TRAINING
HANDOUTS

Online Training:

Stop Costly Telehealth Mental Health Billing Errors and Payer Audits

HEALTHCARE TRAINING LEADER®
Expert Medical Practice Solutions

Presented by:
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About Your Experts

Stephanie Allard, CPC, CEMA, RHIT

Senior Compliance Specialist for Doctors Management

Stephanie Allard is a Senior Compliance Specialist for Doctors Management. She is a multi-specialty auditor with proficiency in more than 40 specialties including, but not limited, to orthopedics, cardiology, vascular, neurology, general surgery, OB/GYN, PM&R, and PT/OT. In addition to performing external audit reviews, Stephanie provides feedback and education to help clients implement practices and strategies that will reduce risk in the future. She also performs forensic auditing that includes focused reviews to be used in court cases.

Stephanie brings more than a decade of medical and management experience and a strong understanding of the entire medical billing and coding process. She has managed large teams of coders and understands the importance of quality reviews, productivity tracking and coding education. Clients appreciate that Stephanie stays current with the ever-changing regulations and is able to convey new information in a way that helps improve their overall results. She often provides guidance and support to other coding professionals.

Stephanie holds the Certified Professional Coder (CPC®), the Certified E&M Medical Auditing (CEMA®), and the Registered Health Information Technician (RHIT®) designations. She is an active member of the National Alliance of Medical Auditing Specialists (NAMAS), the American Health Information Management Association (AHIMA) and the American Academy of Professional Coders (AAPC).

When she's not solving complex coding and auditing cases, Stephanie can be found volunteering at their local church with her husband and two daughters. She also enjoys family adventures to local lakes and rivers.

Expert Online Training for Your Healthcare Practice

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Expert: Expert: Stephanie Allard, CPC, CEMA, RHIT

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Mental Health Services

- Providers of mental health services
- Non-Physician Practitioners (NPP)
- Teaching Physicians
- Diagnostic evaluations - documentation requirements and used for prescription drug management
- Multiple providers billing for an evaluation on the same DOS
- Coding E/M in place of a diagnostic evaluation
- Psychotherapy services
- E/M on the same day as psychotherapy
- Psychotherapy for crisis
- Psychological and neuropsychological testing
- Developmental screenings
- Neurobehavioral status exam
- Health and behavior assessment and intervention

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Providers of Psychiatric Services

- Medicare recognizes the following suppliers who are eligible under Part B to furnish diagnostic and/or therapeutic treatment for mental, psychoneurotic, and personality disorders:
  - Physicians (medical doctors [MD] and doctors of osteopathy [DO]), particularly psychiatrists
  - Clinical psychologists (CP)
  - Clinical social workers (CSW)
  - Clinical nurse specialists (CNS)
  - Nurse practitioners (NP)
  - Physician assistants (PA)
  - Independently Practicing Psychologists (IPP)
- Other providers of mental health services ***licensed or otherwise authorized by the state in which they practice*** (e.g., licensed clinical professional counselors, licensed marriage and family therapists) may be able to bill incident to.

Source: https://www.cms.gov/files/document/medicare-mental-health.pdfs

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Non-Physician Practitioners (NPP)

- *For approved providers of mental health services, the state licensure or authorization must specify that the provider's scope of practice includes the provision of clinical psychotherapy for the treatment of mental illness. It is the responsibility of providers to be aware of their own state licensure laws and written agreements or protocols required, including changes as they occur.*
- Psychiatrists, Clinical Psychologists (CP), Clinical Social Workers (CSW), psychiatric nurse practitioners (PNPs), Clinical Nurse Specialists (CNS) and Physician Assistants (PA) may provide all psychotherapy services described in this section ***with the following exceptions:***
  - Clinical Social Workers may not render inpatient services (defined as inpatient hospital settings, partial hospitalization settings or SNF homes for beneficiaries who are at that time receiving benefits under Medicare Part A payment for skilled services) represented by these CPT codes: 90832, 90833, 90834, 90836, 90837, 90838, and 90785
  - CNSs may not render psychoanalysis (CPT code 90845) services
  - **MDs, DOs, qualified CNSs, nurse practitioners and PAs are the only providers that may render psychotherapy codes that include an E/M component** (CPT codes 90833, 90836, 90838)

Source: https://www.novitas-solutions.com/webcenter/content/conn/UCM_Repository/uuid/dDocName:00171101
https://www.cms.gov/medicare-coverage-database/details/lcd-details.asp

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"Incident To"

