

American Academy of Child and Adolescent Psychiatry

CPT CODE TRAINING MODULE

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**MAINTAINED BY THE CPT CODING SUBCOMMITTEE OF THE HEALTHCARE
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CPT TRAINING MODULE

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CPT TRAINING MODULE FOR CHILD AND ADOLESCENT PSYCHIATRISTS

INTRODUCTION

Current Procedural Terminology (CPT) codes came into existence in 1966 as a way to describe medical procedures and services provided by physicians and other qualified healthcare professionals. The American Medical Association sponsored a conference in 1992 that explored application of CPT and the Resource Based Relative Value Scale (RBRVS) beyond Medicare.

In 1996, Congress passed the Healthcare Insurance Portability and Accountability Act (HIPAA) that set standards for electronic billing (Title II), among other things. These standards require use of CPT codes to report physician services billed electronically.

The Center for Medicare and Medicaid Services (CMS) assigns each CPT code a place in the RBRVS, the CPT code's Relative Value Unit (RVU). The Relative-value Update Committee (RUC) - sponsored and maintained by the AMA - recommends RVUs to CMS, who publishes the value in the Final Rule of the Federal Register every November.

This module explains this process and how it works. The module also discusses consequences of failing to utilize correct coding (fraud and abuse), CPT codes from the psychiatry section of the current CPT manual, and the Evaluation and Management codes. Appendix A is a glossary of commonly used terms; Appendix B discusses the Conversion Factor and Sustainable Growth in Healthcare; Appendix C discusses CPT code categories: Category 2 (tracking) and Category 3 (emerging technology/services) codes. Appendix D presents the Merit-based Incentive Payment System (MIPS) from the Patient Protection and Affordable Care Act (ACA) 2010.

RELATIVE-VALUE UPDATE COMMITTEE (RUC)

Relative value units (see next section) are assigned to CPT codes by CMS after receiving recommendations from the RUC of the AMA. The RUC consists of 31 voting members representing the largest medical societies in the AMA House of Delegates and has advisors from the remainder of the medical societies in the House of Delegates. The RUC's recommendations are based on the presentation of the specialty society that requests the code valuation. The RUC arrives at specific work and practice expense values, which are then sent to CMS for review and published in the Federal Register. Congress mandates these values be reviewed every 5 years.

THREE COMPONENTS OF RELATIVE VALUE UNITS (RVUs)

Three components determine the resource cost of providing a service:

- physician work
- practice expense
- professional liability insurance expense

Physician Work (Relative Value Work or RVW)

The physician work component accounts, on average, for 54% of the total relative value for each service. The factors used to determine physician work include:

- the amount of physician time involved

- the technical skill and physical effort required
- the mental effort and judgment required
- the stress to the physician resulting from potential risk to the patient from the underlying illness or procedure

Practice Expense (PE)

Practice expense RVUs account for an average of 41% of the total value for each service. These PE values reflect office costs like play equipment, rent, utilities, billing expenses, etc. Since 2004, all new or revised codes presented to the RUC must include both work and PE values. The RUC then recommends a specific value for each to CMS.

Professional Liability Cost (PLI)

The professional liability cost component is derived from a formula. In 2010, allergy and immunology replaced psychiatry as the specialty with the lowest malpractice cost. Consequently, psychiatry is no longer the denominator in the formula.

CONVERSION FACTOR

The sum of these 3 components (work units + practice expense units + malpractice expense units) yields the RVU. The RVU is then multiplied by a **conversion factor** (a monetary figure determined by CMS) and adjusted for geographical variability to arrive at the payment. For example: 99213, RVW is 0.97, PE for non-facility is 1.00, PLI is .07; therefore, $0.97 + 1.00 + .07 = 2.04$ (Total RVU). That number is multiplied by 35.9335 (the Conversion Factor for 7/1/15-12/31/15) to arrive at the Medicare payment of \$73.30 (before the geographic factor is applied) for 99213. (Go to <https://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx> for the complete list of CPT codes and their RVUs.)

The Conversion Factor is crucial for CMS to control Medicare's professional payments (Medicare Part B).

SCOPE OF CPT AND RUC

While HIPAA (1996) mandates that private payers use current CPT codes, CPT code reimbursement values are, strictly speaking, applicable only to services billed to Medicare through any of its regional carriers. Private payers may choose ~~whether~~ to use the reimbursement values published by CMS for the CPT codes they reimburse or set their own values.

5 YEAR REVIEWS AND THE 2013 CPT CODE CHANGES

In 1997, AACAP along with the American Psychiatric Association, American Nurses Association, American Psychological Association, and the National Association of Social Workers, administered a survey for the psychiatry CPT codes, a series of codes originally adopted by HCFA (later CMS) on January 1 1997, as G codes. Working with these organizations, the AACAP helped forge a consensus reimbursement recommendation for these codes, which the RUC sent HCFA for its consideration. HCFA published its decision in the *Federal Register Final Rule* in November 1997. With the American Psychiatric Nurses Association (APNA) joining the American Nurses Association, these groups conducted a similar process from 2010 to 2012 as a part of the 2010 Congressionally mandated 5-year review. The Psychiatry Code section was completely revised in this review. Many AACAP members

completed RUC surveys in the springs of 2012 and 2013. The RUC used these results to make recommendations to CMS for physician work RVUs and practice expense RVUs for each of the psychiatric services. CMS opted to publish *interim* results in November 2012 in the *Federal Register Final Rule*. They wanted to wait until ALL psychiatry codes were valued before publishing final results in 2013's *Federal Register Final Rule*. Hence the surveys of Interactive Complexity and crisis codes were completed in spring 2013.

That review resulted in significant changes in the way child and adolescent psychiatrists report services. The fate of the more commonly used codes is listed below. See "CPT CODES FOR CHILD AND ADOLESCENT PSYCHIATRISTS," for the new code definitions and how to report these services.

2013 FATE OF THE PREVIOUS CPT PSYCHIATRY CODES

Service	CPT Code	2013 Status
Diagnostic interview examination	90801	DELETED
Interactive diagnostic interview examination	90802	DELETED
Individual psychotherapy	90804, 90806, 90808, 90816, 90818, 90821	DELETED
Interactive individual psychotherapy	90810, 90812, 90814, 90823, 90826, 90828	DELETED
Individual psychotherapy with E/M	90805, 90807, 90809, 90817, 90819, 90822	DELETED
Interactive individual psychotherapy with E/M	90811, 90813, 90815, 90824, 90827, 90829	DELETED
Family psychotherapy	90846, 90847, 90849	Retained
Group psychotherapy	90853	Retained
Interactive group psychotherapy	90857	DELETED
Pharmacologic management	90862	DELETED

FRAUD AND ABUSE

The only legal way to be paid for a service is to bill using the correct CPT code. You also must document that the level of service claimed was medically necessary and delivered. Prior to 1996 there was no distinction between fraud and sloppy billing practices. In 1996, the standard of "intent to knowingly and willingly deceive" was adopted, but if one consistently billed

incorrectly and had no audit system to find and correct billing errors, one is vulnerable to this standard.

