MD ENCOUNTER DOCUMENT REFLECTING CODING CHANGES

Revised 1-7-2014

Evaluation and Management (E/M) Codes

Frequently Asked Questions

1. **What are the most common Evaluation and Management (E/M for short) codes?**

   99212, 99213, 99214, and 99215. There are four categories of E/M codes, the codes that we are keeping are for only one of those categories, the Established Patient Office category. As before the CYS MD ED does not include E/M codes for new patients since in our system it is difficult to know if a patient may have already been seen somewhere else in the system in which case a new patient E/M code is invalid. And as before the CYS MD ED does not include E/M codes for inpatient treatment (new or subsequent patient) since we do not provide inpatient services in our clinics or in our contract agencies. **You must select the E/M code based on the face to face minutes with the client, not on the total minutes.**

   MDs can chose to document to E/M codes based on the Time Method or the Key Component Method. If choosing the Time Method, the MD must check the statement "Greater than 50% of face to face time spent providing counseling and/or coordination of care" (Long Form and Progress Note Form) or ">50% of time spent in Counseling and/or Coordinating Care" (Brief Monitoring Form) if you are billing the E/M codes. If the check box is not checked, an auditor will assume the E/M code was selected using the key component method and will expect to see the documentation to support the key component method. For more information regarding the Key Component Method, see the training material posted on http://www1.ochca.com/ochealthinfo.com/training/bhs/cpt/CPT-changes.pps

2. **How do I decide which E/M (99212, 99213, 99214 & 99215) code to use since the time can overlap between E/M CPT codes?**

   You will need to select the code based on the face-to-face (FTF) minutes with the client. FTF can be with the client alone, client and parents or client for some time and then with the parents (same session). In order to bill for an E/M code using the Time Method, you must check the box "Greater than 50% of face to face time spent providing counseling and/or coordination of care." If you decide to use the Key Component Method, you will need to make sure you have all the necessary Key Component documentation requirements in your progress note.

3. **The Time Method versus the Key Component Method?**

   In order to get the process of implementing the new CPT rules started by January 1, 2013, BHS decided that initially we would develop a form that is suited to the Time Method. The Time Method requires that during the session more than 50% of the face-to-face time is spent providing counseling and/or coordination of care. In the PowerPoint (that was provided with the new EDs) there are slides that discuss these issues and new progress notes have been designed to remind and prompt the MD to document according to the requirements of the new codes.

   Other forms may follow later that would use the Key Component Method. Because our form is not designed to use the Key Component Method the form also is not designed to use the combination of an E/M Code and an add on psychotherapy code since that combination requires that the documentation of the E/M code must follow the Key Component Method. Our form does allow the MD to choose a plain Individual Psychotherapy code when that is appropriate, but it is expected to be rarely used, since the regular psychotherapy codes cannot be used when the service includes evaluation and management services e.g. medication monitoring. (This is an unfortunate loss from the previous CPT codes since in the past there were single codes for the combination of psychotherapy with evaluation and management (e.g. 90809) and those codes only required the Time Method for documenting the combined service,)

4. **When using the Brief form, can the MD only mark the check box? Does the MD have to add documentation in the text area when the MD checks "other"?**

   It is OK to check the box for normal. That would be enough. However, you can't just check the boxes and put nothing else down, i.e. leave a blank space in the text area. A typical note will address the pertinent symptoms any time the checkbox "Other" is used. Those using the Brief note might want to structure their text box in a SOAP format and thus they can address the issues noted in the checkboxes in an organized manner.

5. **Should an MD use 99215 as the Initial psychiatric CPT code?**

   99215 could be the E/M code to choose when doing a new evaluation resulting in prescribing medication. A new evaluation is usually a longer session and the time range for the 99215 code begins with the longest typical minimum time of up to 69 minutes without using a prolonged visit code. The 99215 code can be used if the session is face to face and more than 50% of the face to face time was spent in counseling and/or coordination of care. If this code is used when the client is already in treatment with a clinician, the MD needs to make sure Medication Support Services is listed on the Client Service Plan (CSP) before they can use 99215. If the case is in the assessment phase and treatment is prescribed then a Mini-CSP needs to be in place in order to use 99215 or any other medication services code. The 90899-6 code is another code that can be used for an evaluation but it can only be used when you are doing an evaluation and not resulting in prescribing medication.

   It is also possible to use the 90899-8 code for a new evaluation when treatment is provided. The 90899-8 code may be used when the evaluation is a very long one and when it is not appropriate to say that more than 50% of the face to face time was spent in counseling and/or coordination of care. For example if the evaluation is a long session in which mainly information is gathered and documented in the note, and when it might not be appropriate to say that most of the face to face time was spent in counseling and/or coordination of care. In that setting and if treatment is provided the 90899-8 code is more appropriate and a Mini-CSP must be in place. Finally, if the evaluation was based on information from the parent and if the child was not seen at that session, and if treatment was given, then the 90899-8 code would be the appropriate code to use.

