AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

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CPT Code Training Module

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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 describe medical procedures and services provided by physicians and other qualified healthcare professionals (QHP). The American Medical Association (AMA) owns and maintains CPT codes. The Healthcare Insurance Portability and Accountability Act (HIPAA) of 1996 included electronic billing standards requiring CPT codes to report physician services.

The Center for Medicare and Medicaid Services (CMS) uses a physician payment system known as the Resource Based Relative Value Scale (RBRVS) to assign each CPT code a Relative Value Unit (RVU). The Relative Value Scale Update Committee (RUC) - sponsored and maintained by the AMA - recommends RVU values to CMS. CMS publishes the RVU value in the Final Rule of the *Federal Register* every November. Congress mandates reviewing these values every five years.

This module explains:

- The RVU determination process for CPT codes,
- consequences of failing to utilize correct coding (fraud and abuse),
- CPT codes from the psychiatry section of the current CPT manual, and
- 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 Scale Update Committee (RUC)

Relative Value Units (see next section) are assigned to CPT codes by CMS after receiving recommendations from the RUC. The RUC consists of 31 voting members representing the largest medical societies in the AMA House of Delegates. Advisers serve from the remainder of the medical societies in the House of Delegates. The American Psychiatric Association has a voting member and the American Academy of Child & Adolescent Psychiatry has an advisor, currently Dr. Sherry Barron-Seabrook.

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 for an average of 51% of the total relative value for each service. The factors used to determine physician work include:

- amount of time to perform the service/procedure plus pre- and post-service time
- technical skill and physical effort involved in performing the service/procedure
- mental effort and judgment required
- stress due to potential risk to the patient from the underlying illness or procedure

Practice Expense (PE)
Practice expense RVUs account for an average of 45% 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.

Professional Liability Insurance (PLI)
The professional liability insurance component accounts for an average of 4% of the total; relative value for each service.

Conversion Factor
The sum of these 3 components (work units + practice expense units + professional liability 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: for 99213, RVW is 0.97, PE for non-facility is 1.02, PLI is .07; therefore, 0.97 + 1.02 +.07 = 2.06 (Total RVU). That number is multiplied by 35.99 (the Conversion Factor for 2018) to arrive at the Medicare payment of $74.14 (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.)

Scope of CPT And RUC
While the Healthcare Insurance Portability and Accountability Act of 1996 (HIPAA) mandates that private payers use current CPT codes, CPT code reimbursement values are applicable only to services billed to Medicare through any of its regional carriers. Private payers may set their own reimbursement values.

FRAUD AND ABUSE

The only legal way to be paid for a service is to bill using the correct CPT code. You must document that the level of service claimed was medically necessary and delivered.

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.

- The 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 Billing for services not provided (False Claims Act (FCA) 1986).

Up coding Reporting a higher-level service or procedure than one that is performed or is medically necessary (eg, 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) (eg, 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. (eg, multiple psychotherapy sessions for the same patient on the same day). Originally, the edits were called "medically unbelievable," but because of physician objection, the term "unlikely" was substituted for "unbelievable," maintaining the acronym MUE. MUEs for the current psychiatry code set continue to be developed.

Consequences:
- 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 <oig.hhs.gov/publications/docs/hcfac/hcfacreport2012.pdf> (HCFAC = Healthcare 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 whistle-blower could still receive 15% to 25% of the claim. The whistle-blower may proceed alone and keep up to 30% of the final recovery. Such cases are also called "qui tam" cases.

Code Categories

The Health Insurance Portability and Accountability Act (HIPAA) required CMS to request proposals for alternative coding systems. The AMA 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). HIPAA (1996) and Mental Health Parity and Addiction Equality Act of 2008 (MPHAEA) require providers to use CPT in all electronic claims for psychiatric services to all insurance companies, both private and government sponsored. Psychiatrists use CPT Codes to report these services:

- Evaluation and Management (E/M) Services
- Psychiatric diagnostic evaluation
- Psychotherapy
- Interactive complexity
- Other psychotherapy
- Other psychiatric services
- Collaborative care services
- Other codes
- Modifiers

Evaluation and Management (E/M) Codes

History

CPT (2013) deleted 90862 (pharmacologic management) with instructions to use E/M codes to report 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 all 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 prescribing one or occasionally two psychotropic medications at a time had become outdated. Revisions were needed to address the increased complexities of psychopharmacologic management in current practice. E/M codes best describe the work and medical decision making now required.

E/M codes may report evaluation and management services either alone (pharmacological/ medical management and no other service reported that day) or 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.

