CodingAID's 2019

Coding for Behavioral Health

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CODINGAID

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AGENDA

01 Evaluation and Management Tips

02 E & M versus Psychiatric Evaluation

03 Psychiatric Diagnostic Evaluation

04 Psychotherapy Services

05 Health & Behavioral Assessments

06 Adaptive Behavior Services

07 Psychiatric Collaborative Care Management Services

08 Central Nervous System Assessments/Tests

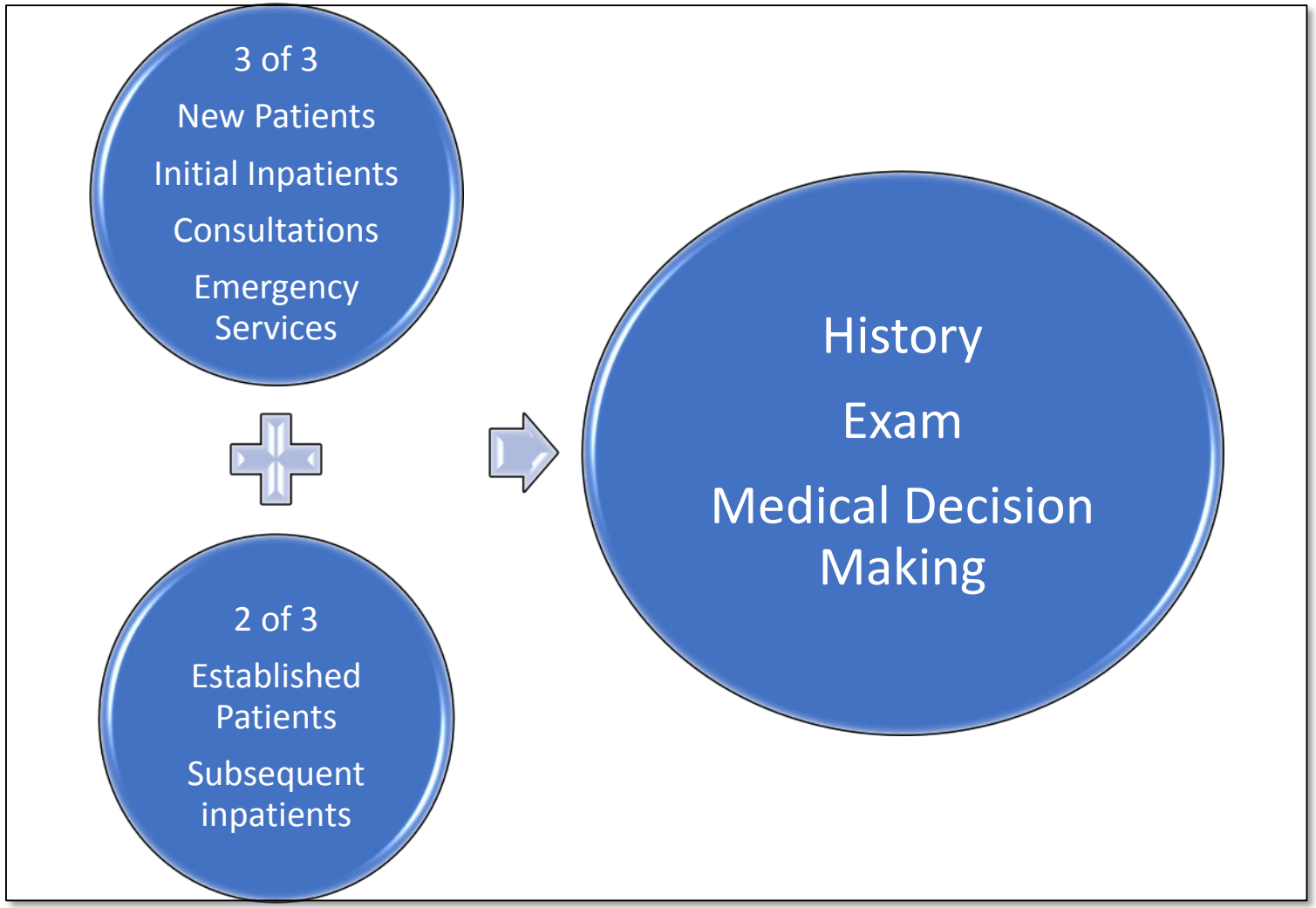
09 Mental & Behavioral ICD-10-CM

10 Questions

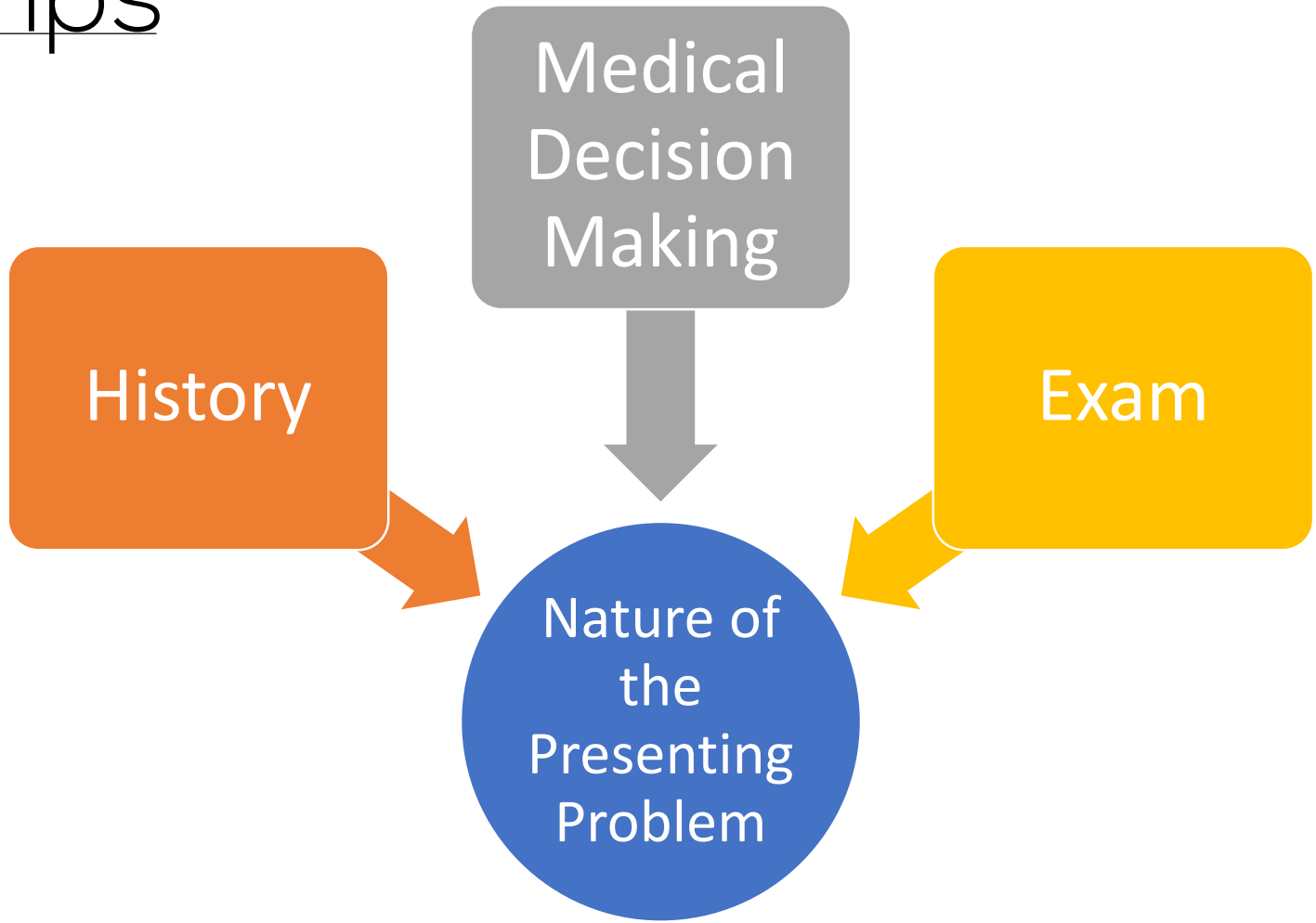
E&M Tips

E&M Tips

E/M KEY COMPONENTS REQUIREMENT (3 YEAR RULE)



E&M Tips



"Time/Counseling" are considered contributory factors

E&M Tips

HISTORY DOCUMENTATION REVIEW

History

Chief Complaint (CC)	History of present illness (HPI)	Past, family, social history (PFSH)	Review of systems (ROS)
Reason for the visit	Location; Severity; Timing; Quality; Duration; Context; Modifying Factors; Associated signs and symptoms	Past medical; Family medical; Social	Constitutional; Eyes; Ears, Nose, Mouth, and Throat; Cardiovascular; Respiratory; Genitourinary; Musculoskeletal; Gastrointestinal; Skin/Breast; Neurological; Psychiatric; Endocrine; Hematologic/Lymphatic; Allergic/Immunologic

CC	HPI	PFSH	ROS	History Type
Yes	*Brief* (1-3 elements or 1-2 chronic conditions)	N/A	N/A	*Problem focused* (PF)
			Problem pertinent (1 system)	*Expanded problem focused* (EPF)
	Extended (4 elements or 3 chronic conditions)	*Pertinent* (1 element)	*Extended* (2-9 systems)	*Detailed* (DET)
		Complete (2 elements (est) or 3 elements (new/initial))	*Complete* (10-14 systems)	*Comprehensive* (COMP)

E&M Tips

HISTORY

DETAILED (99203/99214)	COMPREHENSIVE (99204/99205/99215)
4 HPI	4 HPI
2 Review of Systems	10+ Review of Systems
Past, Family & Social History • Only 1 required	Past, Family & Social History • All 3 required

E&M Tips

PSYCH EXAM GUIDELINES REVIEW

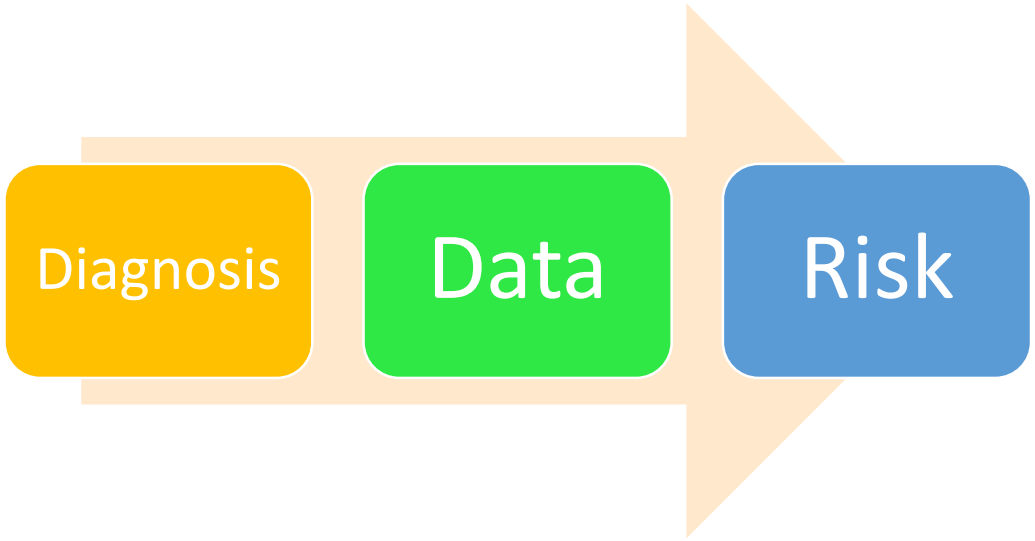
Examination

System/body area	Examination
Constitutional	• 3/7 vital signs: sitting or standing BP, supine BP, pulse rate and regularity, respiration, temperature, height, weight • General appearance
Musculoskeletal	• Muscle strength and tone • Gait and station
Psychiatric	• Speech • Thought process • Associations • Abnormal/psychotic thoughts • Judgment and insight • Orientation • Recent and remote memory • Attention and concentration • Language • Fund of knowledge • Mood and affect

