Psychiatry Coding & Reimbursement Alert

Mythbuster: What You Don't Know About Psychodiagnostic Evaluation Coding Could Hurt Your Claims

Hint: Every assessment might not translate to 90792. Find out why.

When your psychiatrist performs an initial evaluation of a patient, it is quite easy to get into the trap of getting confused between reporting a psychodiagnostic evaluation code or an E/M for the visit.

Bust these four myths to arm yourselves with the right information, and ensure reporting success for every initial evaluation of a patient.

Myth 1: 90792 and E/M Can be Used Interchangeably

Reality: When reporting an assessment of a patient, although your psychiatrist is allowed to use both E/M services as well as 90792 (Psychiatric diagnostic evaluation with medical services), you cannot use both these codes interchangeably. You will have to base your reporting on the work involved and the services that went into the encounter.

According to CPT® guidelines, the code 90792 includes an integrated biopsychosocial and medical assessment, including history, mental status, other physical examination elements as indicated, and recommendations. The evaluation may include communication with family or other sources, prescription of medications, and review and ordering of laboratory or other diagnostic studies. In comparison, an E/M service includes history, examination (which may include mental status), medical decision making, and counseling and/or coordination of care.

So, when reporting an assessment of a patient, you will have to look at what services your clinician performed in order to check whether you need to report 90792 or an E/M service. If your psychiatrist's orientation of the patient's evaluation was more towards "an integrated biopsychosocial and medical assessment," you will have to report 90792 and not an E/M code for the visit.

If your clinician's evaluation of the patient was more medically or physically oriented, you will have to claim an appropriate E/M service code for the visit. You will still use these codes even if your clinician touched some psychosocial issues.

Caveat: If you are still in doubt about whether to use 90792 or an E/M code for an encounter, it is best to check with your clinician to help you identify what services went into the visit. This will help you identify which code you will need to report for the visit.

Myth 2: E/M Codes Always Gets Higher Reimbursement Than 90792

Reality: This is not always necessarily true. So, don't automatically think of reporting an E/M service whenever your clinician performs an evaluation of a patient.

Different levels of E/M codes receive different reimbursement, reflecting their different levels of complexity and other factors that drive selection of an E/M code. So, a level-three E/M code fetches you less reimbursement than a level-four or level-five encounter in the same code family.

Code 90792 will fetch a non-facility Medicare reimbursement of about $144.37 (4.03 total non-facility RVUs multiplied by the 2014 Medicare conversion rate of 35.8228). On the other hand, a level-three new patient E/M code (99203) will only fetch you about $108.18 (3.02total non-facility RVUs multiplied by the 2014 Medicare conversion rate of 35.8228).

A level-four or a level-five new patient encounter will pay out higher than 90792. A level-four new patient non-facility code (99204) will pay out approximately $166.22 while a claim for 99205 will fetch $207.06. However, a level-four established patient E/M receives less reimbursement than 90792.

Heads up: As told previously, you will have to govern your coding based on the type of service and work that went into the encounter. If the services provided are better described by reporting 90792, then you will have to stick to reporting this code instead of an E/M even though you might have thought reporting an E/M code would have fetched higher reimbursement. Don't drive your coding based on the reimbursement. Rather, it is best to look at what services were provided and what code is more apt for the encounter.

Myth 3: You Can Report 90792 Multiple Times Per Day

Reality:CPT® guidelines only limit the frequency of reporting 90792 to once per day. Depending on the circumstances and medical necessity, you can report 90792 multiple times for evaluation of the patient within three years of the initial claim for 90792.

"Three years plays a key role in distinguishing new and established patient E/M codes," observes **Kent Moore**, senior strategist for physician payment at the American Academy of Family Physicians. "However, code 90792 may be used with both new and established patients, so the three-year rule does not come into play the same way it does for E/M codes like office visits," adds Moore.

According to Medicare, you can only claim for one unit of 90792 in a year. But, if the necessity arises, you are allowed to claim more than one unit of 90792 in a year.

So, don't automatically reach out to reporting an E/M service when your clinician evaluates the patient within three years of the initial psychodiagnostic evaluation. If the nature of service provided is best described by a psychodiagnostic evaluation code, you may report 90792 instead of an E/M code.

Example: Your psychiatrist reviews a previously seen patient for recurring signs and symptoms of depression. The patient was initially evaluated in July 2012 and was prescribed anti-depressant medications and concomitant psychotherapy. The patient had continued with her medications for sometime until she began to feel fine and then had discontinued the medications.

Her symptoms of depression began to recur about three months prior and had been getting severe since then. Your clinician performed a complete psychodiagnostic evaluation to check the adverse effects of discontinuation of her medication and to check for change in mental status.

Since he performed a psychodiagnostic evaluation to check the patient for change in mental status, you will report this visit with 90792. Even though it is less than two years since the first evaluation, you are justified in reporting another unit of 90792. Provide documentation indicating the medical necessity of the evaluation.

Myth 4: You Can Report 90785 With E/M Services

Reality: The code for reporting interactive complexity, +90785 (Interactive complexity [List separately in addition to the code for primary procedure]), can be reported only with psychiatric codes. Although you might be opting to report an E/M code for the encounter, you still are not allowed to report +90785 to compensate for the extra time and effort your clinician had to spend in communicating with the patient.

You can only claim +90785 when you are reporting a psychodiagnostic evaluation code or one of the following psychotherapy codes: 90832-90838 and 90853.

"Note that 90839 (Psychotherapy for crisis; first 60 minutes) and +90840 (. . . each additional 30 minutes [List separately in addition to code for primary service]) are excluded from this list, so you should not use +90785 with either of those codes," Moore points out.

"Also note that if you are using an E/M code and a psychotherapy add-on code, such as 99213 and +90833

(Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service [List separately in addition to the code for primary procedure]), you can use +90785, too," Moore says. But, you cannot report 90785 with just an E/M code. Instead, you can reach for a prolonged services code such as +99354 (Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour [List separately in addition to code for office or other outpatient Evaluation and Management service]) if your clinician spent 30 minutes or more beyond the typical time described by the level of E/M service.