Common Evaluation and Management Code Families Used by Psychiatrists

E/M Description	Codes
Office or Other Outpatient Services, new patient	99201 to 99205
Office or Other Outpatient Services, established patient	99211 to 99215
Office or Other Outpatient Consultations, new or established patient	99241 to 99245
Initial Hospital Care, new or established patient	99221 to 99223
Subsequent Hospital Care, new or established patient	99231 to 99233
Inpatient Consultations	99251 to 99255

Other E/M code families include observation care (99218 to 99220, 99224 to 99226), observation or inpatient care services (99234 to 99236), nursing facility care (99304 to 99306, 99307 to 99310), emergency department services (99281 to 99285), domiciliary, rest home, or custodial care services (99324 to 99328, 99334 to 99337), home services (99341 to 99345, 99347 to 99350), and neonatal and pediatric critical/intensive care (99468, 99469, 99471, 99472, 99475, 99476, 99291, 99292, 99477 to 99480). As most psychiatrists will be using Office or Other Outpatient Services, Established Patient (99211 to 99215), this section will use this code family as examples. First, however, one must distinguish a "new" from "established" patient to use CPT correctly.

What is a "new" patient?

Using new patient E/M codes (99201 to 99205) is more restrictive than using psychiatric diagnostic evaluation codes (90791, 90792; described in the following section.). New patients must not have received <u>any</u> professional services in the past three years by the physician OR another physician in the same group practice of the exact same specialty and sub-specialty. Advanced practice nurses, physician assistants and covering professionals working with physicians are considered as working in the exact same specialty and exact same subspecialties as the physician.

Determining Evaluation and Management Levels by Time

Time or key components determines the level of E/M codes in both outpatient or inpatient settings. Time is a simpler criterion and requires that counseling and/or coordination of care accounts for more than 50% of the encounter. Time for *office and outpatient visits* is <u>only</u> the face-to-face time with the patient and/or family members. *Inpatient or hospital consultation* time is unit floor time and consists of patient and/or family contact, chart review, orders, writing notes, telephone calls, and meeting with the treatment team while on the "floor."

Counseling is discussion with patient and/or family about diagnostic results, prognosis, treatment risks and benefits, risk factor reduction, treatment compliance, and/or education. *Coordination of care* is discussion of patient care with other providers or agencies.

Description	Codes and "Typical" Time				
Office or Other Outpatient Services, new patient	99201 10 min	99202 20 min	99203 30 min	99204 45 min	99205 60 min
Office or Other Outpatient Services, established patient	99211 5 min	99212 10 min	99213 15 min	99214 25 min	99215 40 min
Office or Other Outpatient Consultations, new or established patient	99241 15 min	99242 30 min	99243 40 min	99244 60 min	99245 80 min
Inpatient Consultations	99251 20 min	99252 40 min	99253 55 min	99254 80 min	99255 110 min

Determining Evaluation and Management Levels by Key Components

Rather than using *time* to select the level of E/M code, physicians may use key components. Please see the video webinars under the dropdown Menu (CPT) on the Member Resource tab on the AACAP homepage as well as carefully review the AMA's CPT Manual for a full understanding.

The three key components are *history*, *examination*, and complexity of *medical decision making*. Established patients for office or other outpatient services (99211 to 99215) only require 2 out of 3 key components. "New" patients (as defined above) require 3 out of 3 key components (99201 to 99205). Each key component has four levels.

See Appendix A with E/M Coding Summary Guide v2. (http://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/business_of_practice/cpt/EM_Coding_Summary_Guide_v2.pdf)

History consists of four levels – *problem focused, expanded problem focused, detailed,* and *comprehensive* depending on the amount of information from the history of present illness (HPI), past, family, social history (PFSH), and review of systems (RoS).

Examination consists of four levels - *problem focused, expanded problem focused, detailed,* and *comprehensive* depending on the number of elements. In 1997, for CPT purposes, HCFA (now CMS) recognized 10 single organ systems whose examination could be documented in place of the general multi-system examination to meet standards for the levels of E/M codes. Psychiatry is recognized as having a single organ system examination and includes mental status, constitutional and musculoskeletal elements.

Medical decision making consists of four levels – *straightforward*, l*ow complexity, moderate complexity* and *high complexity*. The calculation of complexity depends on diagnosis, management options, data reviewed (eg, records, labs, test results), and level of risk (eg,

potential complications, morbidity). Please review the AMA CPT manual and the AACAP webinars for a better understanding of this calculation.

See the table of risk on page 16 of the E/M services guide: (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf) or in the Summary Guide (https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/business_of_practice/cpt/EM_Coding_Summary_Guide_v2.pdf)

Psychiatric Diagnostic Evaluation

Psychiatric Diagnostic Evaluation without medical services (90791)
The evaluation may include communicating with family or other sources, as well as reviewing and ordering non-medical diagnostic studies.