Kennedy-Kassebaum (Title II of HIPAA, 1996):

- Added “knowingly and willingly” standard to false claims legislation. Before 1996, physicians could be accused of violating the law if they simply made a mistake. Now, the standard is “knowingly and willingly,” BUT ignorance of coding rules is NOT an acceptable explanation for repeated coding errors.
- Made “falsifying” a private claim a federal offense like falsifying a Medicare/Medicaid claim.
- Added 700 investigators to the Inspector General’s office at CMS.
- Fines collected support the salaries of the investigators.
- Example: Instructing one’s billing agent to code a psychotherapy add on for any visit is a knowing and willful action that places the physician at risk if the level of service does not meet criteria (at least 16 minutes of psychotherapy beyond the E/M service).
- Physician is responsible (and liable) for all coding done in that physician’s name. The physician is responsible for appropriate documentation of services even if the patient or physician’s employer submits the bill to an insurance company.

False Claims (Originally defined in False Claims Act (FCA) 1986) – billing for services not provided.

Up coding Examples: Reporting the psychotherapy add on code for less than 16 minutes of psychotherapy. Coding 99214 while documentation and medical necessity support a lower level of service.

Code edits Billing codes that do not belong together (Correct Coding Initiative – CCI)
Examples: Violating AdminiStar software program – most edits involve surgical procedures like separate billing for amputation of digits and foot when performing a below the knee amputation. Edits for the current psychiatry codes are being developed.
(<http://cms.hhs.gov/physician/cciedits/default.asp>)

Medically Unlikely Edits (MUE)

Codes that are *unlikely* to be billed together. These edits may be appealed on a case-by-case basis. Originally, the edits were called “medically unbelievable,” but because of physician objection, the term “unlikely” was substituted for “unbelievable” (maintaining the acronym MUE).

Examples: 2 psychotherapy sessions for the same patient on the same day. As above, MUEs for the current psychiatry code set are being developed.

Consequences:

- Pay damages up to 3 times the amount of the claim.
- Mandatory penalties of \$5,000 to \$10,000 per claim, regardless of the size of the claim.
- The Return-on-Investment (ROI) is about \$8 for every \$1 spent in the investigation. Funds are transferred to the Medicare Trust Funds (\$2.5 B in FY 2012). Some of these

monies are used to support the salary of the investigators. See <http://oig.hhs.gov/publications/docs/hcfac/hcfacreport2012.pdf> (HCFAC = Health Care Fraud and Abuse Control)

- Whistle-blowers act in the name of the government and may seek the same damages. The Department of Justice may intercede and the realtor could still receive 15% to 25% of the claim. Realtor may proceed alone and keep up to 30% of the final recovery.

CODE CATEGORIES

The Health Insurance Portability and Accountability Act (HIPAA) required CMS to issue a request for proposals for alternative coding systems. The AMA realized that CPT needed to be changed and initiated the CPT 5 project to develop necessary modifications. In August 2000, CMS announced that it would continue to use CPT as the coding system for medical procedures for Medicare patients. Two additional code categories (II and III) debuted in CPT 2002 and are discussed in Appendix C.

CPT CODES FOR CHILD AND ADOLESCENT PSYCHIATRISTS

CPT 2013 redesigned the structure of the commonly used psychiatric codes. From 1997 through 2012, psychiatric CPT codes were divided into “diagnostic or evaluation interview procedures” and “psychiatric therapeutic procedures” (and further sub-divided into office vs facility psychotherapy; other psychotherapy and other psychiatric procedures). The 2013 structure requires psychiatrists to use the following code categories to report services:

- Evaluation and Management (E/M)
- Interactive complexity
- Diagnostic evaluation
- Psychotherapy
- Other psychotherapy
- Other psychiatric services

Evaluation and Management (E/M)

HIPAA (1996) and Mental Health Parity and Addiction Equality Act of 2008 (MPHAEA) changed how psychiatric care is reimbursed. One change requires providers to use CPT to submit all electronic claims for psychiatric services to all insurance companies, both private and government sponsored. CPT (2013) deleted 90862 (pharmacologic management) effective January 1, 2013, with instructions to use E/M codes for these services. The availability of E/M codes to psychiatrists allows psychiatric services to be reported with the same range of complexity and physician work as has long been available to practitioners of all the other medical specialties.

While Medicare always allowed psychiatrists to use E/M codes, until 2010 few private payers reimbursed psychiatrists for E/M codes for outpatient services. Psychiatrists were essentially restricted to the use of the basic “one size fits all” 90862 code for pharmacologic management. Code 90862 poorly described the complexity of current psychiatric practice and accounted for 60% of psychiatrist billing. This code, written when the standard for pharmacologic management was prescription of one or occasionally two psychotropic medications at a time had become outdated and required revision to address the complexities of psychopharmacologic management

in current practice. Current standard of care is more complex. E/M codes best describe the work and medical decision making now required.

E/M codes may be utilized to report evaluation and management services alone (pharmacological/medical management and no other service reported that day) or E/M services with the addition of psychotherapy. Psychotherapy is reported as an “add-on” code to the primary procedure, the E/M service. This change effectively reverses “psychotherapy with or without E/M” to “E/M with or without psychotherapy.” The parameters of psychotherapy, such as time, presence of interactive complexity, and site of service, are discussed below. For additional information, go to the AACAP website, and click on CPT and Reimbursement under Member Resources at the top of the homepage. There are webinars for specific, detailed information on the 2013 codes as well as selecting and documenting E/M codes.

Interactive Complexity

The Interactive Complexity add-on code, 90785, describes 4 specific communication factors, as well as the types of patients and situations most commonly associated with the presence of these factors.

The 4 specific communication factors during the service (listed below) represent significant complicating factors that increase the work of the primary psychiatric procedure. Interactive complexity 90785 may be reported in conjunction with the following psychiatric procedures: psychiatric diagnostic evaluation (90791, 90792), psychotherapy (90832, 90834, 90837), psychotherapy add-on services (90833, 90836, 90838) when reported with E/M, and group psychotherapy (90853). Interactive Complexity refers to communication factors *during* the psychotherapy or psychiatric diagnostic interview procedure. It cannot be reported with E/M Services alone, but rather only when an E/M service is combined with psychotherapy. The 90785 code MAY NOT be reported with family psychotherapy (90846, 90847, 90849) and psychotherapy for crisis (90839, 90840).