Examination Elements	Examination type
1-5 bullets	*Problem focused* (PF)
At least 6 bullets	*Expanded problem focused* (EPF)
At least 9 bullets	*Detailed* (DET)
All bullets in Constitutional and Psychiatric (shaded) boxes and 1 bullet in Musculoskeletal (unshaded) box	*Comprehensive* (COMP)

E&M Tips

COMPLEXITY OF MEDICAL DECISION MAKING



E&M Tips

NUMBER OF DIAGNOSES/MANAGEMENT OPTIONS

Table A. Number of Diagnoses or Management Options			
A	**B x C = D**		
Problem(s) Status	*Number*	*Points*	*Result*
Self-limited or minor (stable, improved or worsening)	Max = 2	1	
Established problem (to examiner); stable, improved		1	
Established problem (to examiner); worsening		2	
New problem (to examiner); no additional work-up planned	Max = 1	3	
New problem (to examiner); additional work-up planned		4	
		TOTAL	

E&M Tips

AMOUNT AND/OR COMPLEXITY OF DATA REVIEWED

Table B. Amount and/or Complexity of Data Reviewed

Reviewed Data	*Points*
Review and/or order of clinical lab tests	1
Review and/or order of tests in the radiology section of CPT	1
Review and/or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than the patient	1
Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider	2
Independent visualization of image, tracing or specimen itself (not simply review of report)	2
TOTAL	

E&M Tips

TABLE OF RISK

Table C. Level of Risk

	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
MINIMAL	• One self-limited or minor problem, eg, cold, insect bite, tinea corporis	• Lab tests requiring venipuncture • Chest x-rays • EKG/EEG • Urinalysis • Ultrasound, eg, echocardiography • KOH prep	• Rest • Gargles • Elastic bandages • Superficial dressings
LOW	• Two or more self-limited or minor problems • One stable chronic illness, eg, well controlled hypertension, non-insulin dependent diabetes, cataract, BPH • Acute uncomplicated illness or injury, eg, cystitis, allergic rhinitis, simple sprain	• Physiologic tests not under stress, eg, pulmonary function tests • Non-cardiovascular imaging studies with contrast, eg, barium enema • Superficial needle biopsies • Clinical laboratory tests requiring arterial puncture • Skin biopsies	• Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives
MODERATE	• One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis, eg, lump in breast • Acute illness with systemic symptoms, eg, pyelonephritis, pneumonitis, colitis • Acute complicated injury, eg, head injury with brief loss of consciousness	• Physiologic tests under stress, eg, cardiac stress test, fetal contraction stress test • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors, eg, arteriogram, cardiac catheterization • Obtain fluid from body cavity, eg lumbar puncture, thoracentesis, culdocentesis	• Minor surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation
HIGH	• One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment • Acute or chronic illnesses or injuries that pose a threat to life or bodily function, eg, multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure • Abrupt change in neurologic status, eg, seizure, TIA, weakness, sensory loss	• Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic Endoscopies with identified risk factors • Discography	• Elective major surgery (open, percutaneous or endoscopic) with identified risk factors • Emergency major surgery (open, percutaneous or endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis

E&M Tips

COMPLEXITY OF MEDICAL DECISION MAKING

Figure 2. Determining Medical Decision Making Level

Draw a line down any column with 2 or 3 circles to identify the type of decision making in that column. Otherwise, draw a line down the column with the 2nd circle from the left

Table A	Number of Diagnoses or Management Options	<1 Minimal	2 Limited	3 Multiple	> 4 Extensive
Table B	Amount & Complexity of Data	<1 Minimal or Low	2 Limited	3 Multiple	> 4 Extensive
Table C	Highest Risk	Minimal	Low	Moderate	High
Type of Decision Making		Straight-forward	Low Complexity	Moderate Complexity	High Complexity

E&M Tips

PUTTING IT ALL TOGETHER

CPT Codes

New Patient Office
(requires 3 of 3)

CPT Code	History	Exam	MDM
99201	PF	PF	Straightforward
99202	EPF	EPF	Straightforward
99203	DET	DET	Low
99204	COMP	COMP	Moderate
99205	COMP	COMP	High

Established Patient Office
(requires 2 of 3)

CPT Code	History	Exam	MDM
99211	N/A	N/A	N/A
99212	PF	PF	Straightforward
99213	EPF	EPF	Low
99214	DET	DET	Moderate
99215	COMP	COMP	High

Initial Hospital/PHP
(requires 3 of 3)

CPT Code	History	Exam	MDM
99221	DET	DET	Straightforward
99222	COMP	COMP	Moderate
99223	COMP	COMP	High

Subsequent Hospital/PHP
(requires 2 of 3)

CPT Code	History	Exam	MDM
99231	PF	PF	Straightforward
99232	EPF	EPF	Moderate
99233	DET	DET	High

E&M Tips

TIME CODING E&M SERVICES

- E & M Services can only be coded by time when;
  - No Psychotherapy is also performed
  - Over 50% of the face to face encounter with the patient and family includes counseling and/or coordination of care
- **Counseling includes:**
  - Diagnostic results, impressions, and/or recommended diagnostic studies
  - Prognosis
  - Risks and benefits of treatment options
  - Instructions for treatment and/or follow-up
  - Importance of compliance with chosen treatment options
  - Risk factor reduction
  - Patient and family education

E&M Tips

COUNSELING—CODING WITH TIME

When counseling makes up more than 50% of the total time spent with the patient during an encounter, time can be used as the key factor in choosing a level of service. Documentation must include:

- Total time spent
- % of time spent in counseling
- What was discussed in counseling

Can be coded by time:

I spent 25 minutes with the patient, greater than 50% of the time was spent discussing her new diagnosis, conservative treatment options and reassurance.

Cannot be coded by time:

A long discussion was held with the patient as to his underlying diagnosis. Course of treatment plan from medication management and the benefits of psychotherapy was discussed with the patient.

E&M Tips

CODING BY TIME

- Sequential Time Coding
  - The physician spends 21 minutes counseling established patients and is more than 50% of this encounter
  - 99213 is for 15 minutes and 99214 is for 25 minutes
  - You would code 99214 since it is closest to the **actual time**

E&M Tips

EVALUATION & MANAGEMENT SERVICES

- When Psychotherapy is performed with medical management or medication management, an E & M Code is selected and documented separately from the psychotherapy (add on) code.
- Separate notes will identify each service (even if on the same page)
- E & M service cannot be time based when billed with Psychotherapy
- Time for the Psychotherapy is still required

E&M Tips

E/M EXAMPLE #1

Chief Complaint: 9-year-old male seen for follow up visit for ADHD. Visit attended by patient and mother; history obtained from both.
Grades are good but patient appears distracted in class. Lunch appetite poor but eating well at other meals.

ROS: denies depression, anxiety, sleep problems

Exam: appropriately dressed, comes to office easily
Speech normal rate and tone, thought content no SI/HI or psychotic symptoms
Associations intact
Orientation x 3
Mood and affect euthymic and full and appropriate

Problem 1: ADHD
Comment: Relatively stable; mild symptoms

Plan: Renew stimulant script and increase dose;
Return visit in 2 months

E&M Tips

E/M EXAMPLE #2

Chief Complaint: 70-year-old male seen for follow up visit for depression. Visit attended by patient and daughter; history obtained from both.
Patient and daughter report increasing distress related to finding that he has repeatedly lost small objects (e.g., keys, bills, items of clothing) over the past 2-3 months (duration). Patient notices intermittent (timing), mild (severity) forgetfulness (quality) of people's names and what he is about to say in a conversation. There are no particular stressors (modifying factors) and little sadness Less attention to hobbies
ROS: Psychiatric: no problems with sleep or anger;
Neurological: no headaches, dizziness, or weakness

Exam: Appearance: appropriate dress, appears stated age
Muscle strength and tone: normal
Speech: normal rate and tone; Thought process: logical; Associations: intact; Thought content: no SI/HI or psychotic symptoms; Orientation: x 3; Attention and concentration: unable to focus on serial 7s; Mood and affect: euthymic and full and appropriate; Recent and remote memory: mild struggle with telling history and remembered 1/3 objects

Problem 1: Depression
Comment: Stable; few symptoms
Plan: Continue same dose of SSRI; write script
Return visit in 1 month
Problem 2: Forgetfulness
Comment: New; mildly impaired attention and memory
Plan: Brain MRI; consider referral to a neurologist if persists

E&M Tips

E/M EXAMPLE #3

17-year-old male seen for urgent visit for depression. Visit attended by patient and parents; history obtained from all 3.
Patient doing well until 2 days ago (timing) when, for no apparent reason (context), he refused to leave his bed and appeared extremely (severity) and continuously depressed (quality); he is sleeping more and eating little (associated signs and symptoms)
Stopped attending school; family history of suicide is noted from patient's initial evaluation

ROS: Psychiatric: no problems with anxiety or anger; Neurological: no headaches; All other systems reviewed and are negative

Exam: BP (sitting) 120/70, P 90 and regular, R 20; Appearance: appropriate dress, appears stated age
Gait and station: normal
Speech: sparse and slow; Thought process: logical; Associations: intact; Thought content: hopelessness, thinks of suicide, no HI or psychotic symptoms; Orientation: x 3; Attention and concentration: impaired; Mood and affect: depressed and constricted; Judgment and insight: poor; Fund of knowledge: good; Recent and remote memory: good; Language: able to repeat phrases

Problem 1: Bipolar disorder
Comment: Major relapse
Plan: Continue current dose of Lithium for the moment

Problem 2: Suicidality
Comment: New
Plan: Refer to hospital; confer with hospitalist once patient is admitted

E&M Tips

E & M TEMPLATE FORMS

- American Psychiatric Association
  - Intial Evaluation New Patient Outpatient (99201-99205),
  - Initial Hospital Care (99221-99223),
  - Initial Nursing Facility Care (99304-99306) DRAFT [posted 12.07.2012]
  - Established Patient Outpatient (99211-99215),
  - Subseq Hosp Care (99231-99233),
  - Subseq Nursing Fac Care (99311-99313) DRAFT [posted 12.07.2012]
- New York State Psychiatric Association

The following Templates were provided by the New York State Psychiatric Association and are available on their website http://www.nyspsych.org/

- Inpatient E&M Template
- Outpatient E&M Template
- Nursing Home E&M Template

E&M Tips

MEDICATION MANAGEMENT

- Code 90862 has been eliminated, and psychiatrists will now use the appropriate evaluation and management (E/M) code when they do pharmacologic management for a patient. When psychotherapy is done during the same session as the pharmacologic management, one of the new psychotherapy add-on codes should be used along with the E/M code.
- 90863, was created for medication management when done with psychotherapy by the psychologists in New Mexico and Louisiana who are permitted to prescribe, but this code is **not** to be used by psychiatrists or other medical mental health providers.
- M0064 is reported for Medicare patients when a “brief” office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental psychoneurotic and personality disorders.