- **Outpatient Setting** – *Incident to is not followed in the inpatient setting*
- Must be an integral part of the patient's normal course of treatment originating from an initial visit with a physician or other NPP that remains actively involved in the course of treatment
- The services and supplies are an expense to the physician or other listed NPP
- The services and supplies are commonly offered in the physician's or other listed NPP's office or clinic
- The physician or other listed NPP furnishes direct supervision, which means they are present in the office suite and immediately available if needed

Source: https://www.cms.gov/files/document/medicare-mental-health.pdf

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Teaching Physicians

- The teaching physician supervising the resident must be a physician
  - The Medicare teaching physician policy does not apply to psychologists who supervise psychiatry residents in approved graduate medical education (GME) programs
- Time-based services
  - For procedure codes determined on the basis of time, **the teaching physician must be present for the period of time for which the claim is made**
  - Do not add time spent by the resident in the absence of the teaching physician to time spent by the resident and teaching physician with the beneficiary or time spent by the teaching physician alone with the beneficiary
- Keep an eye on the attestation statements the teaching physicians are documenting, the typical "I saw and examined patient and agree with plan" etc. will not always support time based codes

Source: https://www.cms.gov/files/document/medicare-mental-health.pdf

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Psychology Graduates

- We need to know if the psychology graduate is working within an approved GME program through CMS
  - If your providers work in a teaching facility there usually is an approved residency program for psychiatrists, but it is not common to see one for psychologist
- We need to consider the types of services being rendered and the extent of the supervision
  - Remember that CPT codes do have requirements for the type of provider who may render each service
    - A psychology graduate is not licensed and not credentialed
  - Is the supervising provider physically there with this graduate? Or is the graduate rendering the service alone?
    - The only way for the services to be billable is if the supervising provider is personally rendering the service and the graduate just observes

Definition of a Qualified Healthcare Professional - A physician or other qualified health care professional' is an individual who is qualified by education, training, licensure/regulation (when applicable) and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.

**You will need to check your individual payers as sometimes they have guidance written into their policies stating that they will pay for this scenario, but a majority of the payers do not and CMS will not reimburse.*

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Psychiatric Diagnostic Evaluation

90791 Psychiatric diagnostic evaluation
90792 Psychiatric diagnostic evaluation with medical services

- Psychiatric diagnostic evaluations can be conducted once, at the onset of an illness or suspected illness
- The evaluation may be repeated for the patient if an extended break in treatment occurs
  - Example: admission to an inpatient status for a psychiatric illness or for a significant change in mental status requiring further assessment
- The intent of this service is for the provider to perform a psychiatric evaluation of the patient with the goal of making a diagnosis
  - In order to assign the code 90792 the visit would need to include medical services in addition to the diagnostic evaluation
    - Example of medical services: prescriptions, monitoring of medication effects, co-morbid medical conditions evaluated, and results of clinical tests.
- Included in the psychiatric diagnostic evaluation:
  - Collecting information about the present and past behavior concerns
  - Gathering of past, family medical and social history
  - Diagnostic testing
- This can be used for new patients or established patients that require a re-evaluation
- Can only be billed once per day regardless of the number of times the provider sees the patient and regardless of the total time spent with the patient on that date of service
- Codes 90791 and 90792 are typically used in place of an E/M service as their documentation requirements are less restrictive

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Diagnostic Evaluation with Medical Services for Prescription Drug Management

- The CPT 90792 is to be used to further diagnosis the patient; it would not be appropriate to use this for prescription management only
  - If the diagnostic evaluation includes prescription management, then 90792 is supported
- Included in the psychiatric diagnostic evaluation:
  - Collecting information about the present and past behavior concerns
  - Gathering of past, family medical and social history
  - Diagnostic testing
  - This can be used for new patients or established patients that require a re-evaluation
  - Can only be billed once per day regardless of the number of times the provider sees the patient and regardless of the total time spent with the patient on that date of service
- The other problem you may run into using 90792 for prescription management is the frequency that it is billed
  - Both of the eval codes 90791 90792 can be billed for a re-evaluation, but the documentation must show an extended break in treatment occurs, if the patient requires admission to an inpatient status for a psychiatric illness, or for a significant change in mental status requiring further assessment
  - If prescription management is the only service rendered an E/M should be billed instead

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Multiple Psych Evaluations on the Same DOS

- Credentialing – Do not just add a modifier -25 to clear the claim edits
  - Are they a part of the same group? Are they credentialed under the same specialty?
    - Remember not all payers will credential subspecialties
- If the providers are in the same group and credentialed within the same specialty, they cannot both bill for their evaluation, only one can be billed on that DOS
- If the providers are from different specialties review the documentation to determine what services they are rendering and what codes should be billed (E/M vs. diagnostic evaluation)
- Remember coverage for the diagnostic interview is limited to physicians (MDs, DOs), Clinical Social Workers (CSWs), Clinical Psychologists (CPs), Clinical Nurse Specialists (CNSs), Physician Assistants (PAs) and Nurse Practitioners (NPs) certified in the state or jurisdiction for psychiatric services.