The specific communication factors are present typically with minors or adults with guardians, or with adults who request that others be involved in their care during the visit, such as adults accompanied by one or more participating family members.

Interactive complexity may be reported with the above psychiatric procedures when at least one of the following communication factors 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 or behavior that interfere with understanding or implementation of the treatment plan.
3. Evidence or 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 or physical devices to overcome significant language barriers¹.

¹ CMS does not allow 90875 to be reported solely for interpretation or translation services as that may be a violation of federal statute (Americans with Disabilities Act).

When performed with psychotherapy, the interactive complexity component relates only to the increased work intensity of the psychotherapy service. It *does not* change the time for the psychotherapy service. If more time is required because of the interactive complexity, then a higher timed psychotherapy code may be used.

Psychiatric Diagnostic Evaluation

The 2 Psychiatric Diagnostic Evaluation Codes differentiate between diagnostic services done without medical services (90791) and with medical services (90792). If present, the interactive complexity component of the diagnostic evaluation is captured by reporting the interactive complexity add-on code 90785 in conjunction with 90791 or 90792.

Code 90791 - Psychiatric Diagnostic Evaluation without medical services.

- The evaluation may include communication with family or other sources, and review and ordering of non-medical diagnostic studies.

Code 90792 - Psychiatric Diagnostic Evaluation with medical services.

- As above (90791), the evaluation may include communication with family or other sources, and review and ordering of diagnostic studies. It *must* include medical services. “Medical services” refers to medical “thinking” as well as medical activities, such as physical examination, prescription of medication, and review and ordering of medical diagnostic tests. Medical thinking must be documented, e.g., consideration of a differential diagnosis, medication change, change in dose of medication, drug-drug interactions.

For both 90791 and 90792:

- In certain circumstances one or more other informants (family members, guardians, or significant others) may be seen in lieu of the patient.
- Both codes may be reported *more than once* for the patient when separate diagnostic evaluations are conducted with the patient and other informants on different days.
- Use the same codes, 90791 and 90792, for later reassessment, as indicated.
- Do not report codes 90791 and 90792 on the same day as a psychotherapy or an E/M service.

Psychotherapy

Time determines the selection of the appropriate psychotherapy code: 16-37 minutes for 90832; 38-52 minutes for 90834; 53- 89 minutes for 90837. The CPT manual states, to report psychotherapy of 90 minutes or more, use 90837 and the appropriate prolonged service code (99354-99357).

All of the individual psychotherapy codes (90804-90829) were deleted in 2013. A new series of psychotherapy codes replaced these codes, with the following differences:

- Site of service is no longer a criterion for code selection.
- Time specifications are changed to be consistent with CPT convention. (See *Time* below.)

- “Individual” was eliminated from the code titles.. Nonetheless, psychotherapy time may include face-to-face time with family members as long as the patient is present for a significant part of the session.
- Interactive psychotherapy codes were deleted. Interactive Complexity is reported with the add-on code 90785. This new code expands the types of communication factors that CPT recognizes (see above, *Interactive Complexity*).

Since 2013, the psychotherapy add-on codes, 90833, 90836, 90838, allow psychiatrists to report psychotherapy with the full range of E/M codes. The code for the delivered E/M service is selected first (based on key components, *never* time for the E/M portion when using the psychotherapy add-on codes) and then the time for the psychotherapy is determined (see #2 below).

The typical psychotherapy with E/M session is not the provider doing psychotherapy and then doing E/M (or vice versa), but is a combined service. This feature has been recognized by CPT: “Medical symptoms and disorders inform treatment choices of psychotherapeutic interventions, and data from therapeutic communication are used to evaluate the presence, type, and severity of medical symptoms and disorders” (CPT 2015 Professional Edition p. 558).

To report both E/M and psychotherapy, the two services must be *significant and separately identifiable*. CPT gives a roadmap for separately identifying the medical and psychotherapeutic components of the service:

The type and level of E/M service is selected first based upon the key components of history, examination, and medical decision-making.

1. For essential information, please see our webinars for a discussion of key components: go to the AACAP website, and click on “CPT and Reimbursement” under “Member Resources” at the top of the homepage.
2. 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 (i.e., 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 to determine E/M code selection. Prolonged Services may *not* be reported when E/M *and* psychotherapy (90833, 90836, 90838) are reported.
3. A separate diagnosis is *not* required for the reporting of E/M and psychotherapy on the same date of service.

Documentation must include the required key components of the selected E/M code and the *additional* time for the psychotherapy service. *Total* time for the encounter is not needed.

If interactive complexity is part of the psychotherapy service, the Interactive Complexity code (90785) is added as well.

Site of Service

The psychotherapy codes are applicable to services in all settings. Site of service is not a criterion for psychotherapy code selection.

Time

Psychotherapy times are for *face-to-face* services with patient, who must be present for a significant part of the service. Face-to-face time with family member informants may account for remaining time. For family psychotherapy without the patient present, use 90846.

CPT convention is that codes reported based on time are described by “exact” times, with ranges determined by the following:

- The “exact” time for a single code or the first code in a series is achieved once the actual time crosses the midpoint (in the case of the Psychotherapy codes, the 30 minute codes therefore require actual time of at least 16 minutes).
- In a series, choose the code with an “exact” time closest to the actual time. (See chart below)

Code	“Exact” Time (in minutes)	Actual Time Range (in minutes)
90832, 90833	30	16-37
90834, 90836	45	38-52
90837, 90838	60	At least 53

Psychotherapy must be at least 16 minutes to be reported.

Interactive Complexity

Code 90785 is an add-on code to report Interactive Complexity services when provided in conjunction with the psychotherapy codes 90832-90838. As stated above, 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. Time is reflected in the timed service code for psychotherapy (90832, 90834, 90837, 90833, 90836, 90838).

Other Psychotherapy

Psychotherapy for Crisis – Codes 90839 and 90840

Psychotherapy for crisis codes (90839 and 90840) are reported when psychotherapy services are provided to a patient who presents in high distress with complex or life threatening circumstances that require immediate attention. Code 90839 covers psychotherapy for crisis for the first 60 minutes and 90840 for each additional 30 minutes. These codes are reported by themselves and may *not* be reported with the psychiatric diagnostic evaluation codes (90791, 90792), the psychotherapy codes (90832–90837) or the add-on psychotherapy codes (90833, 90836, 90838). Codes 90839 and 90840 may not be reported in conjunction with the interactive complexity code 90785 or any of the procedures included in the “Other Psychotherapy” or “Other Psychiatric Services or Procedures” sections.