E&M Tips

QUESTION

- *Question*: Coding E/M level for follow up med management for complex patient where note states client is doing well on meds, no med concerns or changes. There is confusion between provider v. coder on E/M level. Provider feels a 99214/99215 is appropriate. Coders do not based on note stating no med concerns, no changes, etc.
- *Answer*: Based on MDM of 1 stabled established condition this may only be a 99212. But if the provider has extensive discussions with the patient than time coding may be the better option. 99214 would be 20 minutes face to face with over 50% counseling/coordination of care and the content of the discussion in the note.

E&M vs. Psych

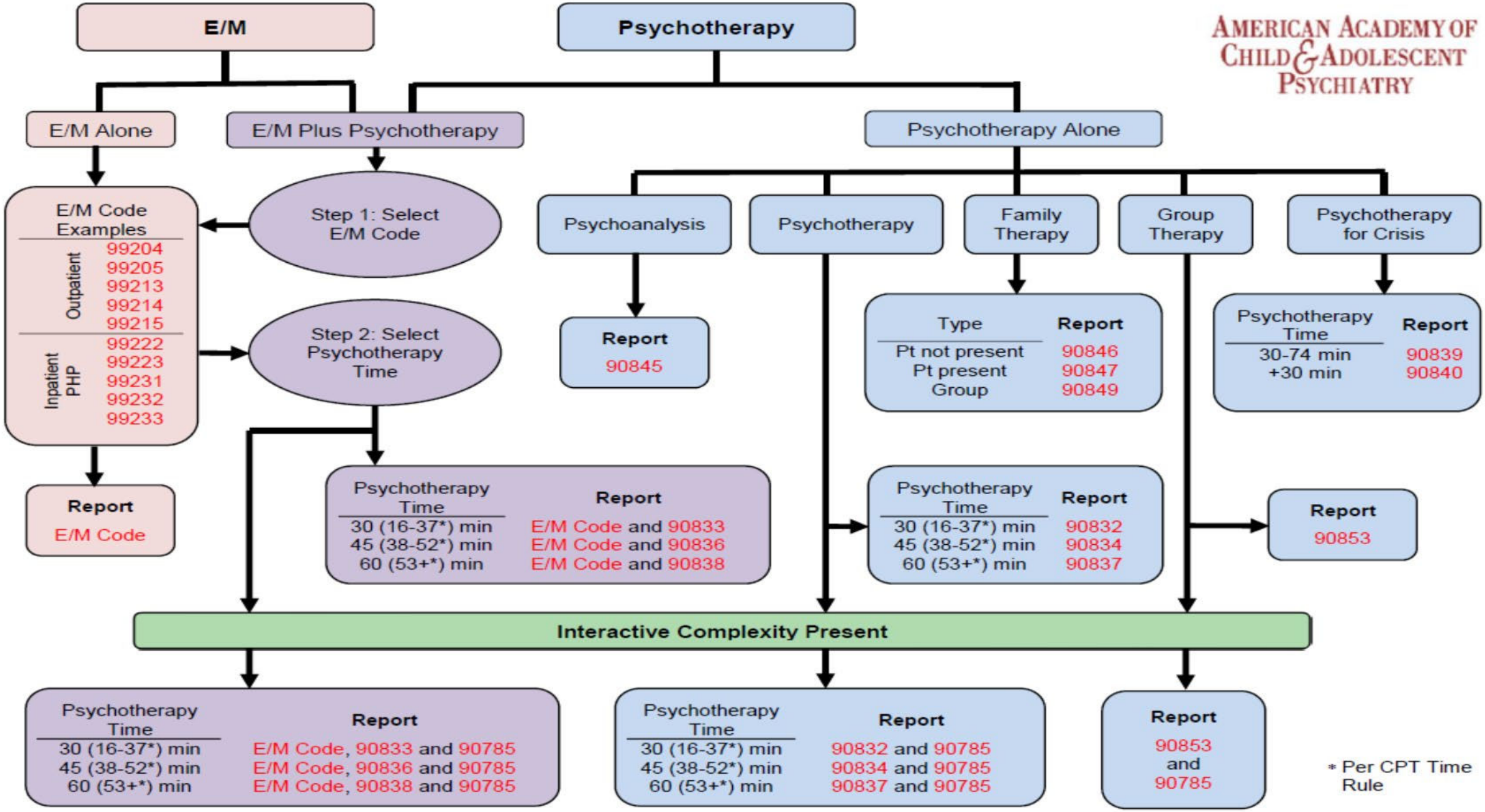
E&M vs. Psych

E & M VERSUS PSYCH DIAGNOSTIC EVALUATION

- Medicare and other payors allow the use of 90792 or the appropriate level of E & M codes to denote the initial evaluation or first-day services for hospitalized patients.
- Both require similar History and Exam documentation
- Differences include:
  - 90792 requires an extensive “Plan of Care” to include type and duration of therapy and the patients ability to participate in the therapy plan.
  - E & M services require “Medical Decision Making” that can be part of the physicians Assessment and Plan.
- What is the intent and intensity of the visit?

E/M and Psychotherapy Coding Algorithm

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY



Psychiatric Diagnostic Evaluation

Psychiatric Diagnostic Evaluation

PSYCHIATRIC DIAGNOSTIC EVALUATION

- 90791
  - Psychiatric Diagnostic Evaluation
    - History and Mental Status
    - Review and order of diagnostic studies as needed
    - Recommendations (including communication with family or other sources)
- 90792
  - Psychiatric Diagnostic Evaluation with medical services
    - Includes all of the above PLUS
    - CMS Psychiatric Specialty Examination
    - Prescription of Medications when appropriate
    - Ordering of Laboratory Tests as needed

Psychiatric Diagnostic Evaluation

CODING TIPS 90791, 90792

- Use for reassessments if required
- Report more than once for the patient when separate diagnostic evaluations are conducted with the patient and other informants. Report services as being provided to the patient and not the informant or other party in such cases.
- Do not report on the same day as psychotherapy or crisis psychotherapy
- Do not report on the same day as an E/M service performed by the same individual for the same patient

Psychiatric Diagnostic Evaluation

DOCUMENTATION REQUIRED FOR DIAGNOSTIC ASSESSMENT

- Date, Chief Complaint, Referral Source
- Complete Medical and Mental Health History:
  - development, strengths and vulnerabilities
  - information obtained from family/caregivers
  - information obtained through review of the medical record
- Examination:
  - Complete Mental Status Exam
- Diagnoses and *Plan of Care*
  - Ordering and/or interpretation of lab or other medical diagnostic tests
  - Formulation of opinion, tentative diagnosis and recommendations
  - Evaluation of the patient's ability and willingness to adhere to the treatment plan

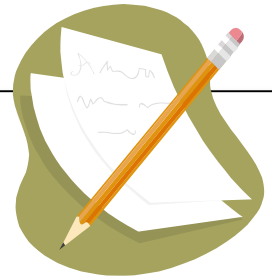
Psychiatric Diagnostic Evaluation

COMPLETE MENTAL STATUS EXAM ELEMENTS

- Affect
- Speech
- Mood
- Thought content
- Judgment
- Insight
- Attention/concentration
- Memory
- Impulse control

Psychiatric Diagnostic Evaluation

PLAN OF CARE



Documentation Requirements

Health record should include a minimum of the following:

- the patient's diagnosis
- short and /or long term treatment goals that are objective and measurable
- the *type*, amount, duration and frequency of services (interventions should be consistent with treatment plan goals)
- an evaluation of the patient's ability and capacity to respond to treatment (client's understanding of treatment plan is documented)

Note: Plan of care must be established before treatment has begun and may be adjusted by the appropriate practitioner. *In limited situations treatment may begin prior to establishing the Plan of care for patients in Group Therapy (per APA)

Psychiatric Diagnostic Evaluation

INTERACTIVE COMPLEXITY 90785

+ 90785 Interactive Complexity (List separately in addition to the code for primary procedure)

- 1 of the following must exist to use this code
  - Maladaptive Communication (e.g. high anxiety, high reactivity, repeated questions or disagreement)
  - Emotional or Behavioral Conditions Inhibiting Implementation of Treatment Plan
  - Mandated Reporting/Event Exist (e.g. abuse or neglect)
  - Play equipment, devices, interpreter, or translator required due to inadequate language expression or different language spoken between patient and professional

Psychotherapy

Psychotherapy

- Psychotherapy with patient or family
  - Site of service is no longer a criterion for code selection
  - Time specifications are changed to be consistent with CPT convention
  - “Individual” is not in the code titles and psychotherapy time may include face-to-face time with family members as long as the patient is present for part of the session
  - Codes for psychotherapy with medical evaluation and management services have been replaced with psychotherapy add-on codes, which are reported in conjunction with codes for E/M services. +90833, +90836, +90838. To report both an E/M code and the add-on code, the two services must be significant and separately identifiable

Psychotherapy

CODING TIPS

- Psychotherapy must be 16 minutes or more face-to-face with patient and/or family
- E & M Services with Psychotherapy:
  - Time associated with activities used to meet criteria for the E/M service is not included in the time used for reporting psychotherapy (i.e. time spent on history, exam, and medical decision making)
  - Time (Counseling and coordination of care) may not be used as the basis of E/M code selection
  - The E/M service and the psychotherapy service may be for the same diagnosis.

Psychotherapy

- 90832 Psychotherapy with patient and/or family: 30 minutes
  - +90833 Psychotherapy 30 minutes, when performed with an evaluation and management service (List separately in addition to appropriate EM code)
- 90834 Psychotherapy with patient and/or family: 45 minutes
  - +90836 Psychotherapy 45 minutes, when performed with an evaluation and management service (List separately in addition to appropriate EM code)
- 90837 Psychotherapy with patient and/or family: 60 minutes
  - + 90838 Psychotherapy 60 minutes, when performed with an evaluation and management service (List separately in addition to appropriate EM code)
  - Use Prolonged Services code (99354, 99355 or 99356, 99357) for psychotherapy services of 90 minutes or longer face to face with the patient. These codes may not be reimbursed for Master Level Clinicians with some payers.

