ProjectTEACH

Reimbursement and Implementation
Presented by: Marc Lashley MD, FAAP
May 1, 2022

NEW YORK STATE | Office of Mental Health

Disclosures

Dr. Lashley is a partner in Allied Physicians Group. A partnership including over 130 clinicians based mostly on Long Island NY

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Coding Prior to 2021

- Was difficult to meet all points needed to code at higher levels.

- Mental Health was coded mostly by time in Primary Care

Medical Decision Making Table

AMERICAN PSYCHIATRIC ASSOCIATION

E/M code selection can be done on the basis of Medical Decision Making (MDM) or time. The level of MDM should be driven by the nature of the presenting problem on the date of the encounter. Time is not a factor when code selection is done on the basis of MDM. When billing E/M along with a psychotherapy service the E/M must be selected on the basis of MDM. To qualify for a particular level of MDM, 2 of the 3 elements for that level of MDM must be met or exceeded.

CPT Code	Level of MDM (Based on **2 out of 3 Elements** of MDM)	Elements of Medical Decision Making with Psychiatric Specific Examples		
		Number and Complexity of Problems	**Amount and/or Complexity of Data to be Reviewed and Analyzed**	**Risk of Complications and/or Morbidity/Mortality of Patient Management**
99211	N/A	N/A	N/A	N/A
99202 99212	**Straightforward**	**1 Self-limited problem or minor** *(Example: Bereavement)*	**Minimal/None**	**Minimal Risk**
99203 99213	**Low**	**Low** • 2 or more self-limited or minor problems; or • 1 stable chronic illness, *(Example: MDD, recurrent, in remission)* or • 1 acute, uncomplicated illness or injury *(Example: Adjustment d/o with depressed mood)*	**Limited** *(Must meet 1 of 2 categories in this box)* **Category 1: Tests and Documents:** • Review of prior external note(s) from each unique source; • Review of the result(s) of each unique test; • Ordering of each unique test **Category 2: Assessment requiring an independent historian(s)** (confirmatory history judged to be necessary)	**Low Risk** Example: • *New patient seen for adjustment disorder and referred to therapist*
99204 99214	**Moderate**	**Moderate** • 1 or more chronic illnesses with exacerbation, progression or side effects of treatment, *(Example: MDD, recurrent, moderate)* or • 2 or more stable chronic illnesses, *(Example: Schizophrenia and alcohol use d/o)* or • 1 undiagnosed new problem with uncertain prognosis, *(Example: Cognitive decline)* or • 1 acute illness with systemic symptoms, *(Example: Anorexia with bradycardia and amenorrhea; or Substance use d/o presenting in acute withdrawal)* or • 1 acute complicated injury	**Moderate** *(Must meet 1 of 3 categories in this box)* **Category 1: Tests, documents, or independent historian:** *(any combination of 3 from the following)* • Review of prior external note(s) from each unique source; • Review of the result(s) of each unique test; • Ordering of each unique test • Assessment requiring an independent historian(s) **Category 2: Independent interpretation of tests** performed by another physician (not separately reported), or **Category 3: Discussion of management or test interpretation** with external physician/other QHP/ appropriate source (not separately reported)	**Moderate Risk** Examples: • Prescription drug management • Diagnosis or treatment significantly limited by social determinants of health • *Management of psychiatric medications* • *Patient whose adherence to treatment is impacted by homelessness*
99205 99215	**High**	**High** • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; *(Example: MDD, recurrent, severe w/ significant functional decline; or Severe akathisia from treatment of schizophrenia with antipsychotic medication)* or • 1 acute or chronic illness or injury that poses a threat to life or bodily function *(Example: Schizophrenia with command hallucinations to kill family members whom the patient believes are imposters; or Depression with suicidal ideation and plan)*	**Extensive** *(Must meet 2 out of 3 categories in this box)* **Category 1: Tests, documents or independent historians:** *(any combination of 3 from the following bullets)* • Review of prior external note(s) from each unique source; • Review of the result(s) of each unique test; • Ordering of each unique test • Assessment requiring an independent historian(s) **Category 2: Independent interpretation of tests** performed by another physician (not separately reported), or **Category 3: Discussion of management or test interpretation** with external physician/other QHP/ appropriate source (not separately reported)	**High Risk** Examples: • Drug therapy requiring intensive monitoring for toxicity • Decision regarding hospitalization • *Management of Clozapine* • *Initiation of Lithium* • *Consideration of inpatient behavioral health admission*

