HIGHMARK CODING TIPS

March 2021

Reporting Information for Psychotherapy Services

Psychotherapy is the treatment of mental illness and behavioral disturbances in which the physician or other qualified health care professional, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

When billing for psychotherapy, choose the code that matches the time of the service:

* 16-37 minutes for 90832 and 90833

* 38-52 minutes for 90834 and 90836

* 53 or more minutes for 90837 and 90838

Psychotherapy times are for face-to-face services with the patient. Although informant(s) may be included, the patient must be present for all or most of the service. For family psychotherapy without the patient present, use 90846.

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 or 90838) as add-on codes to the evaluation and management service. For the reporting of psychotherapy services only, report codes (90832, 90834, or 90837).

Note: When psychotherapy is performed in addition to an E/M, the level of the E/M chosen must reflect the work performed and not the amount of time spent providing counseling and coordination of care.

INTERACTIVE COMPLEXITY – 90785

Code 90785 is an add-on code to report interactive complexity services when provided in conjunction with diagnostic psychiatric evaluation (90791, 90792), psychotherapy (90832, 90834, 90837), psychotherapy when performed with an evaluation and management service (90833, 90836, 90838, 99202-99255, 99304-99337, 99341-99350), and group psychotherapy (90853). Add-on codes may never be reported alone.

Psychiatric procedures may be reported “with interactive complexity” when at least one of the following is present:

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

2. Caregiver emotions or behavior that interferes with the caregiver’s understanding and ability to assist in the implementation of the treatment plan.

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

4. Use of play equipment, physical devices, interpreter or translator to communicate with the patient to overcome barriers to diagnostic or therapeutic interaction between the physician or other qualified health care professional and a patient who:

* Is not fluent in the same language as the physician or other qualified health care professional, or

* Has not developed, or has lost, either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the physician or other qualified health care professional if he/she were to use typical language for communication.

DOCUMENTATION STANDARDS FOR OUTPATIENT BEHAVIORAL SERVICES

The provider’s progress notes for outpatient office visits should, at a minimum, include the following information:

* Member’s name

* Date of service

* Length of session (if billing code submitted is time dependent)

* Therapy/modality utilized

* Appropriate subjective and objective date

* Assessment

* Treatment plan (including plan for next session and adjustments to the treatment plan resulting from new information or change in prioritization of treatment needs).

**Please refer to the Highmark Provider Manual and Medical Policy for additional information.

Nasal Endoscopy and when to report 31231 vs 31231 using 52/53 Modifier

Highmark follows the American Medical Association Current Procedural Terminology (AMA CPT®), as well as other sources (eg, Centers for Medicare and Medicaid Services (CMS), National and State Medical Societies and Associations), for correct coding and reporting, as noted in Reimbursement Policy-035. According to CPT®, codes 31231-31235 represent a diagnostic evaluation of the nasal cavity, the middle and superior meatus, the turbinates, and the spheno-ethmoid recess. Any time the diagnostic evaluation procedures are reported, all of these are inspected by a nasal/sinus endoscope and a separate code is not reported for each area. If all of the elements are not fully examined (eg, judged not clinically pertinent), or because the clinical situation precludes such exam (eg, technically unable, altered anatomy), append modifier 52 if repeat examination is not planned, or modifier 53 if repeat examination is planned.

According to CPT® Assistant, April 1, 2018: A complete diagnostic nasal endoscopy includes visualization of the nasal cavity interior, the middle and superior meatus, the turbinates, and the spheno-ethmoid recess. If any of these structures cannot be visualized (eg, due to anatomic considerations, patient factors) append modifier 52, Reduced services, to code 31231.

During several post payment reviews of code 31231, Highmark auditors found instances where the documentation included only a brief summary of the endoscopy performed, such as “sinus endoscopy shows no abnormalities,” or “endoscopy indicates healing well post-operatively”. This type of documentation is insufficient to support diagnostic nasal endoscopy, code 31231. When the documentation is insufficient to support code 31231, Highmark may reduce or retract payments for services not supported.