mobilizes resources to defuse crisis and restore safety

If more than 74 minutes add +90840

C	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		

Family Psychotherapy

- Focus on Family Dynamics
- Must meet at least 26 minutes of psychotherapy
- Same documentation requirements as individual psychotherapy

D	Psychotherapy w/patient and/or family		Time
90846	Family therapy, patient not present	*Note those present, themes, observations, etc.*	50 min.
90847	Family and patient present		50 min.

Health and Behavioral Assessment/Interventions

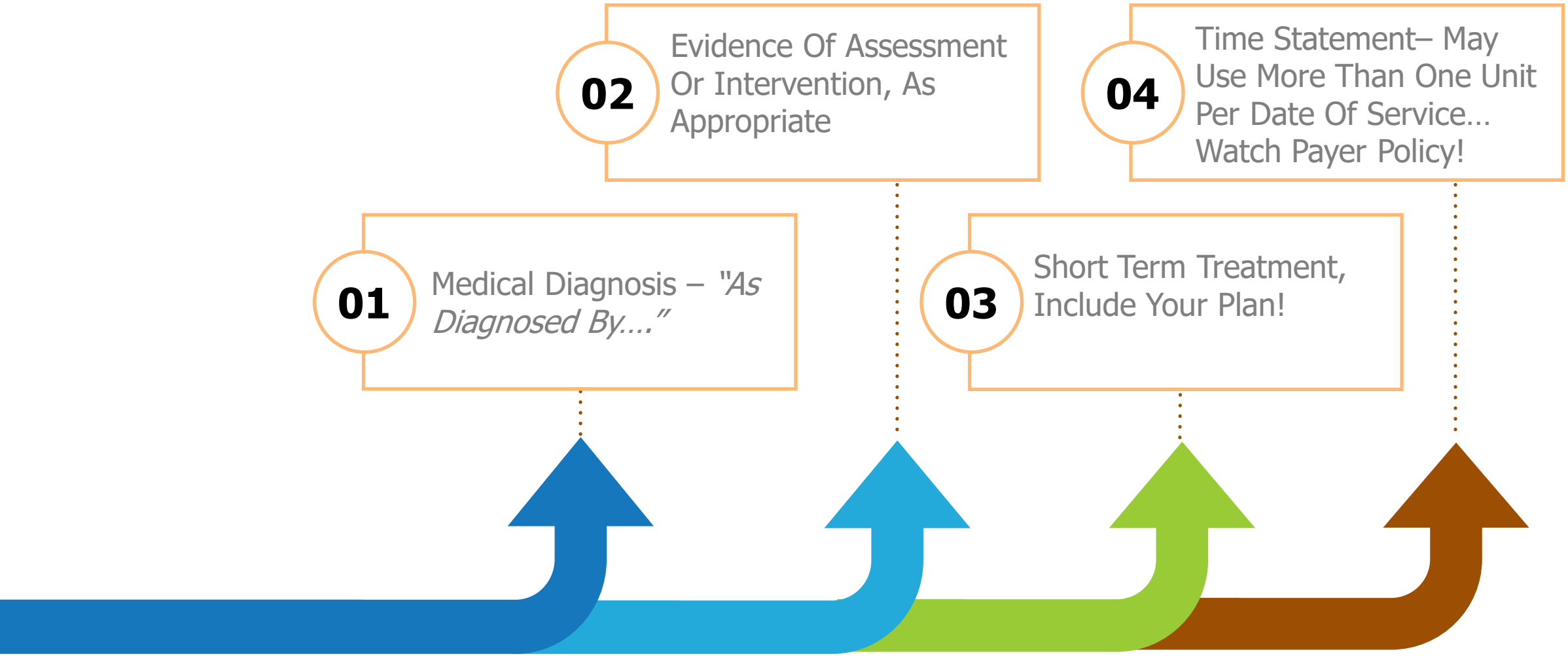
CPT HBAI Codes 96156-96171

E Health Behavior Assessment & Intervention (HBAI)	
Review CPT. Focus of service is not 'mental health' - 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

HBAI Coding Tips

1. Time-based codes
2. 96156 = Assessment/Reassessment
3. 96158 – 96171 = Intervention
4. Non-physicians use these codes
5. If physician performs this same work, it is coded to E/M visit codes.
6. TIP: Do not assign same date as Psychiatry services. Code the predominate service.

HBAI Must-Haves



HBAI Example Note

27 minutes documented

PCP requested visit with 9 yo with new Dx of Type 1 diabetes. Allowed child to share his fear of shots, blood sugar testing & "disease". He doesn't want his peers to know "something is wrong". Validated feelings for this significant change, reinforced facts, dismissed fiction & educated with options for discreet testing/injections at school. Gave mom titles of excellent books for children with diabetes to help him process and normalize responses.

Patient will benefit from a couple more visits eval/intervention re: acceptance and self-care. He will see me on 14th after PCP visit. He and Mom have outline for discussions, she will help him journal these and bring to next session.

Assessment: Type 1 DM as diagnosed by Dr. Smith. FU planned.

Tell Your Story

Every visit record/note tells a story

The beginning of the story...

- CC (Chief Complaint) & HPI (Hx of present illness)
- Status of patient since you last saw them?

What did you see?

- Exam/Observation

Tell Your Story

Every visit record/note tells a story

What did you do about what you heard and what you saw?

- Today's therapeutic intervention? Plans for follow-up?

How do you define what you saw?

- The Assessment (diagnoses) with your comments
- The status of treated problems, next steps with other clinicians(s) e.g., *MDD, moderate, "stable & improving"*
- Collaboration

When will you get them back for the next chapter?

- Your Plan and goals, always with the patient's goal and view of progress

Questions?

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