Speaker 2: Good day, everyone. The American Psychiatric Nurses Association is pleased to welcome you to the 2013 Psychiatric CPT Code Update: Implementing E&M Codes into Daily Practice. If you need technical assistance at any time while viewing this program, please send us an email at apna@compartners.com. I would like to draw your attention to the left side of your screen. You will see the links box which contains links to web sites and documents including the presentation slides that our resource information relative to the program. You may click on any of the links during the presentation and they will open up in a separate web browser window. In order to receive continuing contact hours for this session you must view the entire program. At the conclusion of the presentation you will be provided a web site link and a certificate code to complete the post test and evaluation to obtain a certificate of completion. Now it is my pleasure to turn the program over to Dr. Mary Moller. Dr. Moller, welcome to the program. Let's get started.

Dr. Moller: Hello, everybody. I'm sure you are so excited to listen to this webinar and begin to understand all the major changes that are hitting psychiatric services, inpatient and outpatient, for new codes. I was privileged to be part of the team that has been working on this since 2009, and we're really excited with outcome. I do understand and appreciate that this is a major change for all of us, but hopefully by the completion of this webinar and the two that preceded this you will feel like you have a better understanding and grasp on how to document our work and really finally get credit for all the incredibly complex work that we do on a day-to-day basis that has just not been adequately captured by the previous codes.

This webinar that I'm presenting is part three of a three-part series. Part one was on the history and how all of this came back about. That was presented by Eileen Carlson. The second part is presented by Sandra Cadena who went through the actual changes in the codes that was eliminated and those that are now going to be used. I'm not going to repeat any of that information and refer you to those two excellent webinars. My part of this is to explain now what's going to happen to charting on a day-to-day basis. This webinar is particularly designed for the APRN who is doing mental management of patients as well, meaning prescribing of medication, diagnosing, in addition to doing therapy. As Sandra said, the psychotherapy codes no longer have evaluation and management in them. We will not be using the 908 codes unless we have a psychotherapy add-on which I will explain as we go through this material. I ask that you bear with the first about 40 slides or so to really get a background of what the intricate details are of E&M codes, and then at the end we're going to be going through actual studies and how you would bill it and code it and chart it. Hopefully, by the end of this you'll feel like you have some kind of a better understanding and grasp on the complexities of what's about to hit us in January 1, 2013.

The objectives for my particular session, I want to explain for you the outpatient practice impact for psych mental nursing of changing the primary billing codes from the 908 psychotherapy codes to the 99 codes known as E&M or evaluation and management. Then, I also want to discuss the outpatient utilization of these and processes related to history, the exam, and medical decision making that will allow you to accurately bill and document the care that you give.

Let's get started. Don't panic. I would encourage everyone to purchase a copy of the CPT update. You can get it from the AMA, you can get it from Amazon, and it's updated every year by the American Medical Association. As Eileen mentioned in her webinar, it's a very intricate concept to develop codes and then to get them assigned a value so that we can actually have payment. I'm not going to be going into how the relative value is established. I believe that Eileen did that for you quite nicely.

So - What is an E&M code? These start with 99 as opposed to our former 908 codes. They're used in all other areas of medicine to find out what happens in your visit, your encounter, any time you render a medical service. This is happening actually, I think, in excellent conjunction with the new DSM-5 which is changing _____ so that we don't have that axis I and II, but we have all diagnoses, so our personality disorders will be encoded as to what we are used to being coded as an axis I. This really elevates the care of individuals with complex illnesses into a mechanism now using E&M instead of psychotherapy codes to really grasp the complexity of the work that we do. I'm really excited about these.

What is an E&M? Evaluation is the part of your visit, your session, your encounter where you collect and you assess information that the patient is giving or we get it from the chart or we call another provider or review records, and then management part which is our plan and our treatment and prescribing of medications, therapies, etcetera. As I mentioned, this used by all other medical providers and once you see this in operation through this session it might help clarify some of the charts that you've received from other people.

In the E&M code, we identify our patient in one of two ways. You either have a new patient or an established patient. This is very important to differentiate. A new patient is someone who's new to the practice or a patient that you have previously seen but you haven't seen him for three years and all of a sudden they're reappearing back on your caseload after three years and would be then a new patient documentation which is much more complex and detailed than an established patient. The established patient is defined as someone that has an ongoing relationship not just with you but with your practice. If you're in practice with another APRN and you cover for each other and you are seeing the patient of another one of your colleagues that would not be considered a new patient

because there's a chart that's established and you have records to review it. It's someone that has been seen also within the past three years and has an ongoing relationship.

We have descriptors for our E&M session. This is the whole new vocabulary for you. I drafted a an E&M coding charting worksheet cheat sheet in the handouts that we're going to be going through in depth and you're going to be using these, so I can further explain to you and you'll have a good handy reference to use this in your practice. These are billed and coded as a level one, two, three, four or five. As Sandra mentioned in her session, we have a new patient which would be 99021, 99202, 99203, 99204, and 99205 with a new patient. An established patient would be 99215, 99212, 99213, 99214, and 99215, or commonly referred to as a one, two, three, four or five when you're talking with your colleagues. The only differentiation is if it's a new patient it has a zero before the one, and if it's an established patient it has a one before the 1, 2, 3, 4 or 5.

You and I would never be doing a level one. Level one is a minimal visit. Maybe the patient comes in to pick up a letter that had to be written to sent to insurance and that would be considered a minimal visit where there's no MD or APRN efforts required to complete the session. A level two we also wouldn't do, very rarely, it's considered a problem-focused and it might be where a patient comes to pick up a prescription for a medication that you've written for something that requires minimal time, less than 10 minutes of time. Our visits are primarily level three, four, and five with the primary level being a four. Level three is considered expanded problem-focused, level four is considered detailed visit, and level five is considered a comprehensive visit. All of these are descriptors that are explained in the handout and I will go through in depth with you.