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Multiple Psych Evaluations on the Same DOS

- If you run codes 90791 and 90792 along an E/M through an NCCI edit checker you will see that they are bundled and in red meaning they can never be billed together.

CCI Validation Results:

Code 99223 is a column 2 code for 90791. You may not override the edit.
CCI Edit Rule:
CPT Manual or CMS manual coding instructions

Code 99223 is a column 2 code for 90792. You may not override the edit.
CCI Edit Rule:
CPT Manual or CMS manual coding instructions

Code 90791 is a column 2 code for 90792. You may not override the edit.
CCI Edit Rule:
HCPCS/CPT procedure code definition

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Coding an E/M Instead of a Diagnostic Evaluation

Key Components
Depending on setting 2 out of 3 required or 3 out of 3 required

- History
- Exam (single organ system exam on next slide)
- Medical Decision Making

- **Contributing Factors**
  - Nature of Presenting Problem
  - Medical Necessity

Acute Outpatient Setting

- **Level 5** – An acute problem that poses a threat to the patient's (or others) life or bodily function during the encounter on this DOS
  - Transfer for evaluation in ER or admission by a different specialty or emergency intervention in the clinic for crisis
- **Level 4** – The problem includes complicating factors contributing to the complexity of the care provided to the patient on this DOS
- **Level 3** – The problem is uncomplicated in presentation to the provider
- **Level 2** – The problem is minimal in presentation and it could be questioned as to why the patient need to be seen

Chronic Outpatient Setting

- **Level 5** – A chronic problem that poses a threat to the patient's (or others) life or bodily function during the encounter on this DOS
  - Transfer for evaluation in ER or admission by a different specialty or emergency intervention in the clinic for crisis
- **Level 4** – A chronic problem that is exacerbated or 2+ chronic problems
- **Level 3** – One chronic stable problem without an exacerbation
- **Level 2** – The problem is minimal in presentation and it could be questioned as to why the patient need to be seen

BOX C: Risk of Complication and/or Morbidity or Mortality			
	Presenting Problems	Diagnostic Procedures ordered	Management Options Selected
Minimal		• Lab tests requiring venipuncture • EKG/EEG • Urinalysis	• Rest
Low	• 1 stable chronic illness • Acute uncomplicated illness or injury	• Clinical lab test requiring arterial puncture	• Over-the-counter drugs
Moderate	• 1 or more chronic illnesses w/mild exacerbation, progression or side effects of treatment • Undiagnosed new problem w/ uncertain prognosis		• Prescription drug management
High	• 1 or more chronic illnesses w/ severe exacerbation, progression, side effects of treatment • Injury/condition that pose a threat to life or bodily function (self or others) • Abrupt change in neurologic status	THE ONE ELEMENT IN THE HIGHEST LEVEL IS THE LEVEL OF RISK	• Drug therapy requiring intensive monitoring for toxicity

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Psychotherapy Documentation Requirements

Documentation Requirements - General

- All documentation must be maintained in patient's medical record
- Every page of the record must be legible and include appropriate identification of the patient
- Must support ICD-10-CM code(s) and must be a covered diagnosis code under the LCD guidelines
- Medical Necessity must be supported
- Total number of timed minutes must be documented
- Appropriate patient identification information consists of complete name and dates of service(s).
- The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient.

Documentation Requirements – Specific for Psychotherapy Services

- Time spent in the psychotherapy encounter
- Therapeutic maneuvers
- All the following elements should be contained in or readily inferred from the medical record:
  - 1. Time spent 2. Type of service 3. Results of clinical tests 4. Summary of: diagnosis, functional status, treatment plan, symptoms, prognosis, progress, and progress to date 5. Therapeutic techniques and approaches, including medications 6. Clearly identify the person performing the service (including title, education background)
- For interactive therapy, the medical record should indicate adaptions utilized and rationale for employing these interactive techniques
- For services that include an E/M component, the E/M services should be documented

https://www.novitas-solutions.com/webcenter/content/conn/UCM_Repository/uuid/dDocName:00171101