Psychotherapy

QUESTION

- *Question*: I have a question on what is considered billable time.... A school based health provider speaks to the principal in regards to the actions of a child during the breakfast line. Provider then speaks to the child and performs psychotherapy on the patient. Later in the afternoon, the same child presented to therapists office because the child was removed from the classroom because of disruptive behavior. Is the three different meetings considered as billable therapist time for the patient?
- *Answer*: As long as the majority of the time is spent face to face with the patient you can include the time gathering information about the patient from informants.

Psychotherapy

PSYCHOTHERAPY TIME

- CPT Time Rule
  - A unit of time is attained when the mid-point is passed
  - When codes are ranked in sequential typical times and the actual time is between the two typical times, the code with the typical time closest to the actual time is used.
  - With Psychotherapy codes
    - 30 minutes (16-37 minutes)
    - 45 minutes (38-52 minutes)
    - 60 minutes (53+ minutes)
- Psychotherapy less than 16 minutes is not reported

❖ *TIME MUST BE DOCUMENTED*

Psychotherapy

Example

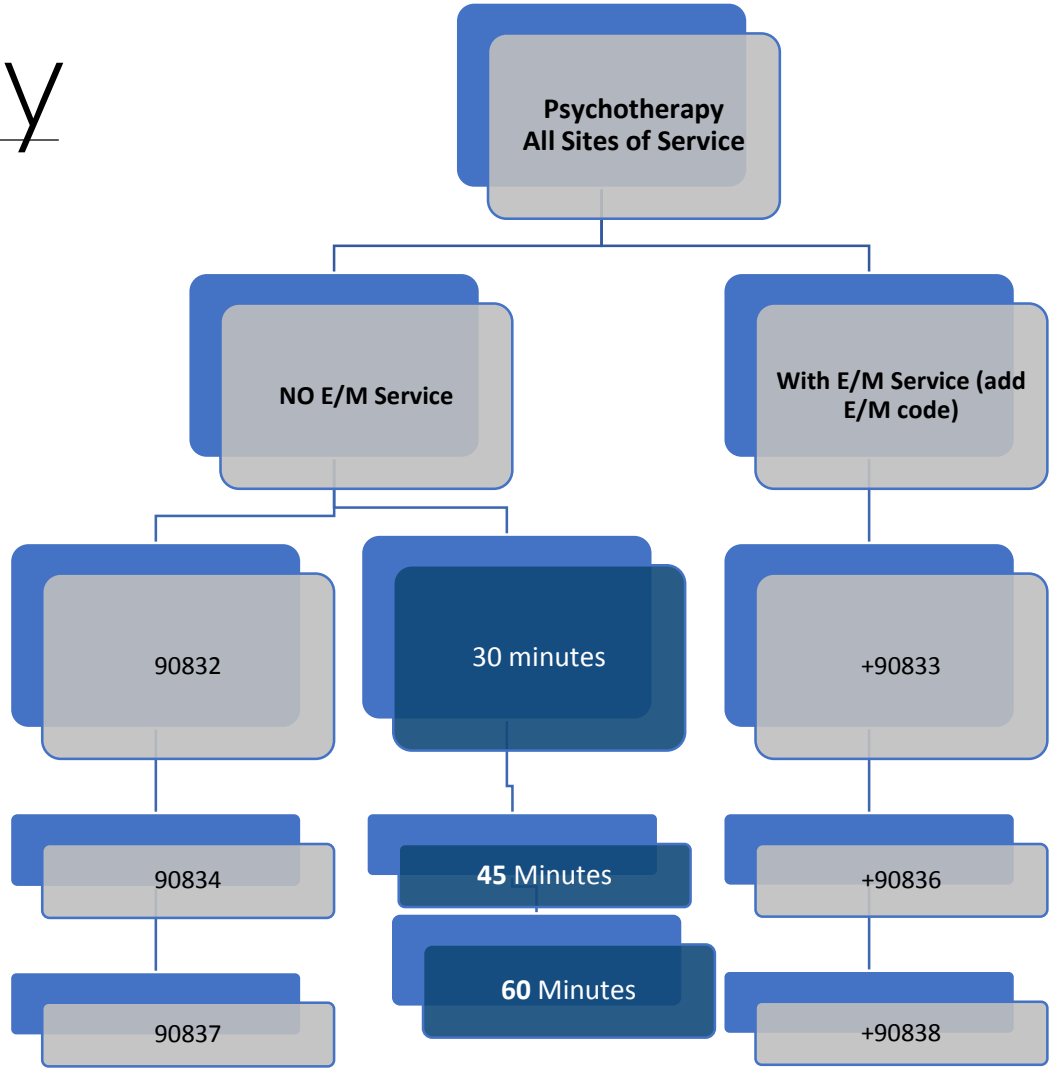
- Patient is seen for a 50 minute psychotherapy session
  - 90834, Psychotherapy 45 minutes
  - 90837, Psychotherapy 60 minutes
    - 50 minutes is closer to 90834

Psychotherapy

MINIMUM DOCUMENTATION GUIDELINES

- Date
- Time Spent with the patient (length of session)
- The ***specific therapeutic maneuvers used***, such as cognitive restructuring, behavior modification, to produce therapeutic change.
- Diagnosis: needs to be clearly documented for each visit and related to treatment/therapy.
- A periodic summary of goals, progress toward goals, and an updated treatment plan must be included in the health record.
- Progress or lack of progress toward the goals stipulated in the individual treatment plan
- Legible signature

Psychotherapy



Psychotherapy

INDIVIDUAL PSYCHOTHERAPY VERSUS FAMILY PSYCHOTHERAPY?

- Now that the Psychotherapy services may include a family member (as long as the patient is present for a portion of the time), when would we use the Family Psychotherapy codes?
  - Using one code category or the other depends not just on who was present in the room, but the primary clinical focus of treatment.
  - Are you treating someone with severe depression, whose spouse just happens to be present for support? (90834) Or is your “client” really a marriage in distress, where you are doing active couple therapy? (90847).
  - How are they documented in your clinical record, will form the basis of coding decisions.

Psychotherapy

FAMILY PSYCHOTHERAPY: 90846-90849

- One or more family members participation in the treatment process of the client during some of the patient's sessions of psychotherapy
- Documentation must include:
  - Persons present for the services
  - Length of time for each session
  - Type of therapeutic intervention
  - Target Symptoms (Diagnoses)
  - List of general topics addressed in that session
  - Content notes:
    - Patients interpersonal and/or interverbal exchanges
    - Progress or lack of progress toward the goals in the treatment plan
    - Impairment, severity/complexity of illness, and intensity of needed services

Psychotherapy

FAMILY PSYCHOTHERAPY: 90846-90849

- 90846
  - used when there is a need to assess the capability of and assist family members in the management of the patient (without the patient present)
- 90847
  - used when there is a need to observe the patient's interaction with family members (with the patient present some or all of the time)
    - Includes couples/co-joint therapy
- 90849
  - Used with Multiple-family group psychotherapy
    - *Talking to family members after a session about the client's progress does not meet the criteria for reporting these codes*

Psychotherapy

GROUP PSYCHOTHERAPY: 90853

- Psychotherapy administered in a group setting with a trained group leader in charge of several clients
  - Other than of a multiple family group
- Documentation includes:
  - Length of time for each session
  - Number of persons in the group
  - Documentation of key issues presented
  - Individual client's unique issues related to the whole group
  - Attempt to relate the specific group sessions to a therapeutic theme or goal for the individual client

Psychotherapy

GROUP PSYCHOTHERAPY: 90853

- One group note, that is common to all clients, is only one aspect of appropriate documentation.
- In addition to the group note, the patient's unique issues (including diagnosis) should be documented in each individual client's record
- 90853 does not include:
  - Socialization, music therapy, recreational activities, art classes, excursions or eating together and sensory stimulation

Psychotherapy

GROUP PSYCHOTHERAPY: 90853

- Use Interactive Complexity add-on code +90785 with 90853 to report for 1 or more group members
  - A group of 8 adults is being seen in a group session with the addition of an interpreter for one patient with a hearing impairment.
    - Only the patient utilizing the interpreter receives the add-on code
      - 90853 and 90785
    - If more than one patient is using the interpreter, they each would receive the add-on code

Psychotherapy

PSYCHOTHERAPY FOR CRISIS

- The provider performs psychotherapy for a patient in a state of crisis.
- A crisis state is defined as a life–threatening or complex state requiring immediate attention to a patient in high distress. The provider primarily aims the treatment at mobilization of resources to defuse the crisis and restore safety of the patient to minimize the potential for psychological trauma.

Psychotherapy

PSYCHOTHERAPY FOR CRISIS

- 90839: Psychotherapy for crisis; first 60 minutes
  - In this service, the provider performs psychotherapy for a crisis situation when the patient is in a life–threatening state and needs immediate attention. The treatment session typically lasts anywhere between 30 to 74 minutes.
  - Do not report his code more than once per day
- +90840: Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)
  - You may not report +90840 until you've reached the halfway point of the 30 minutes mentioned in the code descriptor

✓ Do not report 90791/90792 or any of the Psychotherapy codes on the same day as 90839.

Psychotherapy

INTERACTIVE COMPLEXITY IS INTEGRAL TO CRISIS MANAGEMENT

- In most situations where your clinician performs a crisis management, you will see that your clinician had trouble with communication with the patient. But, you should not reach out to the interactive complexity add-on code, +90785 (Interactive complexity [List separately in addition to the code for primary procedure]) whenever you see such a situation.
- The reason codes 90839 and +90840 are excluded from the use of this add-on code is because psychotherapy for crisis inherently involves specific communication factors that complicate the delivery of a psychiatric procedure, which is what the code for interactive complexity is otherwise intended to capture. For instance, according to CPT®, one of the reasons to report interactive complexity is the need to manage maladaptive communication (related to, e.g., high anxiety, high reactivity, repeated questions, or disagreement) that complicates delivery of care. This need is almost always present in psychotherapy for crisis. Since interactive complexity is inherent in the use of the psychotherapy for crisis codes, you should not bill +90785 in addition to 90839 and +90840. A parenthetical notation following code +90785 in CPT® explicitly states, “Do not report 90785 in conjunction with 90839, 90840, or in conjunction with E/M services when no psychotherapy service is also reported.”
- Also, since crisis management codes are time-based codes, reporting the appropriate units of codes 90839 and +90840 captures any extra time necessitated by interactive complexity without the need to report +90785. So, even though your clinician had to spend extra time face-to-face with the patient overcoming the communication issues, he will receive appropriate compensation for the additional time spent, because you will report crisis management codes on the basis of time.