6. **Would there ever be a time when Face to Face (FTF) Minutes will differ from service minutes for 99214 and 99215?**

   Yes, it is very likely that the Service Minutes will often be more than the FTF minutes for all of the E/M codes, not just the two mentioned. For example, if the MD reads the chart before seeing the client, then that time is time that can be incorporated in the Service minutes. (Example-MD spends 16 minutes with client and then 69 minutes with parent alone. The total FTF would be 85 minutes. If in addition the MD reviewed records for 10 minutes prior to the session, the FTF minutes would still be 85 minutes, but the Service Minutes would be 95 minutes.) Usually the NFTF minutes should be brief (about 10-15 minutes spent reviewing a chart and/ or consulting with the therapist) before or after the FTF part of the session.

7. **In looking at the MD CPT Modifier III, I only see the 99355 add on code, not the 99354 which I thought was to be used to extend the 99212-99215 code series.**

   The prolonged visit codes are used in sequence. An E/M code is chosen, then the first prolonged visit code, +99354, is chosen from the drop down in the MD CPT Modifier II box (**99354 can only be used once). T**hen if more time is needed, the MD CPT Modifier III box is used to select +99355 (used as many times as needed based on 30 minutes increments). (Ex. If an MD selects E/M code 99214 and the FTF minutes falls between 55 and 99 min, the +99354 is used once. If the MD selects E/M code 99214 and the FTF minutes falls between 100 and 130, the +99355 is used x 1. The +99355 is used as many times as needed for every increment of 30 minutes. So if the MD selects E/M code 99214 with a FTF minutes of 160 minutes then the MD needs to use +99354 and +99355 x 2.) So it is possible that for a really long session all three boxes will be used.

8. **Why are there different versions of the Medication Monitoring form, a Brief and a Long version, and manual versions?**

   The Brief version has boxes to prompt you to document according to the E/M guidelines for time and counseling. In the Brief version there is basically only one text box (and a continuation page if necessary) to type in your note. In the computer version you will need to click onto the next page to continue your note if you need more room. In the Manual version you can print it out and handwrite everything in or you can fill in some

of the sections on your computer and then print it out to finish handwriting the text and you even can use the Manual form to type the note, but you will still have to click onto the next page if your note needs to go onto the next page in the Manual version, it won't automatically move onto the next page.

The Long version is set up in 6 sections to follow the flow of a session and it has two text boxes for you to use, one box at the beginning for the interval history and one box at the end to discuss the objective findings, your assessment and your plan. In the Long version the first text box will not expand, but the second text box will allow you to type as many additional pages as you need. There is also a manual version of the Long note.

9. When would the progress note ED be used?

The plain progress note form can be used very freely by the MD. The plain progress note version allows you to type a note using the format of your own choosing, e.g. an initial evaluation or a brief note to chart, or anything else that does not fit into a medication monitoring category. The plain progress note probably would be the form MDs use for an initial evaluation since they can completely decide what sections of an initial evaluation they want to include and how they want to include it. The plain progress note would also be used when an MD selects an E/M code based on the Key Component method of documentation. The documentation would need to have all of the key component information in order to support that code.

The computer version will allow you to type as many pages as you would like. The Manual version comes with an initial page and then a continuation page. If you are using the Manual version you will have to print out additional pages of the continuation page to have more pages for a long note.

10. What version do you recommend for follow-up notes- brief or long version ED?

There are two versions of the follow-up note. The two versions have the words Brief or Long in their titles. The Brief and Long version of the Medication Monitoring forms are also at the discretion of the MD. Some might like the Long form since it proceeds section by section through the categories of information that would be gathered in a follow-up visit. The Long form also has boxes for the vital signs and has more boxes for entering the medications. But others might like the Brief form since it has only one section in which to type the MD's documentation and the Brief form allows the MD to decide how they want to structure their documentation.

11. What is the Interactive Complexity Code (+90875)?

This is an add-on code that can only be used if a psychotherapy codes has already been selected. Thus the +90875 code can only be used in addition to a psychotherapy code (90832, 90834, or 90837) or in addition to a psychotherapy add-on code (+90833, +90836, or +90838) when one of those codes is used with an E/M code. This code can never be used as an add-on to just an E/M code.

Interactive complexity may be reported with the above psychiatric procedures (psychotherapy alone or E/M with psychotherapy) when at least one of the following communication difficulties is present:

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

2. Caregiver emotions/behavior that interfere with implementation of the treatment plan.

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

4. Use of play equipment, physical devices, interpreter or translator to overcome significant language barriers.

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

12. When do I use the new Custodial Care E/M or Patient Home Visit E/M codes?

When an MD provides treatment to an established patient in a group home or custodial care facility, E/M codes (99334-99337) code must be used. If the treatment occurs at the patient's home, then codes 99347-99350

would be used. The MD must document in their progress note why the client is in the group home or custodial care facility. Either Time Method or Key Component Method can be used with these codes. If using the Time Method, you need to remember that the patient must be present and 50% of the time was spent counseling and/or coordinating care. If you chose to use the Key Component Method, then all required elements will need to be documented in your Progress Note. Refer to the Revised November 2013 QRTips for further information regarding Established Patient Custodial Care and Established Patient Home Visit E/M Codes.)

13. Where can I find the latest version of all the MD forms?

You can find all the MD ED/PNs on the CYS QRT website under 2013 Annual Provider Training-Forms/Resources/Notes and CYS-QRT downloads

The MD ED Encounter Document Coding guide has been developed to assist MDs whenever using the Manual ED/PN. To obtain the guide go to MD Coding Guide.