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Time

- The CPT "TIME RULE" applies
  - A unit of time is attained when the mid-point is passed
  - If the time is more than half the time of the code, then, the code is used
  - For example, an hour is attained when 31 minutes have elapsed (more than midway between zero and sixty minutes)
- Do not report psychotherapy codes for any session lasting less than 16 minutes
  - Remember, if applicable, the teaching physician must be present for the period of time for which the claim is made

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Psychotherapy Services with Patient

Without an E/M Service

- ***90832*** *Psychotherapy, 30 minutes with patient*
- ***90834*** *Psychotherapy, 45 minutes with patient*
- ***90837*** *Psychotherapy, 60 minutes with patient*

With an E/M Service

- ***+90833*** *Psychotherapy, 30 minutes with patient when performed with an E/M service*
- ***+90836*** *Psychotherapy, 45 minutes with patient when performed with an E/M service*
- ***+90838*** *Psychotherapy, 60 minutes with patient when performed with an E/M service*

Interaction between a trained professional and patient on issues related to mood, behavior, feelings, and thoughts, also referred to as talk therapy
The provider involves the patient to explore the thoughts, feelings, and behavior of the patient
Multiple techniques can be used relationship building, communication, and behavior change that target improvement of the mental health of the patient

Time Thresholds

- 90832 and 90833 [“30 minutes”] (16 to 37 minutes)
- 90834 and 90836 [“45 minutes”] (38 to 52 minutes)
- 90837 and 90838 [“60 minutes”] (53+ minutes)

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Psychotherapy with Patient

Time In/Out: 1610 to 1715 **90837 - 65 minutes documented**

Goals of Therapy: Decrease OCD symptoms by providing education, CBT and Exposure and Response Prevention therapy; support parent with shifting response to OCD at home and encouraging child to participate in weekly exposure practice.

Focus of Session: The psychologist met with Joseph individually to follow up on his OCD and the homework completion since his last session. He initially was tired and had trouble engaging. Went for a walk to help wake him up. Once walking, Joseph was more engaged. He shared that he has been doing a better job controlling his whistling and it has helped reduce the urge. When asked what has helped him fight back to the OCD, he shared that it is his fear that he will have to write his name in the book (a disciplinary action at school). The psychologist expressed that it seems that the consequences is something that works in his favor. He agreed and shared that kids find the whistling really annoying so it is good that he has stopped it. He struggled, however, to identify areas that he feel confident in fighting back against his OCD. Specifically, it was mentioned that he wanted to work on fighting back the eye blinks and glances in specific directions. He seemed to have forgotten that this was a goal and shared he did not engage in the homework practice. Overall, he expressed feeling that he has slight improvement with his OCD. He also did not present information or content in today's session to help him engage in a new exposure. Instead, he was very stuck and fixated on an upcoming camping trip and how he only wants to ruin everyone's time since they are making him go. He demonstrated angry, aggressive and vengeful thoughts and when these were challenged, it only further drove him to get angrier and more adamant about how "horrible" it will be and how "unfair" it is. Despite multiple different attempts to redirect or disengage from this topic, it seemed to keep resurfacing. Feedback was provided to parent that it seemed to be a "stuck" area of Joseph's brain and perhaps not speaking of it would be a better approach than trying to help him engage in reasonable strategies. Mother expressed that this is the approach that they use at home as otherwise it can last for hours and only end up in a very escalated situation. It was reflected back that it may actually be OCD at play in some capacity but it is unclear.

Diagnosis:
OCD
Plan: Follow up in 2 weeks. ERP and CBT for treating OCD and possible GAD, meet every 2-3 weeks.

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Psychotherapy Services with Family

Without Patient Present
- **90846** *Family psychotherapy (without the patient present), 50 minutes*

With Patient Present
- **90847** *Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes*

The emphasis during family psychotherapy is on the patient's care and the family's involvement in the patient's treatment
- Without Patient Present - A provider meets with a patient's family without the patient present to counsel the family members and help them understand the patient's problem and how their responses to the patient can negatively affect or benefit the patient
- With Patient Present- A provider meets with the patient and their family to assess the interpersonal relationships between the patient and his family members and to observe the family members in coping with conflicts

The treatment plans often include the responsibilities of the family members as it pertains to the patient's treatment

Time Thresholds
90846 and 90847 ["50 minutes"] (minimum of 26 minutes)

**Carefully review the documentation of time if the patient is seen separate from their family member(s) on the same DOS*

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Psychotherapy with Family

Time In/Out: 1450 to 1540 **90847 - 40 minutes documented with mother**

Goals of Therapy: Reduce anxiety and depression symptoms as well as regurgitation or "spit up" by teaching relaxation strategies and CBT to challenge automatic negative thoughts and anxious thoughts.