They are not timed. You'll no longer be thinking of your visit as a timed session. You could have level four or a level five in 20-30 minutes. When we have a complicated patient that is a level four or five and you realize that we need to do some insight oriented psychotherapy or some purported therapy, then we will use those add-on codes that Sandra mentioned. We would do an add-on psychotherapy code, the 90833, for a 30-minute add-on. That will allow you to be reimbursed for not only your evaluation and your management of the psychiatric problem but also the therapy. It's very exciting that after all these years we're finally going to get paid for what we do.

We have three categories in an E&M visit that have to be charted and documented, the history, the physical exam, and the medical decision making. Always start with the medical decision making to determine the extent then of the history and physical exam you will need to do and to determine your level.

Your level of a three, four, five will be set by your medical decision making that you do with the patient.

We have three components to our medical decision making. I'm asking you now to open up and print out and refer to the handout entitled Evaluation and Management Established Patient Office Progress Note, your established patient office progress note. The first page that you will see is a detailed tabulation on how to do medical decision making. For an outpatient patient that's established we need the highest two out of three of these to establish our visit level. A new patient requires all of these, three out of three. We're going to be going through these columns in depth and hopefully it will not seem like Greek to you by the time we're done with this.

If we look across your handout, you will see that we have three categories in medical decision making. Number one is the number of diagnoses or management options and this is based on problem points. A chart was developed because the language that is in this is rather ambiguous, so a nice problem point chart was developed for audit purposes. The second column is about the amount of complexity of data and that's also developed up points and data points charts, again, because the language is ambiguous. Then, the third component is the level of risk of significant complications, morbidity, and/or mortality. We're going to go through these now.

The first column on your handout and on the slide is the number of diagnoses or management options. That's actually based on the number and type of problems, how difficult or complex it is for you to establish your diagnosis, and then the decisions that you have to make about what to do with this patient. That's all influenced by the fact maybe there's undiagnosed problems, you've seen this patient maybe a couple of times now and you keep finding out new information on each session or they keep bringing up maybe new traumas that they didn't feel comfortable in talking about. We tend to have quite a few diagnoses and options to consider for our patients. It's also influenced by types of tests, do we need to order lab to monitor lithium, or do we need to do drug screens, do you need to call the case manager, do you need to talk with the family, do you need to do a hallway consult and talk with another one of your colleagues, another influence then is needing to have advice from other people. The fourth one is if the problem is worsening or not responding to treatment and now we have to consider a different medication regimen, we might need to engage in therapy, we may need to get an ACT team involved. This section, the number of diagnoses or management options, really helps us capture all of that complexity around diagnosis and managing the patient.

The problem points we can see on this slide. If the problem is self-limiting, or minor, or maybe just stable, or it's improved and you have to document that, or

it's worsening you get one point per problem. You're allowed to have two problems that are self-limiting, so you could get a maximum of two for that. If it's established problem to you who is the examining and the terminology, and the CPT is physician, so I apologize it doesn't say slash APRN, but I'm taking this right from the Medicare guideline and we're working on Medicare here, and that problem is stable and improved that's one point. If it's established but it's worsening it's two points. If it's a new problem, a new symptom has emerged, but you really don't have to do too much about it, order new procedures, but it's a new thing for you talk about you get three points for that and you only get one new problem. You might have three or four, but you can only count three because that's the rule. If it's a new problem and you have to do something extra, additional workup, that gives you four points. Oh my goodness, maybe you see something and you're wondering about a drug screen and you're going to have to think about getting your patient to the lab and the complexities that may result, revolve around that, that's going to give you four points.

The next area is the number of diagnoses or management options. Again, there're four levels and this is considered minimal, limited, multiple, or extensive. If you look on your handout under the column two, amount and complexity of data, if you have to review your chart data related to labs or order new labs that's a point. If you have to review x-rays or scans or maybe somebody has migraines and they had an MRI and you have to review that you get a point. If you have to review or any other tests that are in the medical section of CPT that's a point so anything that has been ordered for the patient, maybe they have neuro psych testing and you need to review that you get a point for discussing test results with the person that provided that test. Maybe you need to call the neuropsychologist that you referred the patient to, you get a point for that. Now maybe you're just going to review or summarize the chart that's in front of you, or you're going to obtain history from somebody other than the patient, or maybe you need to call the family, or maybe you need to call another provider, you get a point for that. Now if you're going to review their old records and get information from somebody other than the patient and discuss that with another provider such as the case manager, that's two points. Then, finally, if you are, and this would not really apply to us at all, but if we're going to be looking at an x-ray and trying to analyze that or maybe you're really good at an EKG and you're looking at that and going to explain that to the patient, you get two points. If we look at the bottom of column two there on your handout we see that we have language, straightforward, low complex, moderate complex, or high complex. We have that language on the bottom of each of these. That is the language that is used to correlate to your 99212's, threes, fours and fives.

Moving on. We talked about on this slide by looking at your handout, the amount and complexity of data. To summarize, that's based on the type of tests, we need to get records, or get history from someone else, and that's going to be

influenced by maybe you find some new information. It was unexpected or you are independently interpreting some information or you're discussing this with someone else. All of that goes into the second component of medical decision making.

Here's the points that are assigned to those on slide as a summary of what we looked at on your handout. Here are the points that are assigned to those in summary fashion. I really encourage you to use the handout, but the information is summarized for you here on your slides as well.

The third component of medical desiccation making is risk. Risk is based on the problem that the patient presents with, procedures that have to be done with this patient, management options, maybe somebody has to go to the emergency department, it's a crisis situation. This is influenced by any comorbid conditions, maybe somebody has bipolar disorder and comorbid diabetes and their blood sugars are 400 and you're really concerned. We look at the comorbidities, underlying conditions the patient has, maybe migraines, maybe asthma, hypertension, hypercholesterolemia, any metabolic problems, and risk factors in the patient. The patient presents with maybe they're losing their housing, maybe they've lost their SSI, so all of that could complicate their care. Maybe the prognosis is uncertain, maybe they have a new symptom and you don't know what has caused that. You can't just say, "Wow, here's the situation. You're going to increase your medicine by 20 mg and everything should be fine," or that illness is exacerbating its complications, and also you have to order medication. In the case of two people who are doing this for inpatient, maybe something IV has to happen or you're in and ED and they have to give IV meds to the patient in an emergency situation. The last area is something that we definitely would not be involved in, but if you have perform invasive test procedures or major surgery. Again, this is the language right out of the guidelines.

