| moda HEALTH | Reimbursement Policy Manual | Policy #: | RPM081 |
|---|---|---|---|
| Policy Title: | Evaluation and Management (E/M) Services With Psychotherapy Services | | |
| Section: | Behavioral Health | Subsection: | None |

**Scope:** This policy applies to the following Medical (including Pharmacy/Vision) plans:

| | |
|---|---|
| **Companies:** | ☒ All Companies: Moda Partners, Inc. and its subsidiaries & affiliates<br>☐ Moda Health Plan ☐ Moda Assurance Company ☐ Summit Health Plan<br>☐ Eastern Oregon Coordinated Care Organization (EOCCO) ☐ OHSU Health IDS |
| **Types of Business:** | ☒ All Types ☐ Commercial Group ☐ Commercial Individual<br>☐ Commercial Marketplace/Exchange ☐ Commercial Self-funded<br>☐ Medicaid ☐ Medicare Advantage ☐ Short Term ☐ Other: _____ |
| **States:** | ☒ All States ☐ Alaska ☐ Idaho ☐ Oregon ☐ Texas ☐ Washington |
| **Claim forms:** | ☒ CMS1500 ☒ CMS1450/UB (or the electronic equivalent or successor forms) |
| **Date:** | ☒ All dates ☐ Specific date(s): _____<br>☐ Date of Service; For Facilities: ☐ n/a ☐ Facility admission ☐ Facility discharge<br>☐ Date of processing |
| **Provider Contract Status:** | ☒ Contracted directly, any/all networks<br>☒ Contracted with a secondary network ☒ Out of Network |

| | | | |
|---|---|---|---|
| Originally Effective: | 1/1/2021 | Initially Published: | 3/13/2024 |
| Last Updated: | 3/8/2024 | Last Reviewed: | 3/13/2024 |

Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No

| | |
|---|---|
| Last Update Effective Date for Texas: | 3/13/2024 |

## Reimbursement Guidelines

### A. General Policy Statement

When a psychotherapy service and an E/M service are reported on the same day by the same physician or other qualified health professional:

- We follow all the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA) coding guidelines and requirements.
- Both services must be medically necessary.
- All billed services must be both fully documented and correctly coded. ([B])
- The E/M service must be within the billing provider's scope of license. ([C])

### B. Current Evaluation and Management (E/M) Guidelines

1. Effective January 1, 2021, the office and outpatient E/M visit codes (99201-99215) were updated, and guidelines changed.
2. Effective January 1, 2023, all other E/M visit codes were updated, and guidelines changed.

3. For more information about these changes and how to correctly select the level of E/M service and procedure code, see "2021 & 2023 Updates to Evaluation and Management (E/M) Visits and Prolonged Services," Moda Health Reimbursement Policy # RPM076. ([A])

### C. When Reporting E/M and Psychotherapy Services Together

1. Psychotherapy add-on codes 90833, 90836, and 90838 must be used when billing E/M and psychotherapy services together on the same day by the same provider.

   Note: If psychotherapy non-add-on codes 90832, 90834, or 90837 are reported with E/M procedure codes, there are CCI edits that will bundle the services and deny one of the codes due to the coding instructions. These edits are not eligible for a modifier bypass. A corrected claim is needed to resolve those denials.

2. Select the type and level of E/M based on medical decision making (MDM) when E/M services are reported with psychotherapy services. (AMA[2, 3])
3. Prolonged E/M services may not be reported when psychotherapy with E/M (90833, 90836, 90838) are reported. (AMA[3])
4. Select the psychotherapy add-on code based on time spent in psychotherapy only; time spent on activities of the E/M service may not be counted. (AMA[1, 3])
5. A separate diagnosis code is not needed for the two services. (AMA[1, 3])
6. The two services must be significant and separately identifiable in the medical record documentation. (AMA[3])
7. The medical record must also support that both services are medically necessary. (MLN[10])
8. Correct coding and accurate, clear, and complete documentation of the E/M services and psychotherapy services performed will ensure compliance with these requirements.

## Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

| Acronym or Abbreviation | | Definition |
|---|---|---|
| AMA | = | American Medical Association |
| CCI | = | Correct Coding Initiative (see "NCCI") |
| CMS | = | Centers for Medicare and Medicaid Services |
| CNS | = | Clinical Nurse Specialist |
| CPT | = | Current Procedural Terminology |
| CRNA | = | Certified Registered Nurse Anesthetist |
| DO | = | Doctor of Osteopathic Medicine |
| DRG | = | Diagnosis Related Group (also known as/see also MS DRG) |

| Acronym or Abbreviation | | Definition |
|---|---|---|
| E/M<br>E&M<br>E & M | = | Evaluation and Management (services, visit)<br>(Abbreviated as "E/M" in CPT book guidelines, sometimes also abbreviated as "E&M" or "E & M" in some CPT Assistant articles and by other sources.) |
| HCPCS | = | Healthcare Common Procedure Coding System<br>(acronym often pronounced as "hick picks") |
| HIPAA | = | Health Insurance Portability and Accountability Act |
| MD | = | Medical Doctor |
| MDM | = | Medical Decision Making |
| MS DRG | = | Medicare Severity Diagnosis Related Group (also known as/see also DRG) |
| NCCI | = | National Correct Coding Initiative (aka "CCI") |
| ND | = | Doctor of Naturopathy |
| NMD | = | Doctor of Naturopathic Medicine |
| NP | = | Nurse Practitioner |
| PA | = | Physician Assistant |
| RPM | = | Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.) |
| UB | = | Uniform Bill |

Definition of Terms

| Term | Definition |
|---|---|
| Clinical Staff | A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a professional service, but who does not individually report that professional service. Other policies may also affect who may report specific services. (AMA[6, 7, 8]) |
| Medical Decision Making (MDM) | MDM refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by the following elements:<br>• The number and complexity of problems addressed at the encounter.<br>• The number of possible diagnoses and/or the number of management options that must be considered.<br>• The amount and/or complexity of data to be reviewed and analyzed.<br>• The risk of significant complications, morbidity, and/or mortality of patient management. (AMA[9]) |

| Term | Definition |
|---|---|
| Other Qualified Health Care Professional | An "other qualified health care professional" is an individual who is not a physician but is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service. These professionals are distinct from "clinical staff." (AMA[6, 7, 8])<br><br>Other qualified health care professionals consist of Physician Assistants (PA), Nurse Practitioners (NP), Clinical Nurse Specialists (CNS), Midwives, and Certified Registered Nurse Anesthetists (CRNA). |
| Physician | A "physician or other qualified health care professional" is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service. These professionals are distinct from "clinical staff." (AMA[6, 8])<br><br>Physicians consist of Medical Doctors (MD), Doctor of Osteopathic Medicine (DO), and Naturopathic Physicians (ND, NMD). |
| Problem | A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter. (AMA[5]) |
| Problem Addressed | A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice.<br><br>Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service.<br><br>Referral without evaluation (by history, examination, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service.<br><br>For hospital inpatient and observation care services, the problem addressed is the problem status on the date of the encounter, which may be significantly different than on admission. It is the problem being managed or co-managed by the reporting physician or other qualified health care professional and may not be the cause of admission or continued stay. (AMA[5]) |

Procedure codes (CPT & HCPCS):

| Code | Code Description |
|---|---|
| 99202 | Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter. |
| 99203 | Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter. |
| 99204 | Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter. |
| 99205 | Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter. |
| 99211 | Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional |
| 99212 | Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter. |
| 99213 | Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter. |
| 99214 | Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter. |
| 99215 | Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter. |
| 90833 | Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure) |
| 90836 | Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure) |

| Code | Code Description |
|---|---|
| 90838 | Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure) |

**Coding Guidelines & Sources -** (Key quotes, not all-inclusive)

"Psychotherapy services may be reported on the same day as an E/M service. Select the type and level of E/M service based on the history, examination, and medical decision-making. Select the psychotherapy add-on code based on time. Note: The same diagnosis may exist for both psychotherapy and E/M services." (AMA[1])

"MDM [medical decision making] is the correct criterion for E/M level selection when E/M services are performed in conjunction with psychotherapy codes 90833, Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure), 90836, Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure), and 90838, Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)." (AMA[2])

"Some psychiatric patients receive a medical evaluation and management (E/M) service on the same day as a psychotherapy service by the same physician or other qualified health care professional. To report both E/M and psychotherapy, the two services must be significant and separately identifiable. These services are reported by using codes specific for psychotherapy when performed with evaluation and management services (90833, 90836, 90838) as add-on codes to the evaluation and management service.