Psychiatric Diagnostic Evaluation with medical services (90792)
As above (90791), the evaluation may include communicating with family or other sources, as well as reviewing and ordering diagnostic studies. It must include medical services. "Medical services" refers to "medical thinking" as well as medical activities (eg, physical examination, prescription of medication, and review and ordering of medical diagnostic tests). Medical thinking must be documented (eg, 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, for later reassessment, as indicated.
- Do not report on the same day as psychotherapy or an E/M service.
- 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.

Do not report with 90839, 90840, 0364T, 0365T, 0366T, 0367T, 0373T, 0374T
Do not report with 99201, 99337, 99341-99350, 99366-99368, 99401-99444, 0368T, 0369T, 370T, 0371T

Psychotherapy

CPT 2017 removed the words "and/or family" from psychotherapy codes (90832, 90833, 90834, 90836, 90838, 90839). These are considered individual psychotherapy codes focused on the patient. While family member(s) may participate, the patient must be present for all, or the

majority of the service. As long as the patient is present for a majority of the service, psychotherapy time spent with family member(s) or other informant(s) when the patient is not present counts toward the time requirement for selecting the code.

Psychotherapy codes that specify a specific time follow the CPT 2011 time rule (i.e., a unit of time may be billed when the mid-point of time interval is passed), as listed below.

Psychotherapy, 30 minutes (90832)
Psychotherapy, 45 minutes (90834)
Psychotherapy, 60 minutes (90837)

Psychotherapy, 30 minutes, with E/M service (90833)
Psychotherapy, 45 minutes, with E/M service (90836)
Psychotherapy, 60 minutes, with E/M service (90838)
Used when coding psychotherapy conducted on the same day as an E/M service.

Time determines the selection of the appropriate psychotherapy code: 16-37 minutes for 90832 or 90833; 38-52 minutes for 90834 or 90836; 53-89 minutes for 90837 or 90838. Psychotherapy must be at least 16 minutes to be reported. For psychotherapy of 90+ minutes, use 90837 and the appropriate prolonged service code (99354-99357).

Since 2013, the psychotherapy add-on codes allow psychiatrists to report psychotherapy with the full range of E/M codes. To report both E/M and psychotherapy, the two services must be *significant* and *separately identifiable*. However, the time within the service does not have to be distinctly separated (i.e. elements of psychotherapy may be interwoven with evaluation/ management elements). CPT gives a roadmap for separately identifying the medical and psychotherapeutic components of the service:

1. The type and level of E/M service is selected first based upon the *key components* of history, examination, and medical decision-making.
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).
3. Time may not be used to select the E/M code when psychotherapy add-on codes are used.
4. Prolonged Services may *not* be reported when E/M *and* psychotherapy (90833, 90836, 90838) are reported.
5. A separate diagnosis for a psychiatric or medical condition 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. Psychotherapy must be at least 16 minutes to be reported.

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.

Time

Psychotherapy times are for face-to-face services with patient, who must be present for all or a majority of the service. For family psychotherapy, use 90847 (patient present) or 90846 (patient not present).

Table 1. Psychotherapy with Patient		
Code	**"Exact" Time**	**Actual Time Range**
90832, 90833	30	16-37
90834, 90836	45	37-52
90837, 90838	60	53+

Site of Service

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

Interactive Complexity

The Interactive Complexity add-on code (90875) describes 4 specific communication factors that complicate a psychiatric service thus requiring greater technical skill, mental effort and judgment, (i.e., greater work). Typically, these factors are present with third party involvement during the service/procedure (eg, minors with parents or guardians, adults with guardians, or patients who request that others be involved in their care during the visit).

Interactive complexity may be reported with: psychiatric diagnostic evaluation (90791, 90792), psychotherapy (90832, 90834, 90837), psychotherapy add-on services performed with an evaluation and management service (90833, 90836, 90838), and group psychotherapy (90853).

Add-on 90875 may not be reported with E/M Services alone, but rather only when an E/M service is combined with psychotherapy. This code MAY NOT be reported with family psychotherapy (90846, 90847, 90849) and psychotherapy for crisis (90839, 90840).

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, eg, 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 (eg, 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 barriers[1].

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 reported.

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

Other Psychotherapy

Psychotherapy for Crisis (90839, 90840)
Psychotherapy for crisis may be reported for a patient presenting in high distress with complex or life-threatening circumstances requiring immediate attention. Code 90839 covers psychotherapy for crisis for the first 60 minute and the add-on code 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 *any* other psychiatric services (90785-90899).