Determining this level of risk. The slide is right off your handout. In looking at this we have four levels, minimal, low, moderate, or high risk. This is very carefully determined by this chart. What we may think is risky is maybe not really considered as high risk according to this table. Minimal risk is when there's one problem that self-limited, and if maybe they have dysthymia, and it's well managed, and you only have to see this patient maybe every six months. For us, we're pretty looking at the presenting problem and then an option is selected. For the presenting problem for dysthymia, we really wouldn't have a management option that we would select. The example that's given and the point that is assigned here is if you have to just tell the patient stay home and rest.

Low risk is where a patient has two or more self-limited problems or one stable chronic illness or an acute uncomplicated illness. The management options that

are used as an example is that you might use over-the-counter drugs with this patient. Maybe you are talking to someone who is describing some sleep problems and you think that melatonin would be a really good option for this patient. That would be an example of something that's considered low risk. Maybe they have stable bipolar that would be one stable chronic illness, but there's sleep disruption happening and you don't want to order benzodiazepines but you may suggest melatonin and that would be an example of low risk in your treatment.

The last of the categories are moderate and high. In the moderate risk, we have a patient that has one or more chronic illness and it's exacerbating, so maybe this person's depression is they're going into another episode or they have two illnesses that are stable and maybe it's depression and diabetes or maybe it is post traumatic stress disorder with major depression, but this is pretty stable, or it's somebody that has an undiagnosed problem with an uncertain prognosis so a new symptom having _____ someone with a psychosis and you really don't know is that simply going to respond to my treatment or not. Before we go to high risk, the management options are prescribing medications. That goes into our level three and four.

The last risk is high risk, so this is someone who's very ill. They're having an acute episode, maybe somebody's had a psychotic relapse or they're having side effects, maybe side effects from lithium toxicity, for example, or they have a chronic illness that is posing a threat to their life, so maybe someone is suicidal or homicidal that would be how we would look at risk in psychiatry. If we prescribing meds that were at high risk, then the qualifier for that is drug therapy that requires intensive monitoring such as what we would have to do for Clozapine. Those are the four levels of risk determination, minimal, low, moderate, or high.

How we select this. We want to look at the number of diagnoses and management options, amount and our complexity of data, and the risk of complications. If we look at how we determine then our straightforward 99202 or 99212 would be if there is minimal problems or one, minimal data, and minimal risk. Again, that would be somebody who's coming in very quickly to maybe pick up a prescription for an ADHD med and we generally would not be seeing this level of patient in the adult arena, so you might be seeing this level I think kids and adolescents.

Now 99213 is a code we commonly use and it's for a fairly simple patient, limited problems, limited data that you have to look at in the chart or talk to somebody else and low risk. For a moderately complex patient, 99214 is the patient that we see a lot. They have three problem points, so we have a number of chronic diagnoses going on and maybe some new symptoms have emerged and they're

getting to be pretty complex. Over here, we would have multiple data points that we would have to look at, labs we have to order, labs we need to review records, we need to contact other people. finally, our 99215 is our highly complex patient. They have four problem points. They're going to have extensive data points and/or extensive risk.

Now I need to call your attention here that requires two out of three areas in the outpatient office setting to select our medical decision making. Then, we would look at the highest of our two areas that we're looking at. Typically, we're looking at number of diagnoses and/or the amount or complexity of data. Hang in there. It will all make sense when we get to the patient examples.

How to document this _____. We document, if you're just doing a self note, it'll work in a self note. You have a pretty extensive O and A and P. If you're using an electric health record this is already going to be sectioned out for you when you go to document. Documentation includes your assessments, your impressions, your diagnosis. The status of that diagnosis, if it's acute, if it's remitting, if it is exacerbating. Differential diagnosis that we have to look at that we're going to be ruling in and ruling out, we do a lot of that, particularly looking at maybe depression and comorbid hypothyroidism that we're having to manage. Are we going to be initiating any change in that treatment or initiating a brand new treatment? Do we need to refer? Do I need to get some advice from someone else? I need to collaborate and document that. Excuse me, I hit the wrong pointer. Sorry about that. Do we have to order any type of lab or tests to corroborate our diagnoses?

We also have to document is to review our test findings. In the electric health record there's that nice little review button, so that makes it easy. If you don't have an electric health record, then you would need to make a statement about that and you would need to document what were the relative findings from that record. If you discussed any of the tests, oftentimes results come back in and we spend a lot of time talking about with patients and I'll explain how that affects coding later. We're not going to be directly visualizing specimens or images, but we may be looking at explaining blood tests which will be the bullet point before this. We obviously have a lot to do with comorbidities and underlying conditions and looking at how those complicate our patients. We are obviously not going to be talking about surgery. The majority of those bullet points are all involved in how we document our medical decision making.

Once you've decided the MDM, medical decision making, then proceed to your history and exam. I love this cartoon, the American Academy of Family Physicians. Wow, I could've had a 99214. We're finding that we have been so underpaid for what we do. This is a new way now to frame our work with patients that captures what we do. I can't tell you how excited I am to actually

see this go into operation and be able to see correct reimbursement for our efforts.

We have medical decision making which is then going to determine, so if we determine we have a level four patient then we have to do the appropriate history and physical exam for a level four patient or a level five. I'm going to be showing you examples at the end of this, levels three, four, and five to help clarify. We'll be looking at the chief complaint, the history of present illness. We're going to be reviewing systems and the past family and social histories. Those are the four areas that go into history.