These codes do not include medical services. In a crisis situation, psychiatrists may prefer the appropriate E/M code. Non-medical mental health professionals are most likely to report these codes.

Psychoanalysis - 90845

The code for psychoanalysis has not changed since 1992.

Family Psychotherapy – 90846, 90847, and 90849

Codes for family psychotherapy without patient present (90846), family psychotherapy with patient present (90847), and multiple-family group psychotherapy (90849) have been unchanged since 1997. Medical management services are not included in these codes and may be reported separately with a .25 modifier (See “Modifier Codes” below). (One may NOT report interactive complexity (90785) with these codes.)

Group Psychotherapy – 90853

Group psychotherapy (90853) has been unchanged since 1992. The code for interactive group psychotherapy (90857) is deleted and replaced with an instruction to report 90853 with the interactive complexity add-on code (90785) when appropriate for the particular group psychotherapy patient.

Other Psychiatric Services

Pharmacologic Management add-on code – 90863

This 2013 code may only be used by qualified healthcare professionals who *may not* use E/M codes for reporting services. The primary users of this code are expected to be prescribing psychologists (currently practicing in the armed forces, Louisiana and New Mexico, as well as on American Indian Reservations). 90863 is an add-on to a psychotherapy service and may not be used as a stand-alone code. PSYCHIATRISTS, OTHER PHYSICIANS, APRNs and PAs MAY NOT REPORT THIS CODE. These professionals *must* use the appropriate E/M code. CMS does not recognize 90863.

Additional codes that may be useful for child and adolescent psychiatrists are listed below. However, having an established RVU does not guarantee reimbursement by the insurance carriers. The physician must check with each carrier to establish reimbursement policies. If the service is listed as non-covered under the plan, the patient may be billed directly.

Code	Time (Minutes)
90865 – Narcosynthesis	unspecified
90870 – ECT	unspecified
90875 – Psychophysiological therapy	30 min
90876 – Psychophysiological therapy	45 min
90880 – Hypnotherapy	unspecified
90882 – Environmental manipulation	unspecified
90885 – Psychiatric evaluation of records	unspecified
90887 – Interpretation with family	unspecified
90889 – Preparation of report	unspecified
90899 – Unlisted psychiatric service	unspecified

Central Nervous System Assessments/Tests (Neuro-Cognitive, Mental Status, Speech Testing)

These may be performed by physicians or other qualified healthcare professionals and are typically reported per hour, face-to-face time, preparation and interpretation of a report. Developmental screening (96110) may be used for various rating scales like Brown or Connors ADD scales. It has only a practice expense, no relative value work associated with it. Report for each rating scale used.

96101	Psychological testing by psychologist or physician
96102	Psychological testing by technician
96103	Psychological testing administered by computer
96105	Assessment of aphasia
96110	Developmental screening
96111	Developmental testing,
96116	Neurobehavioral status exam
96118	Neuropsychological testing by psychologist or physician
96119	Neuropsychological testing by technician
96120	Neuropsychological testing administered with computer
96127	Brief behavioral/emotional Assessment

Modifier Codes

Modifier codes are used to document a procedure or service that has been altered in some way due to a specific circumstance, however its definition or code has not been charged.

-22 Unusual Procedural Services

When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier '-22' to the usual procedure number. A report may also be appropriate. Documentation must support the substantial additional work and the reason for the additional work. This modifier may *not* be appended to an E/M service.

-25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Day of a Procedure

The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the usual pre-procedure and post procedure care associated with the procedure that was performed. This circumstance may be reported by adding the modifier '-25' to the appropriate level of E/M service. For example, if one provides an E/M service to the identified patient in addition to family therapy (90847), one reports the E/M service with a .25 modifier (e.g., 99213.25).

OTHER CODES

Medical Team Conferences Without Direct Contact with the Patient and/or Family

99367 Medical team conferences require face-to-face participation by at least three qualified health care professionals of *different* specialties or disciplines who provide direct care to the patient. At least 30 minutes (range 16 – 45 minutes) must be devoted to the patient billed for this service. Also, do NOT report when participation in the team conference “is part of a facility or organizational service contractually provided by the organization or facility provider.” (CPT 2012, Professional Edition, p. 33) If the patient is present, use the appropriate E/M codes.

Telephone Services

Telephone Services are non-face-to-face E/M services provided to the patient on the telephone. The service must be provided at least 7 days *after* a face-to-face visit, otherwise it is considered part of the post-time of that visit and cannot be reported separately. If the telephone contact results in a face-to-face visit in the next 24 hours or the next available appointment time, the time becomes part of the pre-time of that visit and cannot be reported separately. (Remember to check with the patient’s insurance whether these services are covered.)

99441	Telephone E/M service provided to an established patient, parent/guardian -5-10 minutes of medical discussion
99442	11-20 minutes of medical discussion
99443	21-30 minutes of medical discussion

Online Medical Evaluation

An online electronic medical evaluation is a non-face-to-face E/M service by a physician to a patient/guardian/health care provider using Internet Resources in response to a patient’s on-line inquiry. There must be a permanent storage (electronic or hard copy) of the encounter. The reportable service encompasses the sum of the communications (online-telephone-prescription provision, lab orders, etc.) that pertain to the specified encounter.

99444	Online (internet or similar electronic communication network) evaluation and management service provided by a physician to an established patient/parent/guardian/health care provider not originating from a related E/M service provided within the previous 7 days
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Care Coordination

For years, CPT struggled with a way for physicians to bill for non-face-to-face services including phone calls, teams meetings, and activities of clinical staff. Some of these services have been covered as an expected part of codes for face-to-face services, but most of them have simply not been reimbursed, despite codes in the CPT Manual describing non-face-to-face services.

In 2012, CMS recognized that these care coordination services are important and indicated a willingness to pay for them if a “different” way could be found. The AMA Care Coordination CPT Workgroup designed 2 sets of codes, one set for care of patients making a transition from a facility setting to a home setting (transition care management or TCM codes, 99495 and 99496) and one set for care coordination of patients with complex chronic conditions (complex chronic care management or CCCM codes, 99487 and 99489) that require substantial non-face-to-face activity by office clinical staff. In 2015, chronic care management (99490) was added. These codes were designed for use by primary care providers but may be useful for some child and adolescent psychiatric practices. Currently, Medicare reimburses TCM (99495 and 99496) and CCM (99490) but not CCCM (99487 and 99489).

