Behavioral Health Services

An essential coding, billing, and reimbursement resource for psychiatrists, psychologists, and clinical social workers.
Introduction

Coding systems and claim forms are part of the reality of modern health care. This Coding and Payment Guide provides a comprehensive look at the coding and reimbursement systems used by behavioral health providers. It is organized topically and numerically, and can be used as a comprehensive coding and reimbursement resource and as a quick lookup resource to solve coding problems.

Coding systems grew out of the need for data collection. By having a standard notation for the procedures performed and for the diseases, injuries, and illnesses diagnosed, statisticians could identify effective treatments as well as broad practice patterns. Before long, these early coding systems emerged as the basis to pay claims. Coding systems and claim forms have evolved to become the basis of reimbursement for health care services. The correct application of codes and knowledge of payer policies correlates directly to payment.

The administrative simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 required the standardization of the several hundred health care claim formats previously in existence as well as the establishment of standardized code sets for medical data including diagnoses, drugs, procedures, equipment, and supplies. The goal of the national standards is to reduce the administrative encumbrances of the existing system; simplify the way medical claims are paid, reducing costs; and promote the growth of electronic business in the health care industry.

This Coding and Payment Guide provides a comprehensive explanation of the coding and reimbursement systems used for behavioral health services.

Coding Systems

Coding systems seek to answer two questions: what was wrong with the patient (i.e., the diagnosis or diagnoses) and what was done to treat the patient (i.e., the procedures or services rendered).

Under the aegis of the federal government, a three-tiered coding system emerged for physician offices and outpatient facilities. Physicians’ Current Procedural Terminology (CPT®) codes report procedures and physician services and comprises Level I of the system. A second level, known informally as HCPCS largely report supplies, nonphysician services, and pharmaceuticals. Dovetailing with each of these levels is the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) classification system that reports the diagnosis of illnesses, diseases, and injuries. Further explanations of each of these coding systems follows.

HCPCS Level I or CPT Codes

The Centers for Medicare and Medicaid Services (CMS), in conjunction with the American Medical Association (AMA), the American Dental Association (ADA), and several other professional groups, developed, adopted, and implemented a coding system describing services rendered to patients. Known as HCPCS Level I, the CPT coding system is the most commonly used system to report medical services and procedures. Copyright of CPT codes and descriptions is held by the AMA. This system reports outpatient and provider services.

The three categories of CPT codes predominantly describe medical services and procedures, and are adapted to provide a common billing language that providers and payers can use for payment purposes. The codes are required for billing by both private and public insurance carriers, managed care companies, and workers’ compensation programs. A requirement of HIPAA is that CPT codes are used for the reporting of physician and other health care services.

The AMA’s CPT Editorial Panel reviews the coding system and adds, revises, and deletes codes and descriptions. The panel accepts information and feedback from providers about new codes and revisions to existing codes that could better reflect the services.

The majority of codes are found in Category I of the CPT coding system. These five-digit numeric codes describe procedures and services that are customarily performed in clinical practices.

CPT Category II codes are supplemental tracking codes that are primarily used when participating in the Physician Quality Reporting System (PQRS) established by Medicare and are intended to aid in the collection of data about quality of care. At the present time, participation in this program is optional and physicians should not report these codes if they elect not to participate. Category II codes are alphanumeric, consisting of four digits followed by an F and should never be used in lieu of a Category I CPT code. This series of codes is updated on a biannual basis (January 1 and July 1), with codes that are released becoming effective six months later (e.g., codes released on January 1 become effective July 1). Refer to the AMA CPT website at http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt/category-ii-codes.page.

Category III of the CPT coding system contains temporary tracking codes for new and emerging technologies that are meant to aid in the collection of data on these new services and procedures. Category III codes are indicated by four numeric digits followed by a T. Like Category II codes, Category III CPT codes are released twice a year (January 1 and July 1) and can be found on the on the AMA CPT website. Relative value units (RVUs) are not assigned for these codes, and payment is made at the discretion of the local payer. Once implemented, a service described by a Category III CPT code may eventually become a Category I code. The most current list of these codes can be found at http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt/category-iii-codes.page.

ICD-10-CM Codes

In response to ICD-9-CM’s shortcomings, new coding systems were developed and have been implemented in the United States. The World Health Organization (WHO) created and adopted ICD-10 in 1994 and it has been used in much of the world since then. This system is the basis for the new U.S. diagnosis coding system, International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) effective October 1, 2015.