Chief complaint. We are very familiar with that. That's not anything new for any of us, and we always just document that in the actual words that the patient used. Now the HPI, we often think of this and relate it to pain or headache, but there is actually a really simple way to demonstrate this for psychiatry. The HPI has eight possible descriptors. In a level three, we only need to look at a couple of these, but the number of descriptors that we have to document increases based on the level of intensity and complexity of your visit. Typically, as you'll see in the example that I got to share with you, we actually do seven or eight descriptors oftentimes when we are just charting our basic SOAP note or actually further elaborating on the patient's chief complaint. Let's look at how we define an what operationalize the location which in psychiatry is referred to the emotional and behavioral aspects of our patients presentation are considered location for psychiatry. The quality of the symptom is how the patient describes the symptoms such as feeling sad. Severity, duration, timing, context, modifying factors and associated ____ symptoms are aspects of the HPI that we typically already do.

Here's an example. The patient reports ongoing emotional problems of moderate anger starting with the discovery of spousal marital affairs two weeks ago, now does not want to live in the same house and this is associated with disruptive sleep and loss of appetite. We actually see here that patient reports ongoing, so that's our number one, timing. Emotional is location. Moderate severity, anger is the quality. The context starting with the discovery of an affair, duration two weeks ago, modifying factors doesn't want to live in the house, and associated with sleep and loss of appetite. We don't really have to change anything that we've been used to documenting when we quality that patient's subjective expressions and put it into our language.

Now the complexity. For a brief history we need only one to three elements or the status of one to two chronic, or inactive conditions. So you might not even have to do HPI, but you may just be documenting that depression is stable and migraine headaches are well managed. For an extended HPI would be four of those elements or the status of three or more chronic brain active positions. If

you would turn to page two of your handout we can take a look at how this is actually charted. A problem-focused 99212 uses one to three elements and the 99213 uses one to three elements but expanded problem-focused visit. The 99214, a detailed visit, we have to chart on four of those elements or greater than three chronic conditions, and then a comprehensive level five is four elements or equal to a greater than three condition; 99212 and 99213 we use brief and 99214 and 99215 we use extended.

The third element here is past family and social history of the patient. Again, this is nothing that is new to us at all. Past history you may to document an element of this you may say the patient is also on a triptan for their migraine, review the current medications the patient is taking that you've prescribed, you would want to document any new illness, if the patient has just had the flu or were in a car accident and got a head injury, had to go to the hospital, any new allergies, any new treatments that the patient is undergoing, any change in diet, and if someone has had immunizations. Family history you're looking at medical events in the family. If someone comes in and says, "My goodness, my mother just had a stroke and I have to take off work because now I have to take care of my mother," that would be very important for the progress of the patient and the level of complexity of our visit. You would want to talk about any diseases were occurring in the family and the health hole status change of anybody in the family. Then, the social history would be talking about their marital status, anything in changed in their housing which may become significant for many of our patients, maybe work has been impacted by their depression or an exacerbation of mania or anxiety, if any change in the use of substances, and we need to include caffeine in this. Initially, we were talking about their education but maybe somebody's trying to go to school and that's one of the major areas you're helping them on and that would be very important aspect on social history. Sexual history, if someone has presented with a problem related to sexual functioning or an assault. What's happening with a current job and then anything else related to the social aspect of the patient's life.

We were looking at the level of PFSH. Level one and two are considered pertinent where you would have one item from one of those areas, so either past or family or social but not all of them. If you're doing a complete for a new patient, you have to do all of them. For established, you would do two out of three, so a complete would be a 99214 or 99215. Again, on your handout, I've made this so you can use this as a checklist to use until you get all of this put into your brain. Believe me, I still have to use the checklist, but eventually it'll come to us. It'll be secondhand vocabulary.

The third area of history is the ROS, review of systems. You're going, "My gosh, what do I have to do this." It's not that you have to examine them and we have some special caveats for psychiatry. The review of systems that we'll look at are

very similar to what we do on a new patient visit. We'll be talking a lot about constitutional. That's vital signs, nutritional status, habitus, eyes, cardiovascular. We may be doing something with neurological depending upon if our patient has a comorbid Parkinson's disease or Tourette's syndrome, something else like that we would want to make a note about it. Maybe something's happening with genitourinary functioning, maybe you have a male patient that has developed prostate cancer, then obviously that's a system that you would ask about and review. If someone particularly have a lot of allergies which we know our patients do we'd be reviewing ear, nose, throat, and mouth. Certainly, we would want to pay attention to dental status, so that's significant for us. We know many our medications cause problems or if somebody's been using methamphetamine we can certainly see it in their teeth. We would want to talk about, excuse me, I'm having a hard time with this pointer, I apologize. The GI tract is very significant for us to review looking at if they're having constipation, medication side effects, for example, or if the patient has comorbid GERD or some type of other reflux manifestations. Looking at skin, if someone has new tattoos, new piercings, that's certainly something that we observe. Musculoskeletal, we're going to be talking about in depth because that's a significant part of what we look for in gait and station, in changes in muscle tone or tremors when we're looking at medication side effects. Psychiatric is considered one of the systems, and obviously for us that's the complete system we'll be reviewing. We want to talk about hematological or lymphatic, particularly if patients have any type of allergy or maybe they have anemia, something that you have picked up on in your labs test, we're looking at hemoglobin and hematocrit. We want to talk about respiratory function, particularly of our smokers. We note that if a patient has a cough what it sounds like. Endocrine, we also spend a lot of time talking about this, looking at thyroid functioning when we have our patients with mood disorders and we're looking at comorbid hypothyroidism that maybe we need to consult with or maybe you are managing that for your patient. Finally, anything that's happening with immune dysfunction or that patients who are immunosuppressed or immunocompromised for a variety of reasons. That's considered for the ROS.

For our problem-pertinent, for our 99212 or threes here, we would be looking at the system directly related to the problem. If someone is coming in with a psychiatric question we would be talking about a psychiatric situation which is obviously all of our patients. We would be focusing on the psychiatric ROS. If we're looking at a 99214, which is an extended, then we'd be looking at two to nine systems. That would be psychiatric plus one other, so psychiatric plus constitutional, or psychiatric plus musculoskeletal, or whatever number of systems that you need to review. Then, if our patient is a 99215, we have to document all 10. We have some caveats that the Center for Medicaid and Medicare Services allows that we have to document individually the system that has positive or pertinent positive responses, I apologize for that, and then we

can say all of other systems were reviewed and were negative is a permissible statement, and you'll see this in the sample chart note that I've prepared. If you don't make that notation, you must individually document all 10 systems for a 99215.