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

Table 2. Psychotherapy for Crisis

Code	Time
90839	31 to 74 minutes
90839 and 90840	75 to 104 minutes
additional 90840	*each additional increment of up to 30 minutes*

Psychoanalysis (90845)
The code for psychoanalysis has not changed since 1992.

Family Psychotherapy (without the patient present), 50 minutes (90846)
Family Psychotherapy (conjoint therapy with the patient present), 50 minutes (90847)
CPT 2017 revised the code to include a specified time. Medical management services, if also performed, are reported separately with a -25 modifier (See "Modifier Codes" below). As per the CPT time rule, family psychotherapy codes require at least 26 minutes of service (i.e., greater than ½ of 50 minutes). *One may NOT report interactive complexity (90785) with these codes.*

Do not report 90846, 90847 in conjunction with 0368T, 0369T, 0370T, 0371T (Category III codes, see appendix D).

Multiple Family Group Psychotherapy (90849)
Unchanged since 1997.

Group Psychotherapy (90853)
Group psychotherapy remains unchanged since 1992.

Do not report 90853 in conjunction with 0372T

Other Psychiatric Services

Additional codes that may be useful for child and adolescent psychiatrists are listed below. However, having an established RVU *does not guarantee* reimbursement by 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.

Table 3. Other Psychiatric Services

Code	Service
90865	Narcosynthesis
90867	Therapeutic repetitive transcranial magnetic stimulation (TMS); initial
90868	Therapeutic repetitive transcranial magnetic stimulation (TMS); subsequent
90869	Therapeutic repetitive transcranial magnetic stimulation (TMS); subsequent motor threshold re-determination with delivery and management
90870	Electroconvulsive therapy (ECT)
90875	Individual psychophysiological therapy incorporating biofeedback training, 30 minutes
90876	Individual psychophysiological therapy incorporating biofeedback, 45 minutes
90880	Hypnotherapy
90882	Environmental manipulation
90885	Psychiatric evaluation of records
90887	Interpretation or explanation to family
90889	Preparation of psychiatric report
90899	Unlisted psychiatric service or procedure
90901	Biofeedback training by any modality
90911	Biofeedback training, including EMG and/or manometry

Pharmacologic Management add-on code (90863)
This 2013 code may only be used by qualified healthcare professionals (QHP) who may not use E/M codes for reporting services. The primary users of this code are expected to be prescribing psychologists. 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.

Care Coordination / Collaborative Care Codes

For years, CPT struggled with a way for physicians to bill for non-face-to-face services including phone calls, team 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 appropriate codes could be developed through the CPT/ RUC process. 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.

Chronic Care Management Services (99490)
Chronic care management services involve at least 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month for medical and/or psychosocial needs. Patients must have multiple chronic conditions expected to last at least 12 months (or until death). The chronic conditions must include significant risk of death, acute exacerbation/ decompensation, or functional decline. This service requires that a comprehensive care plan (defined by CMS https://www.medicare.gov/forms-help-and-resources/mail-about-medicare/comprehensive-primary-care-initiative-notice.html) be established, implemented, revised, or monitored.

Complex Chronic Care Management Services (99487, 99489)
These services are more involved and require at least 60 minutes per calendar month under the direction of a physician or other qualified healthcare professional (QHP). They are only reported if the care plan requires more than minimal change. The patient's medical, functional, and/or psychosocial problems require medical decision making of moderate or high complexity.

Pediatric patients typically receive three or more therapeutic interventions (eg, medications, nutritional support, respiratory therapy). Typical adult patients are treated with three or more medications as well as other therapeutic interventions. Patients have multiple chronic continuous or episodic health conditions expected to last at least 12 months (or until death) of the patient, and that place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline.

Patients must demonstrate one or more of the following:

- need for the coordination of many specialties and services;
- inability to perform activities of daily living and/or cognitive impairment resulting in poor adherence to the treatment plan without substantial assistance from a caregiver;
- psychiatric and other medical comorbidities (eg, dementia and chronic obstructive pulmonary disease or substance abuse and diabetes) that complicate their care; and/or
- social support requirements or difficulty with access to care.

Do not report 99487, 99489, 99490 during the same month with 90951-90970, 93792, 98960-98962, 98966-98969, 99071, 99078, 99080, 99090, 99091, 99391, 99339, 99340, 99358, 99359, 99366-99368, 99374-99380, 99441-99444, 99495, 99496, 99605-99607.

Coding Tip: Time of care management with the emergency department is reportable using 99487, 99489, 99490 but NOT while the patient is inpatient or admitted for observation.