Focus of Session: The psychologist met with Tom and his mother together for the first 40 minutes of the appointment to discuss parent observations of Tom's anxiety and provide additional information related to treatment. Mother shared that she can see progress with Tom but also noted that he continues to struggle with anger episodes when his anxiety spikes. She expressed it has been this way with Tom since he was a little child and that when he gets anxious, he is quick to anger. She provided an example of how this still occurs related to his homework and this was processed together. It was noted that Tom struggles to engage in relaxation strategies on his own and seems to need a parent to "force" him to do it. For example, he would not leave the homework to "take a break" when he started to grow frustrated. Instead, he was reported to throw items off his desk and it was only after repeated demands from his parents that he step away or "take a break and come back to it" that he eventually obliged. He noted that when he returned, he felt much better and was able to finish his work. The topic then transitioned to school and strategies he using in this setting to help stay calm. His mother requested a letter to help support the continuation of these strategies. Psychologist agreed and ideas were outlined in session.

The last part of the session was spent individually with Tom helping him breaking down his thoughts and how they are contributing to his anxiety and what ways he can try and change these thought patterns to be more helpful.

Diagnosis:
- Unspecified depressive disorder
- Unspecified anxiety disorder

Plan: Follow up in 1 week. Continue with outpatient therapy every 1-2 weeks.

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Group Psychotherapy Services

90849 ***Multiple-family group psychotherapy***
90853 ***Group psychotherapy (other than of a multiple-family group)***

Multiple-family group psychotherapy is used when the psychiatrist provides psychotherapy to a group of adult or adolescent patients and their family members

- The usual treatment strategy is to modify family behavior and attitudes
- This code is not time based and can only be reported once per date of service

Group psychotherapy (other than of a multiple-family group) relies on the use of interactions of group members to examine the pathology of each individual within the group

- The dynamics of the entire group are noted and used to modify behaviors and attitudes of the patient members
- The size of the group may vary depending on the therapeutic goals of the group and/or the type of techniques used by the therapist
- The code is used to report per-session services for each group member
  - This code cannot be reported more than once a day unless he/she has participated in a separate and distinct group therapy session

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E/M Billed on the Same Day as Psychotherapy

- Per CPT Range Specific Guideline - The medical and psychotherapeutic components of the service may be separately identified as follows:
  - When billing an E/M on the same date as an add-on psychotherapy code time cannot be used to support the E/M service
    - The type and level of E/M service is selected first based on MDM
    - Time associated with activities used to meet criteria for the E/M service is not included in the time used for reporting the psychotherapy service
      - (ie, time spent on history, examination and medical decision making when used for the E/M service is not psychotherapy time)
      - Time may not be used as the basis of E/M code selection and Prolonged Services may not be reported when psychotherapy with E/M (90833, 90836, 90838) are reported.

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E/M Billed on the Same Day as Psychotherapy

With an E/M Service

+ 90833 *Psychotherapy, 30 minutes with patient when performed with an E/M service*

+90836 *Psychotherapy, 45 minutes with patient when performed with an E/M service*

+90838 *Psychotherapy, 60 minutes with patient when performed with an E/M service*

Psychotherapy includes:

Interaction between a trained professional and patient on issues related to mood, behavior, feelings, and thoughts, also referred to as talk therapy

The provider involves the patient to explore the thoughts, feelings, and behavior of the patient

Multiple techniques can be used relationship building, communication, and behavior change that target improvement of the mental health of the patient

Time Thresholds

90833 [“30 minutes”] (16 to 37 minutes)
90836 [“45 minutes”] (38 to 52 minutes)
90838 [“60 minutes”] (53+ minutes)

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Psychotherapy for Crisis

- **90839** - Psychotherapy for crisis; first hour
  +90840 - each additional 30 minutes
- The provider performs psychotherapy for a crisis situation when the patient is in a life–threatening state and needs immediate attention.
- **This is not limited to a provider that specializes in mental health, other providers may bill for this service if the encounter requires that they render this service**
- Codes **90839**, **90840** are used to report the total duration of time face-to-face with the patient and/or family spent by the physician or other qualified health care professional providing psychotherapy for crisis, even if the time spent on that date is not continuous.
- For any given period of time spent providing psychotherapy for crisis state, the physician or other qualified health care professional must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during the same time period. The patient must be present for all or some of the service. Do not report with 90791 or 90792.
- Code 90839 should be used only once per date even if the time spent by the physician or other health care professional is not continuous on that date. *Psychotherapy for crisis of less than 30 minutes total duration on a given date should be reported with 90832 or 90833 (when provided with evaluation and management services).*