Psychotherapy

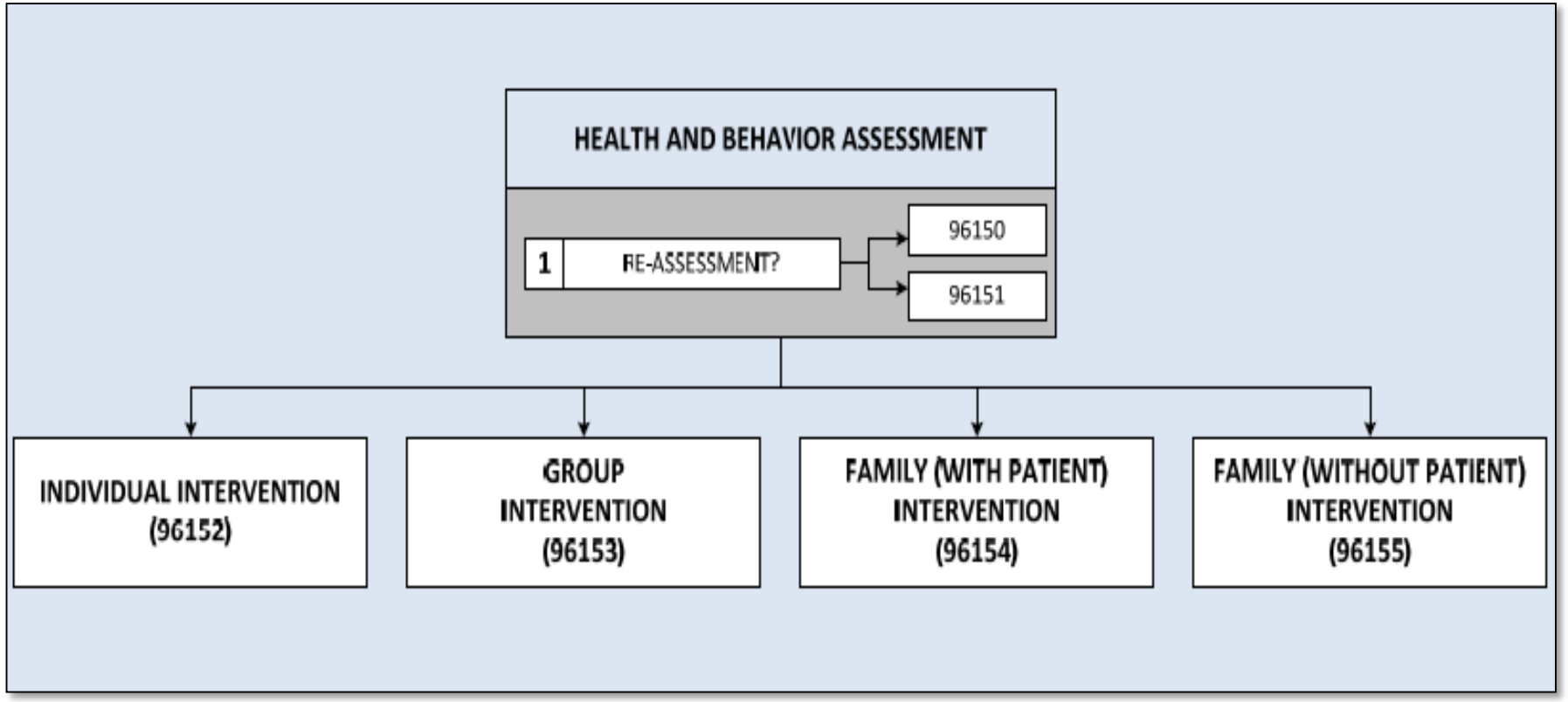
DOCUMENTATION FOR PSYCHOTHERAPY FOR CRISIS

- In addition to noting the face-to-face time spent, documentation should include the following:
  - An urgent assessment and crisis history;
  - Mental status examination;
  - Disposition;
  - Psychotherapy;
  - Implementation of any psychotherapeutic interventions deemed necessary to reduce the potential for psychological trauma;
  - Mobilization of resources to defuse the crisis and restore safety.

Health and Behavioral Assessment/Interventions

Health and Behavioral Assessment/Interventions

HEALTH AND BEHAVIOR CODES



Health and Behavioral Assessment/Interventions

- 96150-96155 describe services:
  - Used to identify the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems
    - An acute or chronic illness (not meeting criteria for psychiatric diagnosis)
    - Maintenance of health not meeting criteria for psychiatric diagnosis or representing a preventive medicine service

Health and Behavioral Assessment/Interventions

- 96150
  - Health and Behavior Assessment, each 15 minutes face to face with the client; initial assessment
- 96151
  - Re-assessment
- 96152
  - Health and Behavior Intervention, each 15 minutes face to face with the client; individual
- 96153: group (2 or more clients)
- 96154: family (with the client present)
- 96155: family (without the client present)

Health and Behavioral Assessment/Interventions

DOCUMENTING ASSESSMENTS

- Date
- Evaluation methods used
- Observations
- Results of psychophysiological monitoring
- Summary of the assessment
- Recommendations
- Number of 15-minute units
- Total time spent with the client
- Diagnosis

Health and Behavioral Assessment/Interventions

DOCUMENTING INTERVENTION PROCEDURES

- Date
- Intervention methods used
- Observations
- Results of psychophysiological monitoring
- Summary of the intervention
- Recommendations
- Number of 15-minute units
- Total time spent with the client or family
- Diagnosis

Health and Behavioral Assessment/Interventions

BARIATRIC SURGERY QUESTIONS

- Question: Can a LCSW perform the Bariatric Psychiatric Clearance and if so what code would be billed?
- Answer: Since LCSW cannot use the E & M codes let's consider either the Diagnostic Psych Evaluation or Health & Behavioral Assessment.

- Question: Can we provide group therapy for patients after Bariatric Surgery?
- Answer: Yes, 90853 is the Group Therapy code that is billed for each patient in the group session. Be sure to document each patients contribution to the group session in each of their charts. These sessions are limited to no more than 12 patients.

Adaptive Behavior Services

Adaptive Behavior Services

- Adaptive behavior services address deficient adaptive behaviors (eg, impaired social, communication, or self-care skills), maladaptive behaviors (eg, repetitive and stereotypic behaviors, behaviors that risk physical harm to the patient, others, and/or property), or other impaired functioning secondary to deficient adaptive or maladaptive behaviors, including, but not limited to, instruction-following, verbal and nonverbal communication, imitation, play and leisure, social interactions, self-care, daily living, and personal safety.

Adaptive Behavior Services

ADAPTIVE BEHAVIOR SERVICES

Definitions

- Functional Behavior Assessment
  - Functional behavior assessment: comprises descriptive assessment procedures designed to identify environmental events that occur just before and just after occurrences of potential target behaviors and that may influence those behaviors. That information may be gathered by interviewing the patient's caregivers; having caregivers complete checklists, rating scales, or questionnaires; and/or observing and recording occurrences of target behaviors and environmental events in everyday situations
- Functional Analysis
  - Functional analysis: an assessment procedure for evaluating the separate effects of each of several environmental events on a potential target behavior by systematically presenting and withdrawing each event to a patient multiple times and observing and measuring occurrences of the behavior in response to those events. Graphed data are analyzed visually to determine which events produced relatively high and low occurrences of the behavior
- Standardized Instruments and Procedures
  - Standardized instruments and procedures: include, but not limited to, behavior checklists, rating scales, and adaptive skill assessment instruments that comprise a fixed set of items and are administered and scored in a uniform way with all patients (eg, Pervasive Developmental Disabilities Behavior Inventory, Brigance Inventory of Early Development, Vineland Adaptive Behavior Scales).
- Nonstandardized Instruments and Procedures
  - Nonstandardized instruments and procedures: include, but not limited to, curriculum-referenced assessments, stimulus preference assessment procedures, and other procedures for assessing behaviors and associated environmental events that are specific to the individual patient and behaviors.

Adaptive Behavior Services

BEHAVIOR IDENTIFICATION ASSESSMENT

- 97151
  - Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan
    - This code replaces deleted Category III temporary code 0359T
- 97152
  - Behavior identification-supporting assessment, administered by one technician under the direction of a physician or other qualified health care professional, face-to-face with the patient, each 15 minutes
    - A technician, supervised by a physician or other qualified healthcare professional, provides supporting assessment of a patient’s destructive behavior and behavioral problems by interacting directly with the patient. Report this code for each 15 minutes that the technician spends face–to–face with the patient.

Adaptive Behavior Services

BEHAVIOR IDENTIFICATION ASSESSMENT

- 0362T:
  - Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior.
  - 0362T is reported based on a single technician's face-to-face time with the patient and not the combined time of multiple technicians [eg, one hour with three technicians equals one hour of service]
- (97151, 97152, 0362T may be repeated on the same or different days until the behavior identification assessment [97151] and, if necessary, supporting assessment[s] [97152, 0362T], is complete)

Adaptive Behavior Services

GUIDE TO SELECTION OF CODES 97152 AND 0362T

	97152	0362T
Physician or other qualified health care professional required to be on site		x
Physician or other qualified health care professional not required to be on site	x	
Number of Technicians	1	2 or more
Deficient adaptive behavior(s) maladaptive behavior(s), or other impaired functioning secondary to deficient adaptive or maladaptive behaviors	x	
Destructive behavior(s)		x
May include functional behavior assessment	x	x
May include functional analysis	x	x
Environment customized to patient and behavior		x

Adaptive Behavior Services

ADAPTIVE BEHAVIOR TREATMENT

- Adaptive behavior treatment addresses the patient's specific target problems and treatment goals as a provider defines in previous assessments.
- This treatment is based on principles including analysis and alteration of contextual events and motivating factors, stimulus consequence strategies and replacement behavior, and monitoring of outcome metrics.
- Goals of adaptive behavior treatment may include reduction of repetitive and aberrant behavior and improved communication and social functioning. Adaptive behavior skill tasks are often broken down into small, measurable units, and the patient practices each skill repeatedly until the patient masters it.

Adaptive Behavior Services

- 97153: Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes
- 97154: Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes
- 97155: Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes
- 97156: Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes
- 97157: Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes
- 97158: Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes
- 0373T: Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior.

Psychiatric Collaborative Care Management Services

Primary Care Provider Services

Psychiatric Collaborative Care Management Services

WHAT IS PSYCHIATRIC COLLABORATIVE CARE?

- Collaborative care management (CoCM) is an approach to behavioral health care that enhances typical primary care by coordinating psychiatric care with primary care for patients receiving behavioral health treatment, particularly regarding patients whose conditions are not improving.
- Provided under the direction of a treating provider during a calendar month.
- The treating provider (MD, DO, NPP) reports the service and includes the services of the treating provider, the behavioral healthcare manager, and the psychiatric consultant who has contracted directly with the treating provider to provide consultation.
- These services are provided when a patient requires a behavioral health care assessment; establishing, implementing, revising, or monitoring a care plan; and provision of brief interventions.

Psychiatric Collaborative Care Management Services

DEFINITIONS

Treating Provider

A health care professional who directs the behavioral health care manager and continues to oversee the patient's care, including prescribing medications, providing treatments for medical conditions, and making referrals to specialty care when needed. Evaluation and management (E/M) and other services may be reported separately by the same physician or other qualified health care professional during the same calendar month.

Behavioral Health Care Manager

Refers to clinical staff with a masters-/doctoral-level education or specialized training in behavioral health who provides care management services as well as an assessment of needs, including the administration of validated rating scales, the development of a care plan, provision of brief interventions, ongoing collaboration with the treating physician or other qualified health care professional, maintenance of a registry, all in consultation with a psychiatric consultant. Services are provided both face-to-face and non-face-to-face and psychiatric consultation is provided minimally on a weekly basis, typically non-face-to-face.

