Psychiatry Coding & Reimbursement Alert

CCI 19.0 Update: Put the Brakes on Reporting E/M Services With Psychiatric Diagnostic Evaluations

Hint: G codes for screening can overcome edits using modifiers.

The latest set of CCI edits (19.0) alters the way you report a psychiatric diagnostic evaluation and any evaluation and management service, so you'll need to be up to speed on correctly filing these services. Current edits for psychiatric diagnostic evaluation codes and E/M services carry the modifier indicator '0,' which means that these code sets are mutually exclusive and cannot be reported together under any circumstance.

How to code: So, when your psychiatrist or clinical psychologist conducts an initial psychiatric diagnostic evaluation, you will have to report only 90791 (Psychiatric diagnostic evaluation) or 90792 (Psychiatric diagnostic evaluation with medical services). According to the edits, any E/M services performed will be included in these codes and cannot be reported separately.

"This makes sense when the E/M services are done at the same encounter as the psychiatric diagnostic evaluation," states **Kent Moore**, Senior Strategist for physician payment at the American Academy of Family Physicians. "When that happens, the appropriate code to report is 90792, which already includes medical services with the psychiatric diagnostic evaluation."

Reminder: The version 19.0 edits extend the code bundles to reporting 90791 and 90792 with prolonged services; these edits also have a modifier indicator of "0" that means you cannot report these services together even with a modifier.

So, you cannot report code ranges 99354 (Prolonged service in the office or other outpatient setting...) □ 99357 (Prolonged service in the inpatient or observation setting...) with 90791 or 90792 under any circumstances. Even if the initial diagnostic evaluation (with or without medical services) took extraordinarily long time to complete, you will still report only one code to report the service.

"Again, this makes sense," says Moore. "Neither 90791 nor 90792 has a typical time assigned to it, so it is impossible, from a coding perspective, to determine when the threshold for reporting a prolonged service code would be met."

Look For Alcohol or Smoking Cessation Screening Bundles

When a patient has an initial diagnostic evaluation with your psychiatrist or your clinical psychologist, you cannot separately report any screening services that are also performed.

So, if your clinician is performing an initial diagnostic evaluation (with or without medical services), and also screens the patient for alcohol abuse, smoking cessation, depression, obesity, or for cardiovascular risk, you cannot report these services separately.

The following prevention and screening codes form column 2 codes for 90791 and 90792:

99401 -- 99404 (Preventive medicine counseling and/or risk factor reduction intervention...)

99406 -- 99407 (Smoking and tobacco use cessation counseling visit...)

99408 -- 99409 (Alcohol and/or substance [other than tobacco] abuse structured screening [e.g., AUDIT, DAST], and brief intervention [SBI] services...)

G0442 (Annual alcohol misuse screening, 15 minutes) G0443 (Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes)

G0444 (Annual depression screening, 15 minutes)

G0445 (High intensity behavioral counseling to prevent sexually transmitted infection...)

G0446 (Intensive behavioral therapy to reduce cardiovascular disease risk, individual, face-to-face, annual, 15 minutes)

G0447 (Face-to-face behavioral counseling for obesity, 15 minutes)

Coding Tip: These above mentioned code bundles between psychiatric diagnostic evaluation and screening "G" codes carry the modifier indicator '1'; which means that the code bundle can be separated in each case by using an appropriate modifier such as 59 (Distinct procedural service), as is appropriate.

Caveat: However, you'll use these modifiers to separate these services only if the time and work effort dedicated for the screening or intervention is distinct and separate from the time and effort spent on the psychiatric diagnostic evaluation service. No modifier will permit separately reporting 99401-99409 with 90791 or 90792, advises Moore.

Don't Report Medication Management Separately

If your psychiatrist performs a diagnostic evaluation of a patient and, in the course of that evaluation, makes an adjustment to a medication that the patient has been taking or reviews a medication prescribed to the patient to evaluate the effects and the side effects of the drug, you cannot report the latter services separately as per the latest version of the CCI edits.

Keep in mind: You cannot report HCPCS code M0064 (Brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental psychoneurotic and personality disorders) along with 90791 or 90792, as these code sets are bundled with the modifier '0' that indicates that these codes cannot be reported together under any circumstances.