Interprofessional Telephone/Internet Consultation codes

After more than 10 years in the making, 4 codes debuted in the 2014 CPT Manual that allow consulting physicians to report telephone/internet assessment and management services with other physicians or qualified healthcare professionals who contact them for help. The consulting physician should report these codes (99446, 99447, 99448, 99449) under the following circumstances:

1. The patient's primary care or attending physician or qualified healthcare professional contacts the consulting physician for advice.
2. The consulting physician:
 - a. Has not seen the patient within 14 days or has NEVER seen the patient.
 - b. Will not see the patient within 14 days or next available appointment
 - c. If the patient is established to the consulting physician, the problem must be new or worsening, and (a) and (b) still apply.
 - d. Must provide a written or electronic report to the primary care or referring physician or qualified healthcare professional.
3. At least ½ of the reported time must be the telephone/internet consultation. The other time may be consumed in records review.
4. The telephone/internet consultation must be > 5 minutes.
5. The primary care or attending physician may report the call using other code(s) as appropriate, such as E/M and prolonged services codes (99354-99359).

This code is designed to report services when one spends more than 5 minutes on the phone/internet advising another professional how to take care of that professional's patient. These codes may be used for scheduled telephone/internet case reviews or calls when the primary care physician or other qualified healthcare professional has the patient in his/her office and is wondering what to do next.

99446: Interprofessional telephone/internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating or requesting physician or qualified healthcare professional 5-10 minutes of medical consultative discussion and review.

99447: 11-20 minutes

99448: 21-30 minutes

99449: >31 minutes

Psychiatry Codes Summary

Service	Codes	Comments	May report same day	May NOT report same day
Evaluation and Management (E/M)	99201-99255, 99281-99285, 99304-99337, 99341-99350	Includes pharmacologic management when appropriate; No psychotherapy		
Interactive Complexity	90785	Add-on code in conjunction with select psychiatric service	Primary procedure: 90791, 90792, 90832-90838, or 90853	90839, 90840; 90846, 90847,90849 E/M when no psychotherapy code reported
Psychiatric Diagnostic Evaluation	90791(no medical) 90792 (with medical)	With or without medical services; in certain circumstances one or more other informants may be seen in lieu of the patient; codes 90791, 90792 may be reported more than once for the patient when separate diagnostic evaluations are conducted with the patient and other informants; codes 90791, 90792 may be reported only once per day	90785	E/M, 90832, 90834, 90837, 90839, 90840
Psychotherapy	90832, 90834, 90837	The choice of code is based on the face-to-face time with patient and/or family member	90785 90863 (prescribing psychologists only) prolonged services (99354-99357) 90846, 90847, 90849 90853	90839 90840
Psychotherapy (same day E/M)	90833, 90836, 90838	Add-on codes in conjunction with E/M service; the choice of code is based on psychotherapy face-to-face time with patient and/or family member; time associated with activities used to meet criteria for the	90785 Primary procedure: E/M 90846, 90847, 90849 90853	Prolonged services (99354-99357)

		E/M service is not included in the time used for reporting the psychotherapy service		
Psychotherapy for Crisis	90839, 90840			90832-90838, 90785, 90791, 90792, all other codes in Psychiatry section
Family Psychotherapy	90846, 90847, 90849	With or without patient present; multi-family group	E/M with .25 modifier 90832-90838	90785
Group Psychotherapy	90853	Does not include a multiple-family group	90785; E/M with .25 modifier 90832-90838	
Pharmacologic Management (same day psychotherapy)	90863	Add-on code in conjunction with psychotherapy service; may report ONLY by providers who may NOT report E/M	May only be reported if one of 90832, 90834, or 90837 is also reported.	(Psychiatrists, APRNs and PAs MAY NOT use this code)
Other Psychiatric Services	90845, 90865-90899	Psychoanalysis, multiple-family group psychotherapy, narcosynthesis, TMS, ECT, biofeedback with psychotherapy, hypnotherapy, environmental intervention, evaluation of records, interpretation or results, preparation of report, unlisted psychiatric procedure		90785

Appendix A

PARTIAL GLOSSARY

HEALTH CARE FINANCING ADMINISTRATION (HCFA) A component of the U.S. Department of Health and Human Services that administers the Medicare program and certain aspects of state Medicaid programs. Renamed CMS (Center for Medicare and Medicaid Services) after June, 2001.

PHYSICIAN CURRENT PROCEDURAL TERMINOLOGY (CPT) "...a list of descriptive terms and identifying codes for reporting medical services and procedures that physicians perform. The purpose of CPT is to provide a uniform language that accurately describes medical, surgical, and diagnostic services, thereby serving as an effective means for reliable nationwide communication among physicians, patients, and third parties" (AMA, 1992).

PHYSICIAN PAYMENT REVIEW COMMISSION (PPRC) A federal advisory body created in 1986 by Congress to design reasonable and rational payments to physicians by Medicare. After three years of study and consultation, the commission recommended that the work of William Hsiao and his colleagues at Harvard University in developing the resource-based relative-value scale be adopted as the method used to revamp the Medicare fee schedule.

RELATIVE-VALUE UPDATE COMMITTEE (RUC) Formed in 1991 to make recommendations to HCFA (CMS) on the relative values to be assigned to new or revised codes in the CPT. It is composed of 31 members; an AACAP member served from 1996-1999 in the non-internal medicine rotating seat. In 1999, the RUC established the PEAC (Practice Expense Advisory Committee) to recommend Practice Expense (PE) Relative Value Units (RVU) for each CPT code to the RUC.

RELATIVE VALUE UNIT (RVU) A unit of measure designed to permit comparison of the amounts of resources required to perform various provider services by assigning weight to such factors as personnel time, level of skill, and sophistication of equipment required to render service.

RESOURCE-BASED RELATIVE VALUE (RBRV) The actual figure or value arrived at in relative, nonmonetary work units (relative value units) that can later be converted into dollar amounts as a means for determining reimbursement for provider (such as physicians and hospital) services. The formula for RBRV for a given service is: $RBRV=(TW)(1+RPC)(1+AST)$, in which TW represents total work input by the provider; RPC is an index of relative specialty practice cost; and AST is an index of amortized value for the opportunity cost of specialized training. Total work input is defined by four attributes: time, mental effort and judgment, technical skill and physical effort, and psychological stress.