How does this all look, the levels and types and history? We're looking at the HPI. We're looking at past family and social history. We're looking at review of systems, and we put that together to come up with our visit. 99202 is a new patient, 99212 is an existing patient. We're looking at having what do we need for our extended problem-focused, our details, and our comprehensive. This is the language that we have to get into our vocabulary. We're going to be talking about expanded problem-focused, detailed visit, or comprehensive.

In a problem-focused, it's very brief, one to three elements or one to two chronic conditions, need no past family or social history, and we don't have to do a review of systems. A brief which is a 99213, we will be doing one to three elements. Excuse me, I'm really having a hard time with this pointer. One to three elements or one to two chronic conditions, no past family or social history, one problem-pertinent review of systems which is going to be psychiatric. For our extended, we one to three of those elements of the HPI or one to two chronic conditions. We need one element that pertinent, the past family and social history, often it's looking at medications or the change in living arrangements or something's happened in the family. Review of systems is going to be considered extended which is two systems, going to be psychiatric and constitutional which we do on a day-to-day basis anyway. Finally, our extended is four elements or three chronic conditions. We'll do a complete past family and social history of three elements for a new patient, only two required for established patients, and we have to make a comment on 10-14 systems. Again, these are spelled out for you on the handout that I provided.

We've covered medical decision making and we have covered the history. Now what we do with physical exam? People go, "I don't do physical exam, I'm a psych person." We have to think about our patients and their symptoms, their body systems which we as nurses this is second nature to us. We have some language to use. In 1997, there was quite a revision to the CPT manual to allow for specialists to be able to bill evaluation and management codes. Prior to that, it was pretty much for primary care, but specialists wanted to be able to better document and capture the amount of work that was included for each their patients. The Center for Medicare and Medicaid Services did a revision and we now can use what's called a single system exam for what you actually have to document for this part of the E&M. For us, it's going to be the psychiatric system.

A psychiatric single system exam is actually comprised of three systems. Constitutional which we had reviewed, and again constitutional we're looking at blood pressure, pulse, temperature, respiration, height, and weight, and certainly we are taking weights these days in all of our patients. We're looking at their general appearance and that's including looking at nutritional status, their grooming, their appearance. You see this phrase shaded border and unshaded border. In the actual CPT workbook if you were to purchase that or if you would go to the Medicare guidelines link that appears on the left slide, you will see explicitly detailed sheets of paper that describe what is mandated in each of the single systems. A shaded border means you have to do that every time. Unshaded border means that that is an area of your single system that general only has to be addressed if you're doing a complete visit, a complex visit, a 99215. Typically, we always document out of constitutional, the patient's appearance, presentation. We should be doing vital signs, weight, and obviously, we always document out of the psychiatric. There are bullet points that are identified, so there's actually eight bullet points under constitutional and that includes what I just went through and what is on your handout, blood pressure and height, weight, TPR, and general appearance. Musculoskeletal, as you see on your handout, looks at gait and station and muscle strength or tone, atrophy, or any abnormal movements. Then, the psychiatric system is defined by 11 bullets. That is on page three of your handout.

Let's look at these. I mentioned constitutional is a shaded border, so it's required. We measure any three of the seven vital signs, general appearance, development if we see that there are some problems looking at their growth and development, particularly in working with kids and adolescents. Nutritional status we'd be looking if the patient is emaciated, if we're looking at levels of obesity. Musculoskeletal, in particular we're looking for motor tics, tremors, any tongue movements, any problems with muscle strength and tone - how is your patient walking, are they able to maintain balance. Again, nothing new for us.

What is different is the terminology that is used in CPT for psychiatric system is a little different from what we're used to, particularly in the areas of thought process and thought content. Let's go through these. Under five of those 11 psychiatric bullets, one is related to speech, and so we would talk about rate, rhythm, pitch, volume, intensity or normal; patient is spontaneous, able to initiate and engage in meaningful conversation with normal voice, no perseverations, etcetera. Thoughts process is a bullet point where included here is the rate of thought and the content of thought, and abstract reasoning and computation which typically we think of in the cognitive status exams that a CPT last included under thought process. Associations have their own bullet point in CPT, loose, tangential, circumstantial or intact association. Abnormal or psychotic has its own bullet and in that we include hallucination, so we don't have a separate perceptual category in CPT. Also, homicidal and suicidal ideation

are contained in this bullet point as well as obsessions. It's pretty comprehensive for one bullet point, but that's CPT says. Judgment is considered its own bullet point, so looking at everyday activities and social situations under judgment and insight, particularly referencing their psychiatric condition.

They call complete mental status what you and I would call cognitive function. Under complete mental status for CPT, there's orientation, recent-remote memory, attention span where we're doing serial sevens and here where we're naming two out of items that kind of thing. Can they name objects, repeat phrases, fund of knowledge, and interestingly mood and affect is considered a component under mental status exam for CPT. As long as you document these what we normally document and the boxes that we normally document encompasses the CPT requirement for the psychiatric single system exam even though these boxes have categories in them that are a little different from what we typically would have included.

Here is a little summary now. In the psychiatric exam, if we have problem-focused it's one to five elements. If it's an extended problem-focused you have to have six for 99213, and we easily meet this category. Detailed, 99214, we have nine of those bullets; and comprehensive, we have to have all the bullets in psychiatry, all the bullets in constitutional, and one bullet from musculoskeletal. Hope this is making sense to you.