Table 4. Complex Chronic Care Management

Code	Time over a calendar month
Not reported separately	less than 60 minutes
99487	60 to 89 minutes
99487 and 99489 x 1	90 to 119 minutes
99487 and 99489 x 2	120 to 149 minutes
additional 99489	*each additional increment up to 30 minutes*

Psychiatric Collaborative Care Management Services (99492 - 99494)
New for 2018, these codes describe work done in a calendar month by a behavior health manager under the direction of a physician (or other qualified healthcare professional) along with a psychiatric consultant. The service includes work done by all three participants.

Patients typically have newly diagnosed or multiple conditions, need help with treatment engagement, have not responded to standard care, and/or require further assessment and engagement before considering higher levels of care.

The bulk of the work for this code is by the behavioral health manager who provides care management, assesses needs (such as with rating scales), develops the care plan, provides brief

interventions, collaborates with the treating physician and psychiatric consultant, and maintains a patient registry. If the health manager provides additional services, such as psychiatric diagnostic evaluation or other psychotherapy, they may report those services separately.

The supervising physician (or other qualified healthcare professional) is typically a primary care physician directing the behavioral healthcare manager and overseeing the patient's care. The psychiatric consultant makes recommendations on diagnosis and treatment communicated through the behavioral health manager. Beyond this non-face-to-face work, any additional services performed, such as evaluation and management codes or psychiatric diagnostic codes, are separately reported.

Initial psychiatric collaborative care management, 70 minutes, first calendar month (99492)
The service includes patient outreach and engagement, initial assessment of the patient including validated rating scales, development of a treatment plan, review by the psychiatric consultant, patient registry and monitoring, weekly caseload consultation with the psychiatric consultant, and brief interventions (eg, behavioral activation, motivational interviewing, and other focused treatment strategies).

Subsequent psychiatric collaborative care management, 60 minutes, subsequent month (99493)
This requires tracking patient follow-up and progress using the registry, weekly caseload consultation with the psychiatric consultant, ongoing collaboration with the treating physician or other qualified healthcare professionals, treatment progress review, patient monitoring using validated rating scales, brief interventions, relapse prevention and any discharge planning.

Initial or subsequent psychiatric collaborative care management, each additional 30 minutes (99494)
Use with either 99492 or 99493 for each additional 30 minutes (using the CPT time rule) that calendar month.

Table 5. Initial Psychiatric Collaborative Care Management

Code	Time over a calendar month
Not reported separately	less than 36 minutes
99492	36 to 85 minutes
99492 and 99484 x 1	86 to 115 minutes
99492 and 99484 x 2	116 to 145 minutes
additional 99484	*Each additional increment up to 30 minutes*

Table 6. Subsequent Psychiatric Collaborative Care Management	
Code	Time over a calendar month
Not reported separately	less than 31 minutes
99493	31 to 75 minutes
99493 and 99484 x 1	76 to 105 minutes
99493 and 99484 x 2	106 to 135 minutes
additional 99484	*each additional increment up to 30 minutes*

General Behavioral Health Integration Care Management (99484)
This service is performed by clinical staff but reported by the supervising physician or other qualified healthcare professional (QHP). The patient must have a behavioral health condition requiring care management services of 20 minutes or more in a calendar month. The required treatment plan does not have to be comprehensive. The office does not need to have all the functions of chronic care management (99487, 99489, 99490).

The reporting professional must be able to perform the evaluation and management (E/M) services of an initiating visit.

General behavioral integration care management and chronic care management services may be reported by the same professional in the same month if distinct care management services are performed. Additional services, such as E/M services or psychiatric services may also be reported by the physician (or other qualified health professional), However, behavioral health integration care management (99484) and psychiatric collaborative care management (99492, 99493, 99494) may not be reported by the same professional in the same month.

Care management services for behavioral health conditions, at least 20 minutes in a calendar month (99484)
Requires: initial assessment or follow-up monitoring using validated rating scales, behavioral healthcare planning, coordinating treatment, and continuity of care.

Coding Tip: Time of care management with the emergency department is reportable using 99484, 99492, 99493, 99494 but NOT while the patient is inpatient or admitted for observation.

Work personally done by physician (or qualified healthcare professional) as behavioral healthcare manager activities may be used to meet elements of 99484, 99492, 99493, and 99494 (if not used to meet criteria for a separate code).

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 healthcare professionals of different specialties or disciplines who provide direct care to the patient. Only one individual from each specialty may report 99366-99368[2]. Reporting participants need to have performed face-to-face evaluations or treatments of the patient, independent of any team conference, within the previous 60 days. 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.