RESOURCE-BASED RELATIVE-VALUE SCALE (RBRVS) A method of reimbursement under Medicare that attempts to base physician reimbursement on the amount of resources, including cognitive and evaluative skills, required to diagnose and treat conditions. The approach weights what resources, such as practice costs and the cost of specialty training, have gone into

the “manufacture” of a service or procedure. Since the 1930's physicians have been paid according to the “customary, prevailing and reasonable” fee for a region of the country, and fee schedules reimbursed disproportionately for procedural services.

Appendix B

SUSTAINABLE GROWTH RATE (SGR) AND CONGRESS

The Medicare Access and CHIP (Children’s Health Insurance Program) Reauthorization Act (MACRA 2015) not only reauthorized CHIP, but also repealed the SGR or sustainable growth rate. The SGR was a controversial economic concept that Congress created in 1997 to control spending for Medicare physician and QHP services. They then overrode the mandated cuts for 17 of the 18 years of the SGR’s life. (2002 was the exception.)

While the SGR was alive, healthcare expenditures increased from 7.2% GDP (1970) to 12.5% GDP (1990) to 17.9% GDP (2010). In fact, as a per cent of GDP, healthcare expenditures increased more than 4.7% per year every year since 1970, and during the 20 years between 1970 and 1990, 17 of the 20 years the increases were >10%. It had increased at a record slow growth in 2009 (3.8%) and close to that in 2010 (3.9%). As a percent of GDP, healthcare expense has risen from 5% in 1960 to nearly 18% in 2010. (By comparison, Germany spends less than 8% of its GDP on healthcare.)

	1970 (\$billions)	1990 (\$billions)	2010 (\$billions)
National Health Expenditures	74.9	724.3	25,93.6
Private	31.7	439.5	1,870.8
CMS	13	183.8	937.6
Gross Domestic Product	1,038	5,801	14,527
Health Exp Share of GDP	7.2%	12.5%	17.9%

SOURCE: Center for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, 2012.

APPENDIX C

CODE CATEGORIES

Category I: these are the current procedure codes. All of the E/M and psychiatry codes are included in Category I.

Category II: These are OPTIONAL codes designed for physicians and/or auditors to track certain services that the Performance Measure Advisory Group (PMAG) - composed of experts from the Agency for Healthcare Research and Quality (AHRQ), The Joint Commission, American Medical Association (AMA), CMS, and the Physician Consortium for Performance Improvement (PCPI) - have determined contribute to quality care and good outcomes. They include performance measures like diabetic foot exam or the initiation of an anti-arrhythmia drug after a heart attack. These quality measures may also be used to determine Pay for Performance reimbursement, currently being considered by private payers. These are 5 digit codes with an "F" occupying the fifth digit slot, e.g. 1234F.

In CPT 2013, there are 23 potentially relevant Category II codes for Major Depression Disorder (MDD), Major Depression Disorder in Adolescents (MDD ADOL), and Substance Use Disorder (SUD). There are 16 codes related to dementia (DEM). (For a complete listing of Category II codes by clinical topic, see <http://www.ama-assn.org/resources/doc/cpt/cpt-cat2-codes-alpha-listing-clinical-topics.pdf>)

Patient Management:

- 0545F Plan for follow-up for major depressive disorder, documented ([MDD ADOL](#))

Patient History:

- 1040F DSM 5 criteria for Major Depressive Disorder documented at the initial evaluation (MDD, MDD ADOL)
- 1000F Tobacco use assessed (CAD, CAP, COPD, PV) (DM)
- 1175F Functional status for Dementia assessed and results reviewed (DEM)
- 1181F Neuropsychiatric symptoms assessed and results reviewed (DEM)
- 1182F Neuropsychiatric symptoms, one or more present (DEM)
- 1183F Neuropsychiatric symptoms absent (DEM)
- 1490F Dementia severity classified mild (DEM)
- 1491F Dementia severity classified moderate (DEM)
- 1493F Dementia severity classified severe (DEM)
- 1494F Cognition assessed and reviewed (DEM)

Physical Examination:

- 2014F Mental status assessed (CAP) (EM)
- 2060F Patient interviewed directly on or before date of diagnosis of major depressive disorder (MDD ADOL)

Screening Process:

- 3011F Lipid panel results documented and reviewed (CAD)
- 3085F Suicide risk assessed (MDD, MDD ADOL)
- 3088F MDD mild (MDD)
- 3088F MDD moderate (MDD)
- 3090F MDD severe without psychotic features (MDD)
- 3091F MDD severe with psychotic features (MDD)
- 3092F MDD in remission (MDD)
- 3093F Documentation of new diagnosis of initial or recurrent episode of MDD (MDD)
- 3351F Negative screen for depressive symptoms as categorized by using standard depression screening/assessment tool (MDD)
- 3352F No significant depressive symptoms as categorized by using a standardized depression assessment depression tool (MDD)
- 3353F Mild to moderate depressive symptoms as categorized by using a standardized depression screening/assessment tool (MDD)
- 3354F Clinically significant depressive symptoms as categorized by using a standardized depression screening/assessment tool (MDD)
- 3700F Psychiatric disorders or disturbances assessed (Prkns)
- 3725F Screening for depression performed (DEM)

Therapeutic, Preventive or Other Interventions:

- 4000F Tobacco use cessation intervention counseling (COPD, CAP, CAD)(DM)
- 4001F Tobacco use cessation intervention pharmacologic therapy (COPD, CAP, CAD)(DM)(PV)
- 4004F Patient screened for tobacco use AND received tobacco cessation counseling (PV)
- 4060F Psychotherapy service provided (MDD, MDD ADOL)
- 4062F Patient referral for psychotherapy documented (MDD, MDD ADOL)
- 4063F Antidepressant psychopharmacotherapy considered and not prescribed (MDD ADOL)
- 4064F Antidepressant pharmacotherapy prescribed (MDD, MDD ADOL)
- 4065F Antipsychotic pharmacotherapy prescribed (MDD)
- 4066F ECT provided (MDD)
- 4067F Patient reviewed for ECT documented (MDD)
- 4158F Patient counseled about risks of alcohol use (HEP-C)
- 4306F Patient counseled regarding psychosocial AND pharmacologic treatment options for opioid addiction (SUD)
- 4320F Patient counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence (SUD)
- 4322F Caregiver provided with education and referred to additional resources for support (DEM)
- 4328F Patient queried about sleep disturbance (Prkns)
- 4350F Counseling provided on symptom management, end of life decisions, and palliation (DEM)
- 4525F Neuropsychiatric intervention ordered (DEM)
- 4526F Neuropsychiatric intervention received (DEM)

Patient Safety:

- 6101F Safety counseling for dementia provided (DEM)
- 6102F Safety counseling for dementia ordered (DEM)
- 6110F Counseling provided regarding risks of driving and the alternatives to driving (DEM)

HEDIS measures that could become Category II codes for attention deficit disorder are currently being considered.