You and I are used to charting on what we call the element of time. When we had 90805, 90807, there is qualifier in CPT for the element of time. If you spend 40 minutes with the patient but you're not doing history and exam, you are spending the entire time discussing thyroid function, the relationship of thyroid function to their anti-depressant and how well the anti-depressant is or isn't working that would be called counseling and/or coordination of care. It's more than half of your visit now, oh my goshness, you have to call the family, you have to call the case manager, you're doing a lot of psycho ed, then you don't have to worry about the physical exam and history. You can document a 99215 if it's 45 minutes, a 99214 is it's 30 minute, and a 99213 if it's 20 minutes, but the whole thing is patient education or you're reviewing the results of neuro psych testing, for example. We do have that available to us which is really nice. The E&M system, as I just have explained, medical decision making, history and exam, is designed to reward efficiency. You can have a level five in less than 30 minutes depending on the situation. You can have several problems. You can have to order a couple of lab tests and you're going to have to prescribe some medication. You can do that for all those elements in a short amount of time, so you can have a 99215 in 20 or 30 minutes.

We code based on the work that's done at the time except for if we choose the counseling and coordination of care except which obviously we will be doing. If

you look at your handout, on page one at the very top, I put in an example of how you would use this to document your level of service. On page one of the handout, we see the client name, date of service, provider name, time in, time out, total time spent, and you're going to check off. Maybe you did a 99214 and you spent 35 minutes with that patient explaining something about their illness. You would make that note on your chart note. Hope that's clear.

In the counseling and coordination, time becomes a controlling factor. It's counted as face-to-face time for an office visit, and on unit time if you are going to visit or if you're in an inpatient setting. You document the length of time of the encounter and of the time spent counseling and coordinating the care and the activities that you did, so length of time, what you did, and if you had family members present.

Examples of when you would use the counseling and coordination of care descriptor. When you're spending your time talking about diagnosis, what you think is going on. You want to spend some time explaining how you derived your diagnoses, and you want to talk about the DSM criteria, and you want to teach the patient terminology related to their illness. If you need to refer them to someone, maybe your patient has migraines and you want to refer to a neurologist and you want to explain what are all these tests that this patient's going to have. Patient asks you, "Do I have to take this medication for the rest of my life," spend time talking about what are the different paths that this illness can take, what is it like to manage chronic bipolar disorder or anxiety disorder OCD. The patient asks you, "I don't really want to take that medicine. Isn't there something natural I can take? I read about St. John's wort. Can you teach me about St. John's wort," and then you have to talk about all of your drug – drug interactions. When we spend a lot of time talking about risk and our management options. When you're giving patient instructions and you're talking about follow-up care, maybe you need your patient to do homework and do a mood chart, or _____ and bring that into you, or maybe you're asking them to go home and write down everything that's in your medicine cabinet so I know what else you're taking or all your herbs and vitamins. Maybe you're spending the bulk of the time with compliance with different aspects of the treatment, or you're talking about reducing risk factors. Maybe you have to do a whole session on safe sex, or you have to do a whole session on counting caffeine milligrams because your patient's taking in so much caffeine that's inactivating all the medications, or you're going to bring in the family in and you're going to be talking about the illness. A lot of what I think you're probably used to trying as coordinative therapy we now can count as counseling and coordination and have a 99215 and be adequately compensated for that. This is. a hugely important aspect of CPT.

You don't want to have all your visits fall under times counseling and coordination. Obviously, we are doing assessments, documentation of that, and risk. We're doing the other elements of medical decision making, history and exam. Again, here's a slide that articulates how we do the time based code with doing counseling and coordination. 99212 is 10 minutes, 213 is 15 minutes, 214 would be 25 minutes, and 215 is 40 minutes or more.

Here is everything we have talked about in the last hour in one dizzy making slide. We have to decide if we're doing an office visit of a new or established patient. If we are doing a 99213, then we have to have a chief complaint, four elements of that, history of the present illness with quality, time, intensity, severity. We have to review the psychiatric system and one other, and you're going to make a mention of one out of three elements of past family and social history. 99214, we see the same number of HPI, we now have 10-14 systems we have to review, and we have to include three out three for our past family and social history and similar to 99215.

The physical exam, for us, we have one to five elements which can, as I said earlier, just be weight and maybe blood pressure and a couple of components out of patient's presentation, their appearance and psychiatric. That's for the brief. When we go to our 99213, four and five, we are being much more articulate. _____ decision making _____ 99213 is considered low for 99213, moderate for a 214, and the high for a 215. We could forget all of this above if we are spending our time doing counseling and coordination of care, then all we have to do is document the time and what we talked to the patient about and who was present and who we contacted. Those are the elements of E&M for CPT. Take a deep breath and you may want to take a pause here. We're going to spend a few minutes now putting all of this together and using some patient examples and what a chart note might look like that would pass Medicare. Maybe there are some of you right now you're at the point where maybe I need to have a glass of wine. It'll all sort itself out. Again, I want to refer you to the handout that I gave you because we are going to be looking at this again.

A 99213. By now that should sound familiar to you. You're going to stick a 99213, that's probably a low complex patient. Here's an example. A 33-year-old married Hispanic female with major depression, moderate, without psychotic features who is stable, six months on an SSRI. She wants to decrease her current dosage because she's having sexual dysfunction. Automatically now you're thinking what's my medical decision making, how do I decide that this is really a 99213? We probably are going to have limited to multiple problem points. We're not going to have much data, probably going to be low risk. Let's take a look at this. Under our problem points for her we're going to figure out in looking at the number of diagnoses and management options, does she have an established problem that's stable, so that's a one. She's not even coming in for that. She's

not coming in depression. She is coming in with a new problem and it doesn't require any additional workup. She's complaining of sexual dysfunction from her SSRI, so that would be considered a three because as I said it's a new problem but we have no additional total workup, so we give her a three. Amount of data that we require. What do we have here? We really only have one. We're just going to go back through her chart. We're going look at her medication and you're not going to call anybody or talk to anybody else. That's really only a one. What's her risk? Her risk is low because she has on self-limited problem that she is presenting. Her other chronic illness, her depression, is stable. That's low risk. To determine this we average these out. We average out these three points and we come up with low. That's a 99213.