Do not report 99367, 99368 during the same month with 99487-99489
Do not report 99367, 99368 when performed during the service time of codes 99495 or 99496

Interprofessional Telephone/Internet Consultation (99446-99449)
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 (QHP) 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 (QHP).
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 QHPs has the patient in his/her office and is wondering what to do next.

2 Codes 99366 and 99368 refer to medical team conferences reported by non-physician qualified health professionals

Table 7. 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	
Code	**Medical consultative discussion and review**
99446	5-10 minutes
99447	11-20 minutes
99448	21-30 minutes
99449	>31 minutes

Other Codes

Central Nervous System Assessments/Tests, Health and Behavior Assessment/Intervention, Prolonged Services, Telephone Evaluation/Management and Online Medical Evaluation codes.

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

These may be performed by physicians or other qualified healthcare professionals (QHP). They are typically reported per hour, for time face-to-face or preparing and interpreting the report.

Table 8. CNS Assessments

Code	Service
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[1]
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
96125	Standardized cognitive performance testing
96127	Brief emotional/behavioral assessment[1]

[1]Please see below for further description

Developmental Screening (eg, developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument (96110)

Brief Emotional/Behavioral Assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument (96127)

Health and Behavior Assessment/Intervention

Administration of Patient-Focused Health Risk Assessment Instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument (96160)

Administration of Caregiver-Focused Health Risk Assessment Instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument (96161)

These four codes - 96110, 96127, 96160, and 96161 - are largely practice expense without any physician work value. This reflects instrument scoring being typically done by administrative staff and does not require a physician or otherwise qualified healthcare professional. Interpretation and diagnosis is separately accounted by another code - usually an evaluation/management code.

Most psychiatrists employing these codes will be using 96127. Screening parents (or other family caregivers) for mental health issues impacting the patient can be reported with 96161. Psychiatrists or QHPs working with young children or patients with autism spectrum disorders may also be use 96110 to report screening for developmental delays. While psychiatrists are unlikely to use 96160, they may if using a standardized scale to evaluate behavioral effects resulting from head injury.

Please note that all these codes can only be reported when:

- there is a practice expense (eg, staff time, screening tool cost),
- the instrument is standardized (i.e., validated tools scored in a consistent manner),
- the results are documented.

Examples (not comprehensive)	96110	96127	96160	96161
Acute Concussion Evaluation (ACE)			x	
Ages and Stages Questionnaire (ASQ)	x			
Ages and Stages Questionnaire: Social Emotional (ASQ:SE)		x		
Beck Youth Inventory – Second Edition (BYI-II)		x		

Examples (not comprehensive)	96110	96127	96160	96161
Behavior Assessment Scale for Children – 2nd Ed. (BASC-2)		x		
Conners Rating Scale		x		*
CRAFFT Screening Interview		x	x	
Edinburg Postnatal Depression Scale (EPDS)		x		*
Modified Checklist for Autism in Toddlers - Revised (MCHAT-R)	x			
Patient Health Questionnaire (PHQ-2 or PHQ-9)		x		*
Parents' Evaluation of Developmental Status (PEDS)	x			
Screen for Child Anxiety Related Disorders (SCARED)		x		
Vanderbilt ADHD rating scales		x		*
**when assessing caregiver, but billing under patient*				

Prolonged Services

These codes are reported when a physician or QHP provides prolonged service(s) beyond the usual service. Clearly document this time separately (i.e. in addition to the time performing the base code).

*Prolonged Services With Direct Patient Contac*t (99354, 99355)
Used for prolonged services involving direct outpatient contact (inpatient service uses 99356, 99357). This is reported in addition to the primary procedure, such as a specific evaluation and management service or psychotherapy code 90837. Using time-based add-on codes requires that the primary evaluation and management service have a typical or specified time published in the CPT codebook, such as 99211 to 99215.

Table 9. Prolonged Services With Direct Patient Contact

Code	Time beyond the time (90837) or typical time (E/M codes) of the primary service
99354	30 to 74 minutes
99354 and 99355 X 1	75 to 104 minutes
99354 and 99355 X 2	105 to 134 minutes
additional 99355	*each additional increment up to 30 minutes*

The extra time spent must be on the same day but does not have to be continuous.
Use 99354 in conjunction with 90837, 90847, 99201-99215, 99241-99245, 99324-99337, 99341-99350, 99483)
Do not report 99354 with 99415, 99416.

Prolonged Service Without Direct Patient Contact (99358, 99359)
Used when the prolonged service is not face-to-face time. This is reported in addition to the primary procedure, Unlike Prolonged Service With Direct Patient Contact, a typical time for the primary service need not be established within the CPT codebook.