Category II code exclusion modifiers:

- 1P - medical reasons; e.g., absence of the organ or limb, contraindicated
- 2P - patient reasons; e.g., refusal, economic, social, and religious
- 3P - system reasons; e.g., lack of resources, insurance limitations
- 8P - reason not otherwise specified

Category III: These are TEMPORARY codes for new and emerging technologies or services. They may be covered by given carriers if you personally arrange for that. They are not covered by Medicare. If these codes are not assigned a category I code within 5 years, they will be retired. These codes are 5 digits with a "T" occupying the fifth digit slot - e.g. 1234T. In 2011, transcranial magnetic stimulation was assigned category I codes (90867, 90868) after several years as a category III code. Adaptive behavior assessments and adaptive behavior treatments were added in 2015. These code families are used to report assessment and treatment services typically used to work with patients with “impaired social skills, communication deficits, destructive behaviors, and additional functional limitations secondary to maladaptive behaviors” (p. 674). Applied behavior analysis for patients with autism spectrum disorder is an example of these services.

Many new code proposals are being assigned category III status to determine whether they are indeed widely used by physicians or other qualified healthcare professionals and have an evidence base for efficacy, not simply a manufacturer’s or industry’s sponsorship.

In summary, “regular” CPT codes are grouped as Category I codes in this edition of CPT. Two other code categories are also included in the book. Category II codes are optional and used to track performance measures like eye exam, foot exam, depression screen, etc. which may be part of another general examination. Category II codes exist for Major Depression Disorder, Major Depression in Adolescents, and Substance Use Disorder. Others are being developed for psychiatry. Category III codes are used to track new and emerging technologies and services. You must negotiate directly with the insurance carrier for payment. They are not part of the Medicare payment system.

APPENDIX D

BRIEF OVERVIEW OF SOCIAL HISTORY OF AMERICAN MEDICINE, BASED ON THE WORK OF PAUL STARR

In his sweeping sociological history of American medicine published in 1982, Paul Starr traces the origins of physician's status and authority. He carefully describes the political, economic, and cultural interactions that resulted in US healthcare 15 years after Medicare and 30 years before the Affordable Care Act (ACA, 2010). He couldn't quite understand how physicians, who lacked the capital necessary for the scientific research, building of hospitals and managing risk of illness (i.e. insurance companies), remained autonomous and authoritative. Fast forward 30 years, maybe we haven't. Lacking necessary capital to operate private practices (e.g. malpractice insurance premiums; electronic health records; personnel to handle billing, insurance companies, prior-authorizations, etc.), many physicians sought employment. Psychiatry remains the specialty with the highest percentage of self-employed practitioners of all medical specialties.

When we complain about erosion of our authority and status every time we have to obtain prior authorization for a medication or hospital admission, it is sobering to recall our origins. Two thousand years ago in Rome, citizens were not physicians; slaves and foreigners were. Three hundred years ago in Britain, the physician's social status was above surgeons and barbers (members of the same trade) and far below the aristocracy. In France, just last century, physicians who wanted to make it socially, did so by pursuing other cultural avocations, not professional excellence.

Are our days as Rock Stars over? If so, will our reimbursement also decline? And how did we get to this point?

In this country, with its maniacal obsession of the "individual," relying on an outside expert like a doctor never came easy. In the 19th century United States, people commonly relied on themselves and family for medical treatment. Following rational infection control, the introduction of anesthesia, adequate transportation to assure access to healthcare and then the closing of medical diploma mill schools in the early 20th century, doctors were in a position to assert claims for authority and expertise in care of illness. There were enough graduates from scientifically grounded medical schools, available to the general population to make their services meaningful. By limiting the supply of graduates, the medical profession (read "AMA") could control the number of practitioners, allowing them an opportunity to earn a good living. Under these market conditions (limited number of accessible physicians with a scientifically verified knowledge base that helps patients), financial risk to doctors was minimal. Physicians could remain self-employed with patients paying a fee (or barter) for services rendered.

With the rise of hospitals as centers for patients to receive treatment, doctors could be wooed to join their staffs, but should not be employed by them, according to mid-20th century standards. And no third parties should pay for care...well, if a third party was necessary that should be medical society, not an intermediary like an insurance company.

Starr also traces the origins of health insurance. Congress set up compulsory hospital insurance for merchant seamen in 1798, but not much else was done for over 100 years. He notes the first

private companies to offer health insurance were formed before the Civil War and went bankrupt. Other companies were formed in the 1880's, but efforts to insure health began in earnest around the turn of the 19th century. The problem was these early efforts returned about 40% of premiums in benefits, retaining about 60% in administrative costs. In contrast the ACA limits administrative costs to 15-20%.

Early last century during the Progressive Era, the American Association for Labor Legislation (1906) began pushing for legislation to help workers who were injured on the job to receive compensation (workman's compensation). They expanded their agenda to include national health insurance.

During the depression, families could no longer afford to pay doctor and hospital bills. Consequently, physician incomes fell while patients put off doctor visits because they couldn't pay. Further, farmers who were sick defaulted on their federal loans. The New Deal responded with the first experiment in national health insurance (1935) when a federal agency entered into agreement with local medical societies in the Dakotas to limit their total fees in return for subsidized pre-payment plans. The AMA objected to the intrusion of government into medical payment systems.

Collective bargaining (The National Labor Relations or Wagner Act, 1935) called for companies to engage in negotiations with unions that represented their workers. Congress refused to add health insurance to Social Security (1935), so unions negotiated health insurance privately with their industries.

While this process to secure health coverage began before World War II, Congressionally imposed price and wage freezes during the War accelerated the process. Orders for manufactured goods (material for the war effort) were increasing and companies were short on labor. They needed to hire. Without ability to raise wages to attract workers, what was to be done? Companies offered improved benefit packages to recruit workers. The concept of employer's paying for medical insurance grew rapidly. Unions like the United Mine Workers of America (UMWA), United Automobile Workers (UAW), and United Rubber Workers (URW) were driving forces behind this expansion of coverage.

But as more people gained health insurance, doctor fees increased. In order control the fees, some labor organizations began engaging in prepayment plans that fixed costs. St. Louis' Labor Health Institute (LHI) remains a successful example of this practice. Elsewhere, medical societies successfully blocked development of similar programs.