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Psychological and Neuropsychological Testing

- The codes allow for billing based on time for the administration *and* scoring of the tests
- Testing evaluation service codes (CPT codes 96130-96133) represent the professional portion of testing which includes: integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed
  - The key to this is in the review of the CPT code description which states **interactive feedback when performed**
    - With the code descriptions including interactive feedback and the add-on code for time, all of the time spent collectively in evaluation services will have to be totaled and billed on one date of service.
    - What this means is, if performed, the interactive feedback portion has to be completed prior to billing.
      - A new work flow process may need to be implemented to ensure the patient, family member(s) or caregiver(s) are returning timely for the interactive feedback portion of the evaluation service.
- Test administration and scoring codes (CPT codes 96136-96139) represents the technical portion.

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Psychological and Neuropsychological Testing

Evaluation
96130 - Psychological testing evaluation services by physician or other qualified health care professional, first hour
+96131 – each additional hour
96132 - Neuropsychological testing evaluation services by physician or other qualified health care professional; first hour
+96133 – each additional hour
Test Administration and Scoring by Physician or QHP
96136 - Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes
+96137 – each additional 30 minutes
Test Administration and Scoring by Technician
96138 - Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes
+96139 – each additional 30 minutes

- **Evaluation documentation includes:**
  - Integration of patient data
  - Interpretation of standardized test results and clinical data
  - Clinical decision making, treatment planning and report
  - Interactive feedback to the patient, family member(s) or caregiver(s), when performed
    - If provider performs interactive feedback you cannot bill until this has been rendered as all of the services above are included in the time spent for this CPT code category
- **Test administration and scoring documentation includes:**
  - Administration and scoring of 2 or more tests, any method to report psychological test administration using a single automated instrument, use 96146

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Developmental Screening and Testing

96110 - Developmental screening (eg, developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument
96112 - Developmental test administration, by physician or other qualified health care professional, **with interpretation and report**; first hour
+96113 - each 30 minutes

- Documentation includes face-to-face assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed
  - eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities

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Neurobehavioral Status Exam

- **96116** - Neurobehavioral status exam by physician or other qualified health care professional (QHP), both face-to-face time with the patient and time interpreting test results and preparing the report; first hour
  +96121 - each additional hour

- Documentation includes face-to-face clinical assessment of thinking, reasoning and judgment
  - eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities

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Auditing Telehealth – Audio Only

- Documentation of patient consent
- Documentation of type of visit and telehealth macro statement
  - Clear documentation identifying that the visit was Audio Only
- Detail of discussion
  - It is ok if the provider continues to use the SOAP format the history, assessment and plan can still be recorded and would support the details discussed
- **Specific documentation of time spent**

Many payers allow audio only medical management encounters to still be coded as a new or established patient E/M 99202-99215
CMS does not allow this!

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Auditing Telehealth - Audio and Video

(Face-To-Face E/M Codes)

- Documentation of patient consent
- Documentation of type of visit and telehealth macro statement
  - Clear documentation identifying that the visit was Audio *and* Video
- History and exam that was taken during the visit
  - The history and exam is not used to count elements, but the documentation should reflect what was captured and observed during the visit
- Documentation of MDM and if wanting to bill based on time the specific amount of time spent must be documented

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CMS List of Telehealth Services

Code	Short Descriptor	Status	Can Audio-only Interaction Meet the Requirements	Medicare Payment Limitations
90791	Psych diagnostic evaluation		Yes	
90792	Psych diag eval w/med srvcs		Yes	
90832	Psytx w pt 30 minutes		Yes	
90833	Psytx w pt w e/m 30 min		Yes	
90834	Psytx w pt 45 minutes		Yes	
90836	Psytx w pt w e/m 45 min		Yes	
90837	Psytx w pt 60 minutes		Yes	
90838	Psytx w pt w e/m 60 min		Yes	
90839	Psytx crisis initial 60 min		Yes	

Code	Short Descriptor	Status	Can Audio-only Interaction Meet the Requirements	Medicare Payment Limitations
99441	Phone e/m phys/qhp 5-10 min	Temporary Addition for the PHE for the COVID-19	Yes	
99442	Phone e/m phys/qhp 11-20 min	Temporary Addition for the PHE for the COVID-19	Yes	
99443	Phone e/m phys/qhp 21-30 min	Temporary Addition for the PHE for the COVID-19	Yes	