The service may occur on a different date from the related primary service. The related service must be related to ongoing patient management, be face-to-face and may occur in the past or future. This prolonged service time does not have to be continuous but does have to occur on the same day.

Table 10. Prolonged Services Without Direct Patient Contact	
Code	Time
99358	30 to 74 minutes
99358 and 99359 X 1	75 to 104 minutes
99358 and 99359 X 2	105 to 134 minutes
additional 99359	*each additional increment up to 30 minutes*

Do not report for time spent in care plan oversight services (99339, 99340, 99374-99380), home and outpatient INR monitoring (93792, 93793), medical team conferences (99366-99368), on-line medical evaluations (99444), or other non-face-to-face services that have more specific codes and no upper time limit in the CPT code set. Codes 99358, 99359 may be reported when related to other non-face-to-face services codes that have a published maximum time (eg, telephone services).
Do not report during the same month with 99487-99489.
Do not report when performed during the service time of codes 99495 or 99496.

Prolonged Clinical Staff Services With Physician or Other Qualified Healthcare Professional Supervision (99415, 99416)
Reported when a prolonged outpatient evaluation and management (E/M) service is provided by clinical staff directly supervised by a physician or qualified healthcare professional. This service is reported in addition to the designated E/M services and any other services provided at that time. Using time-based add-on codes requires that the primary evaluation and management service have a typical or specified time published in the CPT codebook, such as 99211 to 99215.

The extra time spent must be on the same day but does not have to be continuous. Codes 99415 and 99416 may only be reported for one or two simultaneous patients.

Table 11. Prolonged Clinical Staff Services With Physician or Other Qualified Healthcare Professional Supervision	
Code	Time
99415	30 to 74 minutes
99415 and 99416 X 1	75 to 104 minutes
99415 and 99416 X 2	105 to 134 minutes
additional 99416	*each additional increment up to 30 minutes*

Use 99415 in conjunction with 99201-99205, 99211-99215)
Do not report in conjunction with 99354, 99355.
Facilities may not report 99415, 99416.

Telephone Services (99441-99443)
To report these non-face-to-face E/M codes, services must be provided by telephone *at least 7 days after* a face-to-face visit. Otherwise it is considered part of the post-service 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-service time of that visit and *cannot* be reported separately. (Remember to check with the patient's insurance whether these services are covered.)

Table 12. Telephone E/M service provided to an established patient, parent/guardian	
Code	**Medical Discussion**
99441	5-10 minutes
99442	11-20 minutes
99443	21-30 minutes

Do not report if:

- call refers to an E/M service performed and reported by that individual within the previous seven days (either requested or unsolicited patient follow-up) or within the postoperative period of the previously completed procedure,
- reporting 99441-99444 performed in the previous seven days,
- using 99339-99340, 99374-99380 for the same call[s],
- reporting 93792, 93793 for home and outpatient INR monitoring,
- during the same month with 99487-99489, or
- performed during the service time of codes 99495 or 99496.

Online Medical Evaluation (99444)
An online electronic medical evaluation is a non-face-to-face E/M service provided by a physician to an established patient/ guardian/ healthcare provider. Like 99441-99443, this service may not originate from a related E/M service provided within the previous 7 days. 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.

Do not report when:

- using 99339, 99340, 99374-99380 for the same communication[s]) for home and outpatient INR monitoring,
- when reporting 93792, 93793) during the same month with 99487-99489), or
- when performed during the service time of codes 99495 or 99496).

Modifiers

Modifiers document a procedure or service that has been altered in some way due to a specific circumstance, but not changed in its definition or code.

Increased Procedural Services (-22)
When the service provided is greater work than that usually required for the listed procedure, it may be identified by adding modifier '-22' to the usual procedure number. 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.

Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Professional on the Same Day of a Procedure or Other Service (-25)
Reported when a CPT procedure or service was performed, but 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 (eg, 99213.25).

Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System (-95)
Used when reporting a **real-time** interaction between a physician or QHP and a patient located at a different site. The service must meet the same components as the face-to-face interactions. Modifier 95 may only be applied to services listed in Appendix P of the CPT manual. These services include, but are not limited to: 90791, 90792, 90832 to 90838, 90845, 90846, 90847, 99201 to 99205, 99211 to 99215.