Psychiatric Consultant

Psychiatric consultant refers to a medical professional, who is trained in psychiatry or behavioral health, and qualified to prescribe the full range of medications. The psychiatric consultant advises and makes recommendations, as needed, for psychiatric and other medical care, including psychiatric and other medical differential diagnosis, treatment strategies regarding appropriate therapies, medication management, medical management of complications associated with treatment of psychiatric disorders, and referral for specialty services, which are typically communicated to the treating physician or other qualified health care professional through the behavioral health care manager. The psychiatric consultant typically does not see the patient or prescribe medications, except in rare circumstances.

Psychiatric Collaborative Care Management Services

99492: INITIAL PSYCHIATRIC COLLABORATIVE CARE MANAGEMENT

- Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements:
  - outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional;
  - initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan;
  - review by the psychiatric consultant with modifications of the plan if recommended;
  - entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and
  - provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.

Psychiatric Collaborative Care Management Services

99493: SUBSEQUENT PSYCHIATRIC COLLABORATIVE CARE MANAGEMENT

- Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements:
  - tracking patient follow-up and progress using the registry, with appropriate documentation;
  - participation in weekly caseload consultation with the psychiatric consultant;
  - ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers;
  - additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant;
  - provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies;
  - monitoring of patient outcomes using validated rating scales; and
  - relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.

Psychiatric Collaborative Care Management Services

+99494: INITIAL OR SUBSEQUENT PSYCHIATRIC COLLABORATIVE CARE MANAGEMENT

- Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (List separately in addition to code for primary procedure)

Psychiatric Collaborative Care Management Services

TIME INCREMENTS PER CALENDAR MONTH

Type of Service	Total Duration of Collaborative Care over a Calendar Month	Code(s)
Initial 70 Minutes	Less than 36 minutes	Not reported separately
	36-85 minutes	99492
Initial Plus each additional increment up to 30 minutes	86-115 minutes	99492 and 99494
Subsequent 60 minutes	Less than 31 minutes	Not reported separately
	31-75 minutes	99493
Subsequent plus each additional increment up to 30 minutes	76-105 minutes	99493 and 99494

Psychiatric Collaborative Care Management Services

EPISODE OF CARE

- Episode of care patients are treated for an episode of care, which is defined as beginning when the patient is directed by the treating physician or other qualified health care professional to the behavioral health care manager and ending with:
  - the attainment of targeted treatment goals, which typically results in the discontinuation of care management services and continuation of usual follow-up with the treating physician or other qualified healthcare professional; or
  - failure to attain targeted treatment goals culminating in referral to a psychiatric care provider for ongoing treatment of the behavioral health condition; or
  - lack of continued engagement with no psychiatric collaborative care management services provided over a consecutive six month calendar period (break in episode).
- A new episode of care starts after a break in episode of six calendar months or more.

Psychiatric Collaborative Care Management Services

RULES!

- The behavioral health care manager providing other services in the same calendar month, such as psychiatric evaluation (90791, 90792), psychotherapy (90832, 90833, 90834, 90836, 90837, 90838), psychotherapy for crisis (90839, 90840), family psychotherapy (90846, 90847), multiple family group psychotherapy (90849), group psychotherapy (90853), smoking and tobacco use cessation counseling (99406, 99407), and alcohol and/or substance abuse structured screening and brief intervention services (99408, 99409), may report these services separately. Activities for services reported separately are not included in the time applied to 99492, 99493, 99494.
- The psychiatric consultant may provide services in the calendar month described by other codes, such as evaluation and management (E/M) services and psychiatric evaluation (90791, 90792). These services may be reported separately by the psychiatric consultant. Activities for services reported separately are not included in the services reported using 99492, 99493, 99494.

Psychiatric Collaborative Care Management Services

CARE MANAGEMENT SERVICES FOR BEHAVIORAL HEALTH CONDITIONS

- 99484: Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements:
  - initial assessment or follow-up monitoring, including the use of applicable validated rating scales;
  - behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
  - facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and
  - continuity of care with a designated member of the care team.

Psychiatric Collaborative Care Management Services

RHC AND FQHC CARE MANAGEMENT

- G0511: Rural health clinic or federally qualified health center (RHC or FQHC) only, general care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM), per calendar month
  - G0511 may be billed alone or with other payable services on an RHC claim
- G0512: Rural health clinic or federally qualified health center (RHC or FQHC) only, psychiatric collaborative care model (psychiatric COCM), 60 minutes or more of clinical staff time for psychiatric cocm services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM) and including services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month

Central Nervous System Assessments/Tests

Central Nervous System Assessments/Tests

- Changes in mental illness may require psychological testing to determine new diagnoses or the need for changes in therapeutic measures.
- Repeat testing not required for diagnosis or continued treatment would be considered medically unnecessary.
- Nonspecific behaviors that do not indicate the presence of, or change in, a mental illness would not be an acceptable indication for testing. Psychological or psychiatric evaluations that can be accomplished through the clinical interview alone (e.g., response to medication) would not require psychological testing, and such testing might be considered as medically unnecessary.
- Adjustment reactions or dysphoria associated with moving to a nursing facility do not constitute medical necessity for psychological testing.

Central Nervous System Assessments/Tests

ASSESSMENT OF APHASIA AND COGNITIVE PERFORMANCE TESTING

- 96105 represents the formal evaluation of aphasia using a psychometric instrument such as the Boston Diagnostic Aphasia Examination.
  - This testing is typically performed once during treatment and the medical necessity for such testing should be documented.
  - Repeat testing should only be done if there is a significant change in the patient's aphasic condition.
- 96125: Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report

Central Nervous System Assessments/Tests

DEVELOPMENTAL/BEHAVIORAL SCREENING AND TESTING

- 96110
  - Developmental screening (eg, developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument
    - The provider can use various standardized screening instruments such as the Ages and Stages Questionnaire: Social Emotional, ASQ SE; Australian Scale for Asperger's Syndrome, ASAS; Behavior Assessment Scale for Children, BASC; Behavioral Rating Inventory of Executive Functioning, BRIEF, for Psychological Assessment; Child Development Review; Communication and Symbolic Scales Developmental Profile, CSBS DP; Kaufman Brief Intelligence Test; Parents' Evaluation of Developmental Status, PEDS; Pediatric Symptom Checklist, PSC; and Vanderbilt Rating Scales.
    - The provider then scores and documents the objective data of the findings he detects of any developmental or speech and language delay using an appropriate standardized instrument.

Central Nervous System Assessments/Tests

DEVELOPMENTAL/BEHAVIORAL SCREENING AND TESTING

- 96112
  - Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour
- +96113
  - Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes (List separately in addition to code for primary procedure)
- 96127
  - Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument

Central Nervous System Assessments/Tests

PSYCHOLOGICAL/NEUROPSYCHOLOGICAL TESTING

- 96116
  - Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour
- +96121
  - Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour (List separately in addition to code for primary procedure)

Central Nervous System Assessments/Tests

TESTING EVALUATION SERVICES

96130

Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour

+96131

Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)

96132

Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour

+96133

Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)

Central Nervous System Assessments/Tests

TEST ADMINISTRATION AND SCORING

Testing By Physician:

- 96136
  - Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes
- +96137
  - Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)

Testing by Technician:

- 96138
  - Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes
- +96139
  - Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)

Central Nervous System Assessments/Tests

AUTOMATED TESTING AND RESULT

- 96146
  - Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only
  - (If test is administered by physician, other qualified health care professional, or technician, do not report 96146. To report, see 96127, 96136, 96137, 96138, 96139)
  - The patient is administered a single, standardized psychological or neuropsychological test using an electronic platform such as a computer, which scores the test on completion.

Central Nervous System Assessments/Tests

DOCUMENTING TIME

- Typically, psychological testing will require from four (4) to six (6) hours to perform, including administration, scoring and interpretation.
- If the testing is done over several days, the testing time should be combined and reported all on the last date of service.
- If the testing time exceeds eight (8) hours, a report may be requested to indicate the medical necessity for extended testing.

Central Nervous System Assessments/Tests

QUESTIONS

- Question: How should we bill for services that take place over multiple days? example CPT codes 96132 and 96133
- Answer: Bill the entire testing time on the DOS it was completed.

- Question: Can we bill the base codes for the new codes in psychological/neuropsychological testing (96130/96132) for 1 date of service and the add on codes with a separate DOS (96131/96133)? I was told that NCCI was updated April 1st to allow this for these types of services, which can take days to complete evaluation and testing.
- Answer: Some payers may allow the add on code to be reported alone but some may not. Instead, bill the entire testing time on the DOS is was completed.

Mental & Behavioral Health Diagnosis

ICD-10-CM

Mental & Behavioral Health Diagnosis

THE 5 AXIS DIAGNOSIS

- Axis I Clinical Disorders, Other conditions that may be a focus of clinical attention (exceptions: Personality disorders, Mental Retardation, General Medical Conditions
- Axis II Personality Disorders, Mental Retardation
- Axis III General Medical Conditions (potentially relevant to the individual's mental disorder)
- Axis IV Psychosocial and Environmental Problems
- Axis V Global Assessment of Functioning

Mental & Behavioral Health Diagnosis

DSM-5 VS. ICD-10-CM

- DSM-5: diagnostic and statistical manual of mental disorders, fourth edition, text revision
  - DSM is used for diagnostic coding
  - DSM diagnosis should be consistent with the presenting problem, history, mental status exam and/or other assessment data
- Each DSM description has a corresponding ICD-10-CM code
- ICD-10-CM is updated more frequently(annually), therefore, some ICD-10-CM codes listed in the DSM may be incorrect

Mental & Behavioral Health Diagnosis

DSM-5 TO ICD-10-CM CROSSWALK

The ICD-10-CM codes are alpha-numeric. In DSM-5, they can be found *in parentheses* within the diagnostic criteria box for each disorder.

- If there is only one ICD-10-CM assigned to a disorder, it can be found at the top of the criteria set. For example, Schizophrenia has an ICD-10-CM code of F20.9
- When you look at a disorder in DSM-5, it will appear as below. Note that the ICD-10-CM code have already been listed for you:
  - Schizophrenia
    - Diagnostic Criteria F20.9

Mental & Behavioral Health Diagnosis

DSM-5 TO ICD-10-CM CROSSWALK

- If more than one code can be assigned to a disorder, the codes can be found at the bottom of the diagnostic criteria box. This is the case when subtypes are coded. For example, for schizoaffective disorder, the bipolar type is coded F25.0 and the depressive type is coded F25.1. This will appear in the DSM-5 criteria as below:

  Specify whether:

  - 295.70 (F25.0) Bipolar type: This subtype applies if a manic episode is part of the presentation. Major depressive episode may also occur.
  - 297.70 (F25.1) Depressive type: This subtype applies if only major depressive episodes are part of this presentation.

Mental & Behavioral Health Diagnosis

MORE CROSSWALKS

- For disorders with more complex coding, coding notes and coding tables are provided at the bottom of the criteria box. The substance/medication-induced disorders, for example, have complex coding.
- Clinicians should always check the bottom of the diagnostic criteria box for coding notes, which provide additional guidance. For example, in Schizoaffective disorder, if catatonia is present, an additional code for catatonia should be used, and will be provided in the coding note:

> Specify if:
>
> With catatonia (refer to the criteria for catatonia associated with another mental disorder.
>
> Pp. 119-120, for definition)
>
> Coding note: Use additional code 293.89 (FO6.1) catatonia associated with schizoaffective
>
> disorder to indicate the presence of the comorbid catatonia.