Twenty years after the War, Medicare was enacted (1965) and implemented (1967). Healthcare expenses rose. So did employer's cost of paying for health insurance. While other developed countries devoted no more than 5% of their Gross Domestic Product to health care, the United States was spending no less than 10% on its healthcare. By the 1970s, health benefits added \$500 to the cost of every automobile made in this country.

Unlike many other developed countries, in the United States private companies assumed responsibility for parts of the social safety net: health care and retirement. Elsewhere,

governments take primary responsibility for these services.

In the 1970s, Congress wanted to encourage insurance companies to offer health insurance programs and pension plans (Employee Benefit Plans) to companies. President Ford signed the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provided:

- Federal, not state, control of pension funds
- Exemption of insurance companies from lawsuit
- Assign fiduciary responsibility to funds administrator, even if it is the insurance company.

Because of the fiduciary's need to maintain pension fund's solvency and because healthcare cost had an increasing impact on the company's bottom line, fund administrators became more critical and selective when purchasing health care coverage. Through ERISA, companies had the authority to determine what health care services, packages and limitations their employees could receive, without risk of lawsuit against them or the insurance company.

Before ERISA, insurance companies had to make good faith effort to settle claims or face lawsuit. ERISA changed the liability standard from "bad faith" to "arbitrary and capricious." Even if this higher standard were met, no punitive damages could be awarded. In addition, before filing a claim, the claimant must first exhaust all administrative appeals (internal) to obtain a settlement. The settlement cannot exceed what the insurance company would have to pay if the claim had originally been approved (no punitive damage). The settlement does not include attorney fees for this administrative process; they are the claimant's responsibility.

Starr suggests 2 additional reasons for the post-Medicare cost explosion:

1. In an effort to retain support of doctors and hospitals, or at least mute their opposition, Congress established intermediaries between providers (hospital, doctors) and the Social Security Administration (SSA). These companies (carriers) did reimbursement, consulting and auditing; the SSA paid the bills.
2. Rules of payment to hospitals were based on costs, as opposed to negotiated fees. The higher the cost, the higher the payment. But there was also a rationale: cost based payment increased hospital investment in new equipment and technology, something highly valued.

Congress's Solution

The Health Care Financing Administration (HCFA, 1977) was established within the Department of Health and Human Services of the Federal government to rein in the spiraling costs of administering Medicare. HCFA's charge was to:

- Control expenses.
- Guarantee that the services billed and paid for are the ones that are delivered. For example, if the government paid for an adolescent in an acute psychiatric bed, HCFA assured that the adolescent received documented acute care, as opposed to residential or custodial care. Or, if the government paid for a comprehensive outpatient examination, HCFA assured that the examination was truly comprehensive, with documented evidence that it **was** different from a less thorough examination.

- Adopt procedure codes to accurately describe medical procedures. HCFA chose the Current Procedural Terminology (CPT) codes developed by CPT Editorial Board of the American Medical Association. In 1992 many private insurance companies began using them as well. In 1996, the Health Insurance Portability and Accountability Act (HIPAA) mandated that any insurance companies using electronic billing/payment processes must use CPT codes for claims and reimbursement.
- Assign reimbursement values for each CPT code, based on interpretation of Congressional mandates. To assist them in the process, Congress authorized development of The Resource-based Relative-value Scale (RBRVS) (Hsiao, 1987). Currently, Medicare payment to physicians is based on the RBRVS.

Going into the 1992 Presidential elections, healthcare “reform” was a major issue for both Presidential candidates. The Jackson Hole Group advised both nominees. Systems of managing care were recommended and many businesses adopted them to reduce healthcare costs. (On June 14, 2001, HCFA’s name was changed to the more descriptive Center for Medicare and Medicaid Services (CMS). CMS will be used throughout the remainder of the module.) Congress passed no healthcare legislation until 2003 when President G.W. Bush signed the Medicare Modernization Act. This law created Medicare Part D, the prescription drug benefit plan that went into effect in 2006. The next major overhaul occurred four years later when President Obama signed the Patient Protection and Affordable Care Act (ACA).

Claiming to have learned from the mistakes of “managed care,” the authors of the rules and regulations for this piece of legislation attempted to put physicians and other qualified healthcare professionals in charge of managing resources and healthcare. Instead of insurance company and business created Health Maintenance Organizations, Accountable Care Organizations (ACOs) became the new vehicle to rein in costs while providing world-class care. Congress authorized Medicare, the largest insurance program in the country, to provide incentives for quality care and penalties for suboptimal care.

In June 2012, the Supreme Court in a 5-4 decision ruled that the Affordable Care Act was constitutional (under the Congressional authority to raises taxes and a concurrent opinion finding the authority under the commerce clause). The Act took full effect in 2014.

In his March 4, 2013 Time Magazine Special Report, Why Medical Bills Are Killing Us, Steven Brill points out:

1. Nearly 20% of our Gross Domestic Product is spent on Healthcare.
2. For Congressional lobbying, healthcare concerns spend more than 3 times what the military industrial complex spends.
3. Hospitals figured out a more lucrative charging mechanism than basing them on costs. They simply create them (“charge masters”) and, with a captive customer (the patient in one of its beds), the patient is stuck with the tab. States regulate utilities because customers cannot choose where to buy electricity, gas or water, but no such regulations exist for hospitals.
4. In spite of their tax exempt, not for profit status, each of the largest 10 hospitals in this country collects more than \$100 million above its expenses.

Politics aside, since the early 1980s, physicians have been paid by procedure, whether office visit or surgical. Instead of basing payments to physicians on charges, CMS paid according to a standardized payment schedule based on the resource costs needed to provide each service, called RVU's – "relative value units."

MACRA may change how physicians are paid. After 4 years of 0.5% pay increase, Medicare payments to physicians will freeze for 5 years. Then, in 2026, physicians will choose whether they want to sign up for the Merit Based Payment System or Alternative Payment Models.

The Merit Based Payment System will increase payments by 0.25% annually (beginning in 2026) based on 4 categories of measures: quality, resource use, clinical improvement, and HER use.

For physicians to participate in the Alternative Payment Model Plan, they must demonstrate an increase in income from qualifying alternative payment models (APM) like medical homes or accountable care organizations. From 2019 – 2020, 25% of Medicare revenue must come from APMs; 2021 – 2022, 50% of Medicare Revenue of 50% of all payer revenue along with 25% of Medicare revenue must come from APMs; 2023 and beyond, 75% of Medicare revenue or 75% of all payer revenue along with 25% of Medicare revenue must come from APM's. (E. Cragun: The most important details in MACRA from The Advisory Board Company, <https://www.advisory.com/research/health-care-advisory-board/blogs/at-the-helm/2015/04/sgr-repeal>.)

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