The ICD-10-CM coding system is an alphanumeric system and allows for up to seven digits to be assigned to describe a disease or injury. Generally, the reason the patient seeks treatment should be sequenced first when multiple diagnoses are listed.
Cocaine

Explanation
Cocaine is a refined derivative of the coca plant and is a frequently abused drug. Specimen can be blood or urine. This test may be requested as a qualitative, quantitative, or combination analysis for cocaine. Methods used for analysis include gas-liquid chromatography (GLC) and gas chromatometry/mass spectrometry (GC/MS). This is a definitive drug test, meaning methods of testing would not be performed by enzymatic or immunoassays.

Coding Tips
This code is a resequenced code and will not display in numeric order. For presumptive drug testing, see the appropriate code from the 80300–80304 code range.

ICD-10-CM contains combination poisoning codes that include not only the poisoning itself and the type of poison involved, but also the associated intent (i.e., accidental, intentional self-harm, assault, and undetermined).

Documentation Tips
Documentation must include the laboratory results to support reporting this service.

Medical record documentation must, at a minimum, include signs and symptoms supporting the ordering of this service.

Reimbursement Tips
Medicare reimburses this service under the laboratory fee schedule.

Terms To Know
qualitative. To determine the nature of the component of substance.
quantitative. To determine the amount and nature of the components of a substance.

ICD-10-CM Diagnostic Codes

F14.10 Cocaine abuse, uncomplicated
F14.120 Cocaine abuse with intoxication, uncomplicated
F14.122 Cocaine abuse with intoxication with perceptual disturbance
F14.159 Cocaine abuse with cocaine-induced psychotic disorder, unspecified
F14.180 Cocaine abuse with cocaine-induced anxiety disorder
F14.181 Cocaine abuse with cocaine-induced sexual dysfunction
F14.188 Cocaine abuse with other cocaine-induced disorder
F14.20 Cocaine dependence, uncomplicated
F14.21 Cocaine dependence, in remission
F14.220 Cocaine dependence with intoxication, uncomplicated
F14.221 Cocaine dependence with intoxication delirium
F14.222 Cocaine dependence with intoxication with perceptual disturbance
F14.229 Cocaine dependence with intoxication, unspecified
F14.23 Cocaine dependence with withdrawal
F14.24 Cocaine dependence with cocaine-induced mood disorder
F14.250 Cocaine dependence with cocaine-induced psychotic disorder with delusions

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Medicare Edits

Modifiers

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* with documentation
**G0176**

Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient’s disabling mental health problems, per session (45 minutes or more)

**Explanation**

Activities engaging a patient in music, dance, art creations, or any type of play, not as recreation but as therapeutic processes for the care and treatment of a patient with disabling mental health problems, are reported using these codes. Every session should last 45 minutes or more.

**Coding Tips**

See also 90785 to report the use of play equipment, other physical devices, or a translator to communicate with a patient as a means to overcome communication barriers.

**Documentation Tips**

Documentation should clearly indicate the type of interactive methods used, such as the use of play, or physical device used, and that the patient did not have the ability to communicate through normal verbal means.

**Reimbursement Tips**

This service is for outpatient reporting and is not paid under the Medicare physician fee schedule. Special coverage instructions apply to this service. Check with third-party payers to determine their specific requirements.

**Terms To Know**

Interactive psychotherapy. Use of physical aids and nonverbal communication to overcome barriers to therapeutic interaction between a clinician and a 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 or she were to use ordinary adult language for communication.

**ICD-10-CM Diagnostic Codes**

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

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**Medicare References**

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**G0177**

Training and educational services related to the care and treatment of patient’s disabling mental health problems per session (45 minutes or more)

**Explanation**

Training and educational services are therapeutic procedures related to the care and treatment of patient’s disabling mental health problems. The goal is to alleviate patient discomfort and allow the patient to cope or control mental health issues. Each session should be 45 minutes or more.

**Coding Tips**

To report training of activities of daily living, see 97535 and 99509. To report cognitive skills training, see 97532. Community or work reintegration is reported using 97537.

**Documentation Tips**

All entries to the medical record should be dated and authenticated.

**Reimbursement Tips**

This service is for outpatient reporting and is not paid under the Medicare physician fee schedule. Special coverage instructions apply to this service. Check with third-party payers to determine their specific requirements.

**ICD-10-CM Diagnostic Codes**

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

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**Medicare References**

Modifiers Medicare References

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Evaluation and Management Services

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 represent 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 $33.5 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 xii 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 CPT 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. CPT 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 has not seen the patient for any problem within three years.

Hospital observation services are E/M services provided to patients who are designated or admitted as “observation status” in a hospital.

Codes 99218-99220 are used to indicate initial observation care. These codes include the initiation of the observation status, supervision of patient care including writing orders, and the performance of periodic