Mental & Behavioral Health Diagnosis

LIMITATIONS

- Severe and profound mental retardation (ICD-10 codes F72, F73, F78, or F79) is never covered for psychotherapy services (CPT codes 90832-90838). In such cases, rehabilitative, evaluation and management (E/M) codes, or pharmacological management codes should be reported.
- Patients with dementia represent a very vulnerable population in which co-morbid psychiatric conditions are common. However, for such a patient to benefit from psychotherapy services requires that their dementia to be mild and that they retain the capacity to recall the therapeutic encounter from one session, individual or group, to another. This capacity to meaningfully benefit from psychotherapy must be documented in the medical record. Psychotherapy services are not covered when documentation indicates that dementia has produced a severe enough cognitive defect to prevent psychotherapy from being effective.

Mental & Behavioral Health Diagnosis

MAJOR DEPRESSIVE DISORDERS

- Major depressive disorders:
  - F32-, Major depressive disorder, single episode
  - F33-, Major depressive disorder, recurrent

Similar to ICD-10-CM

- Subdivided with the current severity of the disorder:
  - mild
  - moderate
  - severe without psychotic features
  - severe with psychotic features
  - in partial or unspecified remission
  - in full remission

Mental & Behavioral Health Diagnosis

MAJOR DEPRESSIVE DISORDERS

- Single—Single episode depression means that a person experiences finite depression, according to the criteria for diagnosis, but does not suffer from it again.
- Recurrent—Recurrent depression is defined by sub-criteria:
  - Two or more depressive episodes, each separated by at least 2 months of return to more or less usual functioning (If there has been a previous major depressive episode, the current episode of depression need not meet the full criteria for major depressive disorder.)
  - Has never had a manic episode or an unequivocal hypomanic episode

Mental & Behavioral Health Diagnosis

MAJOR DEPRESSIVE DISORDERS, SINGLE

- F32.0 Major depressive disorder, single episode, mild
- F32.1 Major depressive disorder, single episode, moderate
- F32.2 Major depressive disorder, single episode, severe without psychotic features
- F32.3 Major depressive disorder, single episode, severe with psychotic features
- F32.4 Major depressive disorder, single episode, in partial remission
- F32.5 Major depressive disorder, single episode, in full remission
- F32.8 Other depressive episodes
    - F32.81 Other specified depressive episodes
        - Atypical depression
        - Post-schizophrenic depression
        - Single episode of “masked” depression NOW

Mental & Behavioral Health Diagnosis

MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE

- *Chief Complaint (CC)/HPI*: 29 y/o male patient presents with constant headaches, poor concentration, significantly low self-esteem and depression for approximately two months. His motivation is low and he lacks personal interests. Furthermore, he continues to have hopeless thoughts and crying spells
- *Assessment*: After the patient was examined a diagnosis of Major Depressive Disorder, single episode was determined. The patient will be prescribed anti-depressants and referred for psychotherapy
- Assign code F32.9 This is an unspecified code.
- Provider should document the severity of the MDD as mild, moderate or severe.
  - Example: Severe Major Depressive Disorder, Single Episode with psychotic features
    - Assign code F32.3

Mental & Behavioral Health Diagnosis

CASE STUDY #1

- Chief Complaint
- Depression, Anxiety
- History Of Present Illness
- The patient is feeling BETTER today. The patient is taking the medication AS PRESCRIBED. The patient notes the following suspected drug side effects: SUSPECTED SIDE fatigue. The patient is 4/10 on the Depression Intensity Scale, 3/10 on the Anxiety Intensity Scale and 0/10 on the Mania.
- Intensity Scale. The patient is 0/10 on the OCD intensity scale and 0/10 on Pain Intensity Scale. The patient's AIMS score is N/A.
- We discussed the following concerns: Patient presents for follow up; reports improvement in anxiety and depression since last visit. Patient continues to report daily tremors improved after taking morning medication. Patient reports progression of tremors after 5PM until taking night time medication. denies any thoughts of harming self or others.

Mental & Behavioral Health Diagnosis

CASE STUDY #1 CONT'D

- Assessment
  - Major depressive disorder F32. 9
  - Generalized anxiety disorder F41.1
- Plan
  - Several medications refilled return in 2 months.
- Documentation improvement recommendation
  - Indicate the episode
    - The documentation suggests this is a recurrent episode
  - Specify the severity
    - If the level of severity=severe, documentation should indicate if the patient is with or without psychotic features

Mental & Behavioral Health Diagnosis

MOOD (AFFECTIVE) DISORDERS

- Classification of affective disorders has been particularly influenced by the adoption of the principle of grouping together disorders with a common theme.
  - F34.0: Affective personality disorder (includes cyclothymic disorder)
  - F34.1: Dysthymic disorder
    - Persistent depressive disorder
  - F34.8: Other persistent mood (affective) disorders
    - F34.81 Disruptive mood dysregulation disorder
    - F34.89 Other specified persistent mood disorders
  - F34.9: Persistent mood (affective) disorder, unspecified
  - F39: Unspecified mood (affective) disorder (includes affective psychosis not otherwise specified)

Mental & Behavioral Health Diagnosis

ANXIETY, DISSOCIATIVE, STRESS-RELATED, SOMATOFORM AND OTHER NON PSYCHOTIC MENTAL DISORDERS

- Anxiety disorders are common psychiatric disorders and are considered to be one of the most undertreated and overlooked health problems.
- Anxiety disorders are classified in ICD-10-CM under the following categories:
  - F40 Phobic anxiety disorders
    - F40.00: Agoraphobia
    - F40.01: Agoraphobia with panic disorder
    - F40.02: Agoraphobia without panic disorder
    - F40.10: Social phobia (anxiety)
    - F40.11 Social phobia, generalized
  - F41 Other anxiety disorders
    - F41.0: Panic disorder
    - F41.1: Generalized anxiety disorder
    - F41.3: Other mixed anxiety disorders
    - F41.8: Mixed anxiety and depressive disorder
  - F42 Obsessive-compulsive disorder

Mental & Behavioral Health Diagnosis

OBSESSIVE-COMPULSIVE DISORDER

- F42 Obsessive-compulsive disorder
  - F42.2 Mixed obsessional thoughts and acts
  - F42.3 Hoarding disorder
  - F42.4 Excoriation (skin-picking) disorder
  - F42.8 Other Obsessive-compulsive disorder (includes Anancastic neurosis and Obsessive-compulsive neurosis)
  - F42.9 Obsessive-compulsive disorder, **unspecified**

Mental & Behavioral Health Diagnosis

CASE STUDY #2

- Chief Complaint
  - Depression
  - Anxiety
- History Of Present llness
  - The patient is feeling Worse today. The patient is taking the medication AS PRESCRIBED. The patient notes the following suspected drug side effects: SUSPECTED SIDE sexual side effects. The patient is 7/10 on the Depression Intensity Scale, 9/10 on the Anxiety Intensity Scale and 0/10 on the Mania Intensity Scale. The patient is 0/10 on the OCD intensity scale and 0/10 on Pain Intensity Scale. The patient's AIMS score is 1/40.

Mental & Behavioral Health Diagnosis

CASE STUDY #2 CONT'D

- We discussed the following concerns: Patient presents for follow up: Patient reports isolating self in room but will interact with best friends and family. Patient reports feeling worthless due to not working. Patient reports completing routine shopping in another town due to desire to avoid acquaintances. Patient states " I see people I went to school with working and getting married; it bothers me I feel I can't work". Patient reports increased anxiety with physical symptoms of feeling "hot", rapid speech, increased heart rate and "feeling like I am not in my body". denies auditory or visual hallucinations. denies any thoughts of harming self or others. Patient reports feeling paranoid in public places states " Sometimes I feel like hurting people that are looking at me; but I would never do it; I don't want to hurt anyone". Active listening and emotional support given.

Mental & Behavioral Health Diagnosis

CASE STUDY #2 CONT'D

- Assessment
  - Bipolar 1 disorder depressed F31.9
  - Generalized anxiety disorder F41.1
- Plan
  - Several medications refilled return in 2 months.
- Documentation improvement recommendation
  - Indicate the episode
    - The documentation suggests this is a recurrent episode
  - Specify the severity
    - If the level of severity=severe, documentation should indicate if the patient is with or without psychotic features
    - Category F31, Bipolar disorder, is further subdivided to specify the severity of the current episode; whether the current episode is hypomanic, manic, depressed, or mixed; and whether psychotic features are involved.

Mental & Behavioral Health Diagnosis

USE, ABUSE AND DEPENDENCY

- Alcohol Use-occasional social drinking, limited
- Alcohol Abuse-means having unhealthy or dangerous drinking habits, such as drinking every day or drinking too much at a time. When you abuse alcohol, you continue to drink even though you know your drinking is causing problems
- Alcohol Dependency-Alcohol dependence is also called alcoholism. You are physically or mentally addicted to alcohol. You have a strong need, or craving, to drink. You feel like you must drink just to get by. Alcoholism is a long-term (chronic) disease.

Mental & Behavioral Health Diagnosis

ABUSE, DEPENDENCY AND USE

- In some cases, physicians may document a combination of Abuse, use and dependence of the same substance. ICD-10-CM includes the following hierarchy to follow in those situations:
  - If both use and abuse are documented, assign only the code for abuse
  - If both abuse and dependence are documented, assign only the code for dependence
  - If both use and dependence are documented, assign only the code for dependence
  - If use, abuse, and dependence are all documented, assign the code for dependence

Mental & Behavioral Health Diagnosis

ALCOHOL DEPENDENCE AND ABUSE

- F10 Alcohol related Disorders
  - F10.1XX Alcohol Abuse
  - F10.2XX Alcohol Dependence
  - F10.9XX Alcohol Use, Unspecified
- Examples:
  - F10.129, Alcohol abuse with intoxication, unspecified, is assigned for a diagnosis of simple drunkenness.
  - Acute drunkenness in alcoholism is indexed to F10.229, Alcohol dependence with intoxication, unspecified;
  - Chronic drunkenness is indexed to F10.20, Alcohol dependence, uncomplicated;
  - Chronic drunkenness in remission is indexed to F10.21, Alcohol dependence, in remission.
    - Selection of code F10.21 for "in remission" requires the provider's clinical judgment, as defined by the *ICD-10-CM Official Guidelines for Coding and Reporting*, rather than nursing or other documentation.
  - Note that toxic effect of alcohol is not classified to category F10 but to subcategory T51.0- instead.