Common Psychiatric Codes

Brief Description	CPT Code	Notes[3]
Evaluation & Management, Outpatient		
new	99201-99205	★
established	99211-99215	
Psychiatric Diagnostic Evaluation		
Without medical services	90791	★, may see one or more informants in lieu of patient; may report multiple instances on separate days
With medical services	90792	
Psychotherapy, with patient		
30 minutes	90832	★, time based on face-to-face time with patient, while family may also be seen alone, the majority of time must be spent with the patient
45 minutes	90834	
60 minutes	90837	
Psychotherapy, with patient, with E/M		
30 minutes	90833	★+ (add on to any E/M code), time based on face-to-face time with patient, while family may also be seen alone, the majority of time must be spent with the patient
45 minutes	90836	
60 minutes	90838	
Interactive Complexity	90785	★+ (add on to: 90791-90792, 90832-90838, 90853)
Psychotherapy for Crisis, 1st hour	90839	★
each additional 30 minutes	90840	★+ (add on to 90839); can repeat code for each additional 30 minutes
Family Psychotherapy		
without patient, 50 minutes	90846	★
with patient, 50 minutes	90847	★
multiple-family group	90849	
Group Psychotherapy	90853	*not for multiple-family group*
Psychoanalysis	90845	★
Psychopharmacology with therapy	90863	★+ Not used by psychiatrists (or APRN/PA able to use E/M codes)
Screening/Instrument Codes, per instrument		
Developmental Screening	96110	
Brief emotional/behavioral assmnt.	96127	
Administration of caregiver -focused health risk assmnt.	96161	patient/caregiver assessment for benefit of the patient

★Telemedicine (-95) modifier usable; + Add-on Code

Brief Description	CPT Code	Notes[3]

Appendix A – Partial Glossary

CENTER FOR MEDICARE AND MEDICAID SERVICES (CMS) U.S. Department of Health and Human Services component that administers the Medicare program and certain aspects of state Medicaid programs. Renamed June 2001, and formerly known as the HEALTHCARE FINANCING ADMINISTRATION (HCFA).

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 SCALE UPDATE COMMITTEE (RUC) Formed in 1991 to make recommendations to 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. Now PE RVU's are presented with Work RVU's to the RUC.

RELATIVE VALUE UNIT (RVU) A unit of measure of resources required to perform various provider services; the sum of physician work + practice expense + professional liability

RESOURCE-BASED RELATIVE VALUE (RBRV) The actual number arrived at in relative, nonmonetary units (relative value units) that can later be converted into dollar amounts to reimburse providers for services. Total work input is defined by four attributes: time, mental effort and judgment, technical skill and physical effort, and psychological stress from the patient's illness or risks of the procedure.

RESOURCE-BASED RELATIVE-VALUE SCALE (RBRVS) The ranking of all physician or QHP services/procedures based on work, practice expense and professional liability insurance expense.

Appendix B – E/M Coding Summary Guide

The E/M Coding Summary Guide is available on the AACAP website at the following link:

https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/business_of_practice/cpt/EM_Coding_SUmmary_Guide_v2.pdf

Appendix C - 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% Gross Domestic Product (GDP) in 1970, to 12.5% GDP in 1990, to 17.9% GDP in 2010. In fact, as a percent 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 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	2,593.6
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 D - CODE CATEGORIES

Category I: These are the current procedure codes. All 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) determined as contributing to quality care and good outcomes. The PMAG is 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). 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, eg 1234F.

For a complete listing of Category II codes by clinical topic, see https://www.ama-assn.org/practice-management/category-ii-codes.

Category III: These are TEMPORARY codes for new and emerging technologies or services. They may be covered by Medicare carriers and other payers at the discretion of the payer. 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 - eg 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 E - 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 physicians' 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 (eg 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 experience erosion of our authority and status every time we are required 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 19th century France 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, according to mid-20th century standards, physicians should not be employed by them. 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 limited 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 to 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 World War II, 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 GDP to healthcare, 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: healthcare 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 a pension fund's solvency and because healthcare costs had an increasing impact on the company's bottom line, fund administrators became more critical and selective when purchasing healthcare coverage. Through ERISA, companies had the authority to determine what healthcare 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 a 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 could not exceed what the insurance company would have to pay if the claim had originally been approved (no punitive damages). The settlement did not include attorney fees for this administrative process; they were 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 Healthcare 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). 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 of 2010 (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 creating 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 raise 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:

- Nearly 20% of our GDP is spent on Healthcare.
- For Congressional lobbying, healthcare concerns spend more than 3 times what the military industrial complex spends.
- 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.

- 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."

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) will change how physicians are paid. The first performance year for the Merit Based Payment System was 2017 which will affect payment adjustments, either positive or negative, taking place in 2019. Participation in an Advanced Payment Model, such as an Accountable Care Organization, is another way to participate with Medicare in the post-MACRA world.

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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