You can see this patient, using this patient, you know this patient and you're going to do this, and this is going to take you approximately a lot of time unless something new comes up in the visit, obviously. We know now that we have a 99213 which is an expanded problem-focused visit. We have to have a brief HPI, one to three elements or a documentation of her one to two chronic conditions. We do not need any past family or social history. We need a review of a pertinent system related to her problem. This is obviously going to be her psychiatric system, her depression, and the management of that depression has created a side effect. Let's look at what her HPI would be. The patient reports ongoing decreased libido creating moderate frustration and been going on for the last six weeks. Now that her depression is better she wants an active sex life. Her husband is supportive and isn't pressuring her. There are no associated signs or symptoms. We include many more than a required element for her HPI, but because we are so complete in our charting this is how it would look. For the history now we only have to get one to _____ we have seven and we capture that chief complaint. As I mentioned, no past family or social history required and the ROS is problem specific.

In this psychiatric exam now, because we have a 99213 we have at least six bulleted elements. Let's talk about what those are. Six bulleted items from the psychiatric exam can be one from constitutional, no musculoskeletal needed, so talk about our patient's appearance. We always talk about that. You probably talk about speech, thought process, association of content and assessment.

The progressnote. Chief complaint. Female with major depression, stable on an SSRI for six months, experiencing decreased libido the last six weeks. HPI, no current symptoms of depression and she's experiencing decreased libido. [inaudible 1:12:37] psychiatric [inaudible 1:12:38]. Physical exam, [inaudible 1:12:45] her thought process is logical, associations are intact, and no homicidal ideation. Our impression is base depression responding to SSRI. Our plan, decrease [inaudible 1:13:08] call the pharmacy with the change and ask to see them back in a month. Now this [inaudible 1:13:13] that you want to add that

you can. What I've done here is just captured the minimal that's needed to pass your chart on an audit in case Medicare or Medicaid come in to take a look at it. Is this is a 99213? This is minimal. But it's sufficient.

Let's look at a 99214 of an established patient. We're going to see a little more complication here because we've chosen a 99214. We have a 52-year-old male with a 16-year history of bipolar disorder responding to lithium carbonate and brief insight orient psychotherapy. He's now reporting tremors and some diarrhea. Psychotherapy and prescriptions are provided. Labs are ordered, so this is an overview of this patient. There's a little bit more going on than our previous patient. Medical decision making, let's take a look at our handout. We have high complexity under number of diagnosis or management options. How do we have that? It's because we have a new problem to us as the examiner and we have to do some workup because we know we're going to have to get a lithium level. We're going to have to do a UA. We need a comprehensive metabolic panel. What's going on here. This is a complex number of diagnoses and management options. We don't have a lot of data to be reviewed, however. We might just go back through and look at a previous lithium level, but that's really pretty much it in relationship to this encounter.

What's the risk to this patient? This risk is moderate because there's more illnesses with mild exacerbation and that meets our criteria for moderate. When we look we have a four here and a three here, so this one gives us moderate complexity. That tells us: We have a 99214.

What do I have to do with a 99214 compared to what I had to do with a 99213? Under the history of the present illness, we have an extended history. It's still just one to three elements or reporting on one to two chronic conditions. That is an error. Excuse me, that's right. We have one element of, even I get tongue tied in this stuff, so thanks for bearing with me everybody. Under our past family and social history, we have pertinent to our situation so we need one element that's pertinent related to this patient. Review of systems is going to be considered extended and we need two to nine systems. This becomes a detailed patient encounter for 99214.

Under the history, we only need four elements but we have eight as we captured the chief complaint. We need an element of past family and social history and we have a detailed ROS, so two to nine systems. That's psychiatric and something out of constitutional. For the exam, we have to have for a 99214 we have to have at least nine of those bulleted elements between psych, constitutional, musculoskeletal. We're probably going to look at speech, thought process, association, thought content, judgment, and mood. We want to take look at vital signs. We want to look at weight because he has some urinary

retention going on, and obviously, you know we're going to be checking for these tremors and looking at his gait.

Here's our progress note. His complaint, 52-year-old single white male scheduled visit for treatment bipolar disorder, stable on lithium for 16 months complaining of tremors and diarrhea. Look what we find out. Patient reports increased tremors and diarrhea creating moderate difficulty with fine motor tasks and fear of not being around a bathroom that has been going on for three weeks. This has happened since he had the bad GI flu. He has decreased his salt, his fluid intake because he feels so lousy, but he's continued his lithium as well as feeling dizzy, and he's concerned he won't be able to go to work. In this HPI, we've certainly captured a number of elements and we've looked at the social history and talking about his work. We have context. We have related symptoms. We have intensity. We have duration. We only have to have two systems for his ROS, so we chart this. Psychiatric reports no change in mood, thinking, speech, but continues taking lithium while he had the flu. Constitutionally he reports changes in diet after experiencing fever, nausea, vomiting and diarrhea for four days. GI, he is reporting ongoing diarrhea after getting over the flu and that's really what brought him in because he thought I'm over the flu, I shouldn't have diarrhea anymore. Musculoskeletal, he's complaining of tremors and he tells us that when we do our ROS that he's weak if he gets up too fast. We have a lot of indicators here.

Our physical exam, the psychiatric, we always want to talk about our patient's appearance. We say he's appropriately dressed, really cooperative, attitude is cooperative, speech is clear with no slurring or increased rate, thought process and association are normal, thought content normal with no grandiosity, judgment is adequate and his mood is euthymic. Psychiatrically, he's ok. Constitutionally, I think we have a little problem going on with his blood pressure and his pulse is a little elevated and his temperature's just slightly elevated and his weight's 224 which is an increase of 10 pounds, but he's groomed and he has good hygiene. Musculoskeletal wise, his strength is fine but he does have observable fine tremors that he's never had before, but his gait is normal. I think we've caught this early, glad he came in.

What's our impression? He's stable bipolar, but he has mild lithium toxicity related to continuing lithium while experiencing vomiting and diarrhea, possible dehydration. Our plan, we want to continue lithium in therapy but we had to call the lab, order STAT lithium level, comprehensive metabolic panel, renal function, thyroid function. We reviewed his diet and instructed to return to normal diet and increase his water intake back to his normal two liters a day, and then we also reviewed the effects of lithium during dehydration. Our plan and we're also going to call the patient with lab results and we want to have him come back in two weeks and recheck his vital after he's better hydrated.