Mental & Behavioral Health Diagnosis

DEPENDENCE AND ABUSE

- ICD-10-CM provides combination codes that include both the alcohol or substance abuse/dependence and any associated complications. Examples include:
  - F10.231 Alcoholic withdrawal delirium due to alcohol dependence
  - F10.251 Alcohol-induced psychotic disorder with hallucinations due to alcohol dependence
  - F10.180 Alcohol-induced anxiety disorder due to alcohol abuse
  - F11.250 Heroin dependence with heroin-induced psychosis and delusions

Mental & Behavioral Health Diagnosis

DEPENDENCE AND ABUSE

- Category F19, Other psychoactive substance related disorders, may be used when the specific drug class is not specified.
- Similar to code F10.21, Alcohol dependence, in remission, the selection of codes for “in remission” for categories F11–F19 with -.21 requires the provider’s clinical judgment.

Mental & Behavioral Health Diagnosis

PSYCHOACTIVE SUBSTANCE ABUSE

- When the provider documentation refers to use, abuse, and dependence of the same substance (e.g., alcohol, opioid, cannabis), only one code should be assigned to identify the pattern of use, based on the following hierarchy:
  - If both use and abuse are documented, assign only the code for abuse.
  - If both abuse and dependence are documented, assign only the code for dependence.
  - If use, abuse, and dependence are all documented, assign only the code for dependence.
  - If both use and dependence are documented, assign only the code for dependence.

Mental & Behavioral Health Diagnosis

MENTAL AND BEHAVIORAL DISORDERS DUE TO PSYCHOACTIVE SUBSTANCE USE

- The new arrangement of mental and behavioral disorders due to psychoactive substance use in the block F10-F19 has also been found more useful than the earlier system. The third character indicates the substance used, the fourth and fifth characters the psychopathological syndrome, e.g. from acute intoxication and residual states; this allows the reporting of all disorders related to a substance even when only three-character categories are used.
  - F10.-Mental and behavioral disorders due to use of alcohol
  - F11.-Mental and behavioral disorders due to use of opioids
  - F12.-Mental and behavioral disorders due to use of cannabinoids
  - F13.-Mental and behavioral disorders due to use of sedatives or hypnotics
  - F14.-Mental and behavioral disorders due to use of cocaine
  - F15.-Mental and behavioral disorders due to use of other stimulants, including caffeine
  - F16.-Mental and behavioral disorders due to use of hallucinogens
  - F17.-Mental and behavioral disorders due to use of tobacco
  - F18.-Mental and behavioral disorders due to use of volatile solvents
  - F19.-Mental and behavioral disorders due to multiple drug use and use of other psychoactive substances

Mental & Behavioral Health Diagnosis

DEMENTIA IN OTHER DISEASES CLASSIFIED ELSEWHERE

- When the cause of the dementia is not specified, the dementia is classified to subcategory
  - F03.9X: Dementia, unspecified
    - F03.90: without behavioral disturbance
    - F03.91: with behavioral disturbance (aggressive, combative or violent)
- F02.8X: Dementia in other diseases classified elsewhere,
  - Specifically identifies the presence or absence of behavioral disturbances such as aggressive behavior, violent behavior, wandering off, or combative behavior. The dementia classified in subcategory F02.8 is due to direct physiological effects of a general medical condition.
    - F02.80: without behavioral disturbances
    - F02.81: with behavioral disturbance
  - When assigning codes F02.80 and F02.81, code first the underlying physiological condition associated with the dementia, such as Alzheimer's disease (G30.-) or Parkinson's disease (G20).
  - If the patient has a tendency to wander off, code Z91.83, Wandering in diseases classified elsewhere, may be assigned in addition to code F02.81 or F03.91.

Mental & Behavioral Health Diagnosis

SCHIZOPHRENIA, SCHIZOTYPAL, DELUSIONAL, AND OTHER NON-MOOD PSYCHOTIC DISORDERS

- The block that covers schizophrenia, schizotypal states and delusional disorders (F20-F29) has been expanded by the introduction of new categories such as undifferentiated schizophrenia, postschizophrenic depression, and schizotypal disorder. The classification of acute short-lived psychoses, which are commonly seen in most developing countries, is considerably expanded compared with that in the ICD-9.
- In ICD-10, the diagnosis of schizophrenia depends upon the presence of typical delusions, hallucinations or other symptoms, and a minimum duration of 1 month is specified

Mental & Behavioral Health Diagnosis

SCHIZOPHRENIC DISORDERS

- Schizophrenia is a severe mental illness characterized by a variety of symptoms including, but not limited to:
  - loss of contact with reality
  - bizarre behavior
  - disorganized thinking
  - disorganized speech
  - decreased emotional expressiveness
  - diminished or loss of contact with reality
  - diminished to total social withdrawal

Mental & Behavioral Health Diagnosis

SCHIZOPHRENIC DISORDERS

- Schizophrenic disorders are classified in category F20, with a fourth character indicating the type of schizophrenia as follows:
  - F20.0 Paranoid Schizophrenia
    - Patients are preoccupied with delusions about being punished or persecuted by others
  - F20.1 Disorganized Schizophrenia
    - Patients are usually confused and illogical; behavior is disorganized, emotionless and inappropriate
  - F20.2 Catatonic Schizophrenia
    - Patients become unresponsive and have limited physical response
  - F20.3 Undifferentiated Schizophrenia
    - Characterized by a number of schizophrenic symptoms, such as delusion(s), disorganized behavior, disorganized speech, flat affect, or hallucinations, but that does not meet the criteria for any other type of schizophrenia
  - F20.5 Residual Schizophrenia
    - Decreased severity of symptoms
  - F20.8 Other Schizophrenia
    - F20.81 Schizophreniform disorder
    - F20.89 Other Schizophrenia
  - F20.9 Schizophrenia unspecified

Mental & Behavioral Health Diagnosis

SCHIZOPHRENIC DISORDERS

- Some F20 and F25 categories require a 5th digit to identify the status:
  - 0 unspecified
  - 1 subchronic
  - 2 chronic
  - 3 subchronic with acute exacerbation
  - 4 chronic with acute exacerbation
  - 5 in remission

Mental & Behavioral Health Diagnosis

SCHIZOPHRENIC DISORDERS

- F21 Schizotypal disorder (borderline schizophrenia)
- F22 Delusional disorders (paranoia)
- F23 Brief psychotic disorder (paranoid reaction)
- F24 Shared psychotic disorder (induced paranoid disorder)
- F25.X Schizoaffective disorders
- F28 Other psychotic disorder not due to a substance or known physiological condition
- F29 Unspecified psychosis not due to a substance or known physiological condition

Mental & Behavioral Health Diagnosis

MOOD (AFFECTIVE) DISORDERS

- Classification of affective disorders has been particularly influenced by the adoption of the principle of grouping together disorders with a common theme. Terms such as "neurotic depression" and "endogenous depression" are not used, but their close equivalents can be found in the different types and severities of depression now specified (including dysthymia (F34.1)).

Mental & Behavioral Health Diagnosis

AFFECTIVE DISORDERS

- Bipolar affective diseases are divided into various types according to the symptoms displayed.
- Patients suffering from bipolar diseases experience periods of manic (hyper-excitable) episodes alternating with periods of deep depression
- These disorders are chronic and recurrent with varying degrees of severity
  - F30. - Manic episode (include bipolar disorder, single manic episode, and mixed affective episode)
  - F31. - Bipolar disorder (includes manic-depressive illness, manic-depressive psychosis, and manic-depressive reaction)
  - F34.- Persistent mood (affective) disorders (includes cyclothymic disorder and dysthymic disorder)
  - F39 Unspecified mood (affective) disorder (includes affective psychosis not otherwise specified)

Mental & Behavioral Health Diagnosis

AFFECTIVE DISORDERS

- Category F30, Manic episode, is further subdivided to identify the severity of the current episode and to indicate that psychotic symptoms are involved.
- Category F31, Bipolar disorder, is further subdivided to specify the severity of the current episode; whether the current episode is hypomanic, manic, depressed, or mixed; and whether psychotic features are involved.
    - Additionally, for patients with bipolar disorder currently in remission (F31.7-), fifth characters are available to specify whether the patient is in full or partial remission and whether the most recent episode was hypomanic, manic, depressed, mixed, or unspecified.

Mental & Behavioral Health Diagnosis

NONPSYCHOTIC MENTAL DISORDERS

- ICD-10-CM provides category F43 for coding reaction to severe stress and adjustment disorders.
  - F43.0, Acute stress reaction
    - A result of experiencing or witnessing a traumatic event that cause extreme fear, stress, or pain
  - F43.1, Post-Traumatic Stress Disorder
    - Fifth character for unspecified, acute, or chronic
    - Effect of an event that results in psychological trauma that is more enduring than commonly seen acute stress response
  - F43.2, Adjustment Disorders
    - Fifth character for nature of reaction (anxiety, depression, disturbance of conduct, or other symptoms)
    - Usually associated with a less intense stressor
  - The following situations fall into this category:
    - F43.21 Patient depressed over death of son
    - F43.24 Child adopted from a foreign country, suffering from culture shock with conduct disturbance

Mental & Behavioral Health Diagnosis

OTHER DISORDERS

- F50 Eating disorders
  - F50.0 Anorexia nervosa
  - F50.8 Other Eating disorders
- F52.0 Hypoactive sexual desire disorder
- F52.22 Female sexual arousal disorder
- F52.32 Male orgasmic disorder
- F52.6 Dyspareunia not due to a substance or known physiological condition

Mental & Behavioral Health Diagnosis

GENDER DISORDERS

- F64.0 Transsexualism
  - Gender identity disorder in adolescence and adulthood
  - Gender dysphoria in adolescents and adults
- F64.1 Dual role transvestism
- G64.2 Gender identity disorder of childhood
  - Gender dysphoria in children

Mental & Behavioral Health Diagnosis

CONDUCT DISORDERS

- F84.0 Autistic Disorder
  - Autism spectrum disorder
- F88 Other disorders of psychological development
  - Global developmental delay
  - Other specified neurodevelopmental disorder
- F89 Unspecified disorder of psychological development
  - Neurodevelopmental disorder NOS
- F91.8 Other conduct disorders
  - Other specified conduct disorder
  - Other specified disruptive disorder
- F91.9 Conduct disorder, unspecified
  - Disruptive disorder NOS
- F95.0 Transient Tic Disorder
  - Provisional tic disorder

Mental & Behavioral Health Diagnosis

BEHAVIORAL AND EMOTIONAL DISORDERS WITH ONSET USUALLY OCCURRING IN CHILDHOOD AND ADOLESCENCE

- F90X: Attention-deficit hyperactivity disorders
  - F90.0: predominantly inattentive type
  - F90.1: predominantly hyperactive-type
  - F90.2: combined type
  - F90.8: other type
  - F90.9: unspecified type
- F91.X: Conduct Disorders
- F93.X: Emotional disorders with onset specific to childhood
- F94.X: Disorders of social functioning with onset specific to childhood and adolescence
- F95.X: Tic Disorder
- F98: Other behavioral and emotional disorders with onset usually occurring in childhood and adolescence

Mental & Behavioral Health Diagnosis

FAMILY AND PERSONAL HISTORY CODES (Z CODES)

- Family History
  - Z81.X Family History of mental and behavioral disorders
- Personal History
  - Z86.5X Personal History of mental and behavioral disorders
  - Z91.5 Personal history of self-harm

Questions?

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