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. For the purposes of reporting, the medical and psychotherapeutic components may be separately identified as follows:

1. The type and level of the E/M service is selected based on medical decision making.
2. Time spent on the activities of the E/M service is not included in the time used for reporting the psychotherapy service. Time may not be used as the basis of E/M code selection and prolonged services may not be reported when psychotherapy with E/M (90833, 90836k 90838) are reported.
3. A separate diagnosis is not required for the reporting of E/M and psychotherapy on the same date of service." (AMA[3])

"**Level of E/M Service You Provide the Patient**
The code sets to bill for E/M services are organized into categories and levels. In general, the more complex the visit, the higher the level of code you may bill within the appropriate category.

To bill any code, the:

- Services you provide must meet the definition of the code
- Codes must reflect the services you provide

Medical necessity is the primary reason we pay for a service. It wouldn't be medically necessary or appropriate to bill a higher level of E/M service when a lower level of service is more appropriate." (MLN[10])

## Cross References

A. "2021 & 2023 Updates to Evaluation and Management (E/M) Visits and Prolonged Services." Moda Health Reimbursement Policy Manual, RPM076.

B. "Medical Records Documentation Standards." Moda Health Reimbursement Policy Manual, RPM039.

C. "Scope Of License For Evaluation & Management Codes." Moda Health Reimbursement Policy Manual, RPM080.

## References & Resources


1. AMA. "Psychiatry Changes for 2017." American Medical Association. CPT Assistant, Volume 26 Issue 12, December 2016, pages 11-12.

2. AMA. "Questions and Answers, Medicine: Psychiatry." American Medical Association. CPT Assistant, Volume 32 Issue 8, August 2022, page 19.

3. AMA. "Psychotherapy." American Medical Association. Current Procedural Terminology (CPT) book, Professional Edition. Psychotherapy subsection guidelines (preceding 90832).

4. AMA. "Bonus Questions and Answers, Medicine: Psychiatry." American Medical Association. CPT Assistant, Volume 33 Issue 12, December 2023, pages 44-50.

5. AMA. "Number and Complexity of Problems Addressed at the Encounter." American Medical Association. *2024 Current Procedural Terminology (CPT), Professional Edition*. Chicago: AMA Press, page 7.

6. AMA. "Instructions for Use of the CPT Codebook." *Current Procedural Terminology (CPT)*. Chicago: AMA Press. Introduction. Page xiv (new or revised text in 2023 edition).

7. AMA. "Frequently Asked Questions, Introduction." CPT Assistant, May 2015, pp. 10-11.

8. AMA. "Reporting CPT Codes for Oncology Navigation Services: The Cancer Moonshot℠." CPT Assistant, Special Edition, November Update 2023. pp. 1-11.

9. AMA. "E/M Office or Other Outpatient Visit Revisions for 2021: MDM Part 2." CPT Assistant, June 2020:3-9.

10. MLN. "Evaluation and Management Services Guide." Medicare Learning Network (MLN). MLN006764. Last updated August 2023; Last accessed February 9, 2024.


## Background Information

After reviewing medical records of multiple claims for psychotherapy and E/M services billed on the same day by the same provider, we have found that in many cases the chart notes are not representative of E/M services having been performed; only psychotherapy services are supported. This policy has been written to provide education, clarification, and documentation that we follow CMS and AMA guidelines

and requirements for these codes and code combinations, and that we will uphold these standards when reviewing claims submitted for these services.

## IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

## Policy History

| Date | Summary of Update |
|---|---|
| 3/13/2024 | Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication. |
| 1/30/2024 | Leadership from Behavioral Health, Special Investigations, Clinical Policy & Reimbursement, Provider Networking, the Director of Regulatory Affairs, and the Director of Medical Claims met to discuss a request/proposal for a new policy on this topic.<br>Per the Director of Regulatory Affairs, after discussion of the proposed policy which is based on standard national coding guidelines from the AMA & CMS, it was determined that the proposed policy is not a change in payment policy but merely clarification and provider education on the guidelines we already follow. New policy is not subject to 28 TAC; no additional advance provider notification is required for Texas. |
| 01/01/2021 | Original Effective Date (with or without formal documentation). Policy based on revised office & outpatient E/M guidelines and updated guidelines for psychotherapy with E/M services, both effective January 1, 2021. |

**Attachment**

November 27, 2023

Clinic Name
Street Address
City, State, Zip

Re: E/M coding with Psychotherapy add-on coding
Effective - JANUARY **1, 2024**

Dear Provider,

Moda Health has conducted audits of mental health providers over the last several months and found a common thread of coding irregularities that we hope to address by providing education to assist with correct coding which will result in proper payment for your services. This education letter will provide time to review current billing and coding practice to be compliant with CMS and AMA guidelines by January 2, 2024.

Effective January 1, 2021, Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA) aligned the Evaluation and Management (E/M) Coding with changes adopted by the AMA CPT Editorial Panel for the office/outpatient E/M visits. The revisions apply to the New and Established E/M CPT Codes 99201-99215 and the times and medical decision-making process for all the codes. It also requires performance of history and exam **only** as medically appropriate and not to reach a score and alters the rules allowing clinicians to choose the E/M visits level (1-5) based on their medical decision making or time.

Psychiatric Providers should perform a "medically appropriate history and/or psychiatric examination" with the goal of establishing medical necessity in accordance with Federal, State and Payer rules. "Medically appropriate" means the physician or other qualified healthcare professional reporting the E/M determines the nature and extent of any history or exam for a particular service. The code selection does not depend on the level of history or psychiatric exam as it did in the past. To bill any E/M code, "the services furnished must meet the definition of the code and ensure that the E/M code selected reflects the services furnished" (Evaluation and Management Services Guide, January 2020, CMS). Documentation is the way to comply with this requirement.

The 2021 guidelines also expand older guidelines, clarifying that you should not consider comorbidities and underlying diseases when you select the E/M level "unless they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or comorbidity or mortality of patient management." To qualify as a problem addressed (or managed), the provider must evaluate or treat the problem. A simple note that another professional is managing a problem does not count as addressed. There must be additional assessment or care coordination. Another area that does not qualify as addressing the problem is referral without evaluation (using history, exam, or diagnostic studies) or considering treatment.

Per the AMA CPT 2021 code book "Some psychiatric patients receive a medical evaluation and management (E/M) service on the same day as a psychotherapy service by the same physician or other qualified health professional. To report both E/M and psychotherapy, the two services must be **significant and separately, identifiable**." Codes 90833, 90836 and 90838 are add-on codes to the E/M service. "For the purpose of reporting the medical and psychotherapeutic components of the service may be separately identified as follows:

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 spend on history, examination and medical decision making **when used for the E/M service** is not psychotherapy time). Time may not be used as the basis of E/M code selection and Prolonged Services may not be reported when psychotherapy with E/M (90833, 90836, 90838) are reported.
3. A separate diagnosis is not required for the reporting of E/M psychotherapy on the same date of service."

What Moda has found after auditing patient records is that E/M codes are being added to psychotherapy codes when the chart notes are not representative of E/M services being performed. The nature of the presenting problem should be identifiable and documented as being treated to fulfill the E/M codes prior to the add-on of the psychotherapy codes. There are CPT codes, based on time with the patient (90832, 90834, 90837) for psychotherapy services with the patient that do not include a separately identifiable E/M service.

Evaluation Management coding can be difficult because of the many factors involved in selecting the correct code. This letter is not meant to be punitive but to provide education on the proper coding for psychotherapy codes with E/M and medication management services.

Additional information and resources can be found at:

- **CPT® Evaluation and Management** https://ama-assn.org/practice-management/cpt/cpt-evaluation-and-management
- **1997 Documentation Guidelines for Evaluation and Management Services** https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf

Effective January 1, 2024, Moda will expect billings from providers to be correctly coded based on services provided. Chart notes, when requested, will need to substantiate all codes billed to, and paid for by, Moda.

Any future post-payment audits will use the effective date of this education letter as the farthest "look-back" date for correct billing.

If you have any questions regarding this matter or wish to discuss our findings in detail, I encourage you to contact us directly at (503) 952-5014.

Sincerely,
Special Investigations Unit