At that next visit, we may want to make that one all a time code on counseling and coordination of care or psycho ed. You would've done a little psycho ed with this visit as we indicated, but not enough to count the entire visit under counseling and coordination of care. Next visit, you might want to come in and just do a 99213 but you may be need to do therapy with this patient and do a 90833 add-on code. There's a number of ways that we can code these. I'm just so thrilled that we have all these options available to us now.

The last thing we'll look at, and we're almost done and you're probably really glad about that, is that we're going to have our really complex case in a 99215. The scenario I chose was a 25-year-old male with history of schizophrenia, has been seen bimonthly, partially compliant with medications, but is complaining of a new onset of auditory hallucinations and he's never really had voices before. His problem's related more to thinking and more on the negative symptoms. This is a concern. What's going to be our medical decision making for this situation? I identify with young man that we have four problem points assigned for the number of diagnoses or management options. It's a new problem to the provider with an additional workup needed. What's going on with this young man that he's now having auditory hallucinations and this is brand new? We have three data points that identified for him. Those three data points are that we are getting two points for reviewing and summarizing all his old records as we're going through this and make sure we haven't missed anything. We have to get some history from somebody else. We need to talk with maybe another provider or talk with his family and you're thinking hmmm maybe we need to order a tox screen here, maybe there's some substance abuse going on. We need to allow ourselves three data points for the potential with this patient. Risk is also at the moderate level because we have an undiagnosed new problem with an uncertain prognosis. We're going to rate this one 99215 because we get to use the highest of our options here for medical decision making. This is complex without a doubt. No one is going to question that.

What are we going to do now for our history? For our HPI, it's considered extended, four more elements with three chronic conditions. Past family and social history, we need to hit them all. We have to find out what's going on in all aspects of this patient's life. Review of systems, it has to be complete. We have to look at everything, and it's been obviously since all of these are at the maximum level we have 99215. We only need four elements. We have eight. Again, as we capture the chief complaint we have two elements of past family and social history required in a 99215, and the review of systems is our comprehensive. We have to perform all of our bulleted elements and one element from the non-shaded border. Here's how it looks. Twenty-five-year-old single white male, scheduled visit for treatment of schizophrenia, reports new onset of persecutory auditory hallucinations. In our HPI, patient reports new increased auditory hallucinations creating severe difficulty because it's

persecutory in nature that's been going on for the last three weeks. He's never heard these kinds of voices before. This has happened since increasing marijuana intake to three times daily. He's moved into new supportive living that has drug dealers there. He's also feeling lethargic, is afraid to answer the telephone. His family insists that he come in for an appointment and brought him to the session. We've really captured all of our data points that are needed in our HPI.

For the review of systems, we have to have 10 of them. Here's how we document this. Psychiatrically, he's anxious, he's paranoid, he's unable to maintain eye contact, he's reluctant to engage in conversation. He frequency turns his head and mumbles to unseen voice. His appearance is disheveled and unkempt with a strong body odor. Fingers are stained yellow from smoking. He hasn't eaten in two days. All of systems are reviewed and are negative. That's how we manage the verbiage that's required for documentation on the 99215 of the reviewed systems.

The physical exam. Again, to remind you, we've kept all the bullets in constitutional and psychiatric and one from musculoskeletal. Vital signs, 140/90, pulse 90 and regular, respirations are 20. Appearance unkempt, does not initiate conversation but is cooperative. Speech soft, slowed and he mumbles. Mood and affect, sad, restricted, incongruent. Thought process is illogical, paranoid. Associations are intact. No suicidal or homicide. Persecutory auditory hallucinations, ideas of reference, oriented times two. Recent remote memory impaired. Judgment and insight is poor. Gait and station is within normal limits. Attention and concentration is impaired. Language is good. Fund of knowledge is poor. In just a few words, we've captured all of the critical features of this particular encounter.

Our impression is his schizophrenia is an exacerbation related to substance use, medication nonadherence. He's not able to care for himself as corroborated by the family. His plan is to temporarily move him home with his family until monitored substance use with assistive medication administration and his ADLs. You're going to contact the ACT team. We're going to refer the family to NAMI. We're probably going to try obtain case management prior to ever going back to his apartment, and we need him back in two weeks at least. That gives us some time to do this. We're going to have a lot of what's called post service work to do and that is captured in the reimbursement for the 99215. If you wanted, you can bring him back in a week to see how he's doing and spend 40 minutes doing counseling and coordination of care, working with his family. If that is a follow-up it is totally acceptable and you wouldn't have to then do the history and medical decision making and physical exam. Which is what I was referring to here, so if we take our patient, bring him back, it is based on time and we would cover all of the points identified that we discussed about for counseling and care coordination which he is going to need a lot of. I would anticipate that you're

going to have maybe two or three counseling and care coordination sessions based on this E&M 99215 visit.

That's it. We have covered all you need to know about evaluation and management codes including medical decision making, history and exam, and charting for common _____ of patients that we see in our office. I refer you to the 2013 CPT coding manual you can get from the AMA and the webinars that you received a notice from through the APNA website member bridge that we have access to from the American Association of Adolescent Psychiatrists, wonderful information. I found a really great site I like called the E&M University Online and they do have a free curriculum that also is helpful. Then, finally, I really strongly encourage you to go to the Medicare Learning Network. It has about a 57-page PDF handout that is free to you that is also very helpful in explaining all of this.

I hope I haven't totally confused you, hope I've gone through the criteria, and I wish you all the best. Have a great New Year. This concludes my presentation.

Speaker 1: With that, we will conclude the 2013 Psychiatric CPT Code Update Implementing E&M Codes into Daily Practice. Please follow the URL now on your screen or click on the evaluation link in the links box to complete the evaluation and post test to receive your CE certificate for this session. Please take note of the certificate code that is appearing on your screen. You will need this to complete the process. Once you have completed the post test and evaluation, you will be able to print your CE certificate.