Code	Short Descriptor	Status	Can Audio-only Interaction Meet the Requirements	Medicare Payment Limitations
99202	Office/outpatient visit new			
99203	Office/outpatient visit new			
99204	Office/outpatient visit new			
99205	Office/outpatient visit new			

LIST OF MEDICARE TELEHEALTH SERVICES effective January 1, 2021-updated March 30, 2021

Code	Short Descriptor	Status	Can Audio-only Interaction Meet the Requirements	Medicare Payment Limitations
99211	Office/outpatient visit est			
99212	Office/outpatient visit est			
99213	Office/outpatient visit est			
99214	Office/outpatient visit est			
99215	Office/outpatient visit est			

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

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Common Telehealth Variances Found

- Documentation not clearly identifying whether the encounter was Audio Only or interactive with Audio *and* Video
- The following words are not a clear indication of whether the visit was interactive with Audio *and* Video:
  - Telehealth/Telemedicine, Telephone, Doxy.me, Virtual
- No Telehealth macro statement and the only indication that the visit was telehealth is the use of the modifier 95
- Only the Schedule Shows the visit as telehealth
- No Documentation of time for Audio Only encounters
  - Remember this code category is chosen based on time
- Time is documented as a range of time based on the CPT code description instead of the specific amount of time spent
- The same amount of time is documented for every patient
  - Time is to be unique and specific to each patient and to each encounter
  - When different levels of complexity and medical necessity are seen patient-to-patient was the same exact time actually spent with each of them?
    - The typical time for the E/M being coded is documented for every patient billed at that level
      - Example every patient with 99214 billed has 25 minutes documented or every patient with 99204 coded has 45 minutes documented

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Audit Plan

- Internal and/or external reviews
- What will the organization consider a passing score to be?
- A process should be in place in the event that an audit is not passed
  - Education
  - Re-audit
  - A plan should be in place in the event that a re-audit is not passed
    - 100% pre-bill review
    - Education

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Scoring of an Audit

- The passing score needs to be decided upon as an organization, how much risk are you willing to take?
- Error rates according the OIG, CMS and the Target Probe and Educate (TPE) Program
  - OIG Corporate Integrity Agreement - **5% error rate**
  - TPE Program – **Specific to MAC 15% or 20% Error rate**
  - CMS Program Integrity Manual – **error rate that is greater than or equal to 50%**

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Scoring - Sliding Scale

- *The following guide provides a suggested action plan based on the Precision Rating:*
- **90% or Higher: Providers in this range should read the findings of the review, ensure adequate understanding and move forward to the next scheduled formal auditing cycle**
- **80% or Higher: Providers in this range should read the findings of the review, ensure adequate understanding and attend at least one education training session**
- **70% or Higher: Providers in this range should read the findings of the review, ensure adequate understanding, attend at least one education training session and repeat the audit process within 30-45 days**
- **69% or Lower: Providers in this range should read the findings of the review, ensure adequate understanding, attend at least one education training session and consider a pre-bill validation audit of all services that have caused the significant deficiencies**

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Variances Found

- Many different types of variances:
  - Incorrect Code Category
  - Documentation lacking required detail to support a specific type of telehealth encounter
  - Documentation shows an audio only encounter, but time was not documented?
    - You cannot default to the lowest code 99441
- **Documentation must be corrected**
- **Incorrect codes billed must be corrected**
  - If that sounds like a lot of work (and it often is!!) ask yourself or discuss with the group the level of risk to the organization if you do not. Can you afford to leave the past encounters uncorrected? The answer is NO!!!
    - Telehealth variances are often not limited to a small number of encounters and typically are due to an overall misunderstanding of the coding and documentation guidelines

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Variances Found - Claim Correction

- **How long have the variances been occurring for?**
  - For example what if you realize the following based on your audit?
    - The provider only stated "Telehealth" in their notes
    - Time was never documented
    - You are also aware they did not want to deal with a video platform and all of the encounters were audio only
    - Every encounter was coded as an outpatient E/M (category 99202-99215)

What is your organizations level of risk in the event of an external Telehealth Audit?

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Self Disclosure – High Sustained Error Rate

- Should look to correcting the documentation and claims as stated on the previous two slides before considering this
- A statistically valid sample is the last type of audit you should pull since those are typically used to extrapolate damages and/or for use in Self Disclosure Protocols (SDPs)
- Always get direction from counsel before proceeding with drawing a statistically valid sample
  - There are several types of audit samples/methodologies to choose from (Probability, Convenience, Random Number, Educational, etc.), you just have to determine the best fit for your purpose

https://www.doctors-management.com/annual-audit-elements/

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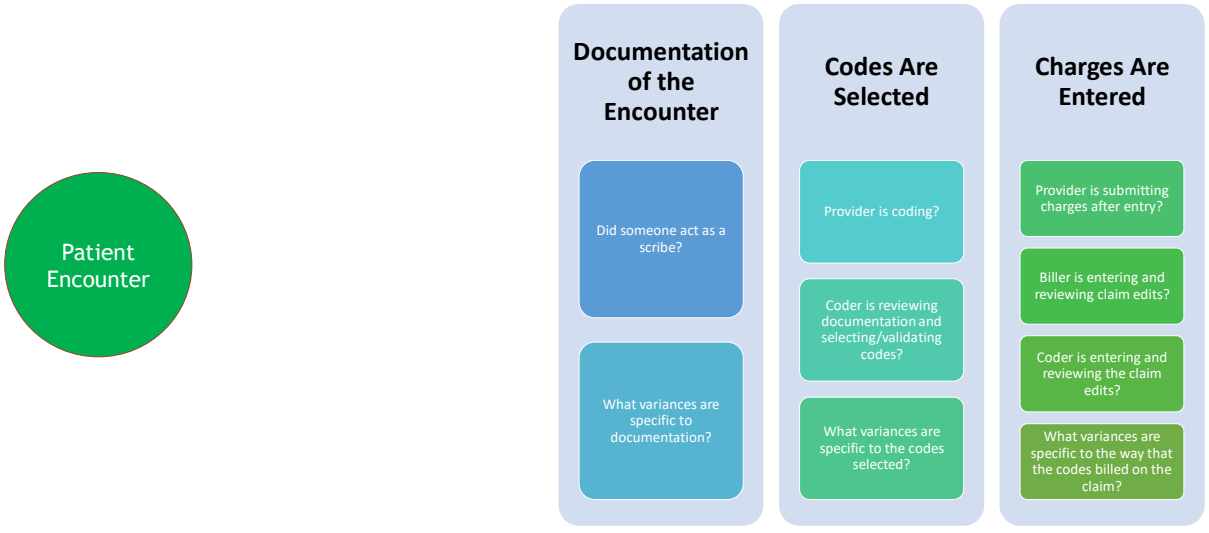
Next Steps Following Audit Completion

- Mandatory post-audit education
- Re-audit following education
  - Should be conducted at least 30 days after education to allow a new "clean" sample after the staff has implemented changes
- Education with 100% pre-bill review and follow up audit
- Failed re-audits

What Staff Member Needs the Education?



Delivery of Audit Results

- Audit findings with specific results and audit summary sent to provider and/or coder
  - Do not blind side the provider or coder with results of time of discussion
  - It is best to give them time to review the patients, scenario and findings
- Scheduling of follow up education if error rate requires
- Education session with individual
  - Remember to come to the discussion ready to review results and with **official** resources that back the findings and decisions made were made during the audit process
  - Do not make accusations about the encounters as the scenario may have supported the codes selected, but the documentation did not
- Follow up with email to provide resources if necessary

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Education

- **Documentation**
  - Variances in elements documented
  - Contradicting information
- **Work flow process**
  - Timing of documentation completion
  - Timing of provider signature
  - Timing of code selection
    - Codes **should not be** selected and submitted for charge entry prior to the completion of documentation
- **Coding**
  - Code category
  - Level of E/M
- **Charge entry**
  - Inappropriate application of modifiers

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Questions?

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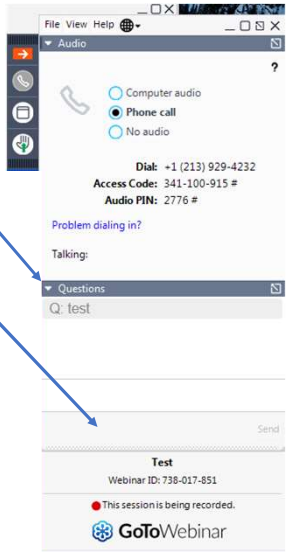
Submit Your Questions

1. To submit your questions, expand the "Questions" box on your webinar toolbar.

2. Type your questions into the "Questions" box to submit.

3. All questions will be addressed at the end of the webinar.



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Thank You For Attending!

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