Italicized text signifies psychiatric specific examples that have been added for educational purposes

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Number & Complexity of Problems

- 1 minor problem – level 2
- 2 or more minor problems – level 3
- New problem with uncertain prognosis – level 4
- Acute illness: uncomplicated – level 3
- Systemic – lvl 4
- Threatening – level 5

- Chronic illnesses: 1 stable illness – level 3
- o 2 or more stable illnesses level-4
- o 1 with exacerbation or progression-level 4
- o Severe or life threatening-level 5

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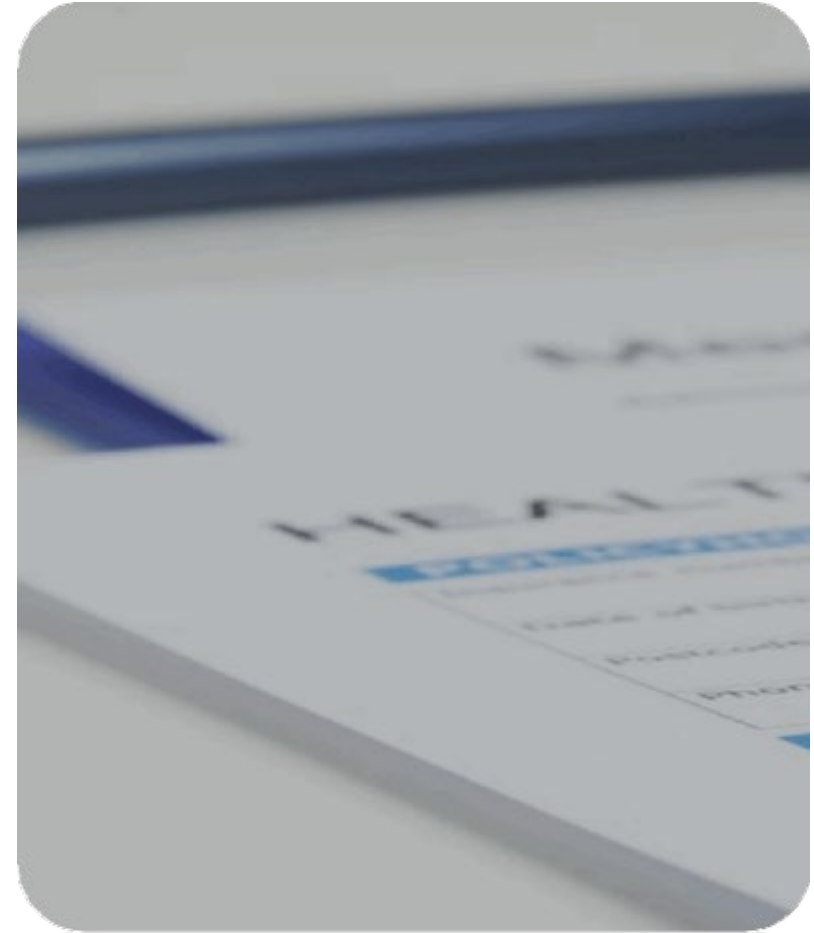
Data Collected
(Rarely Used in Mental Health)

- Test ordered
- Test reviewed
- Parent or Relative is Historian
- External Input
- Independent interpretation
- Discussion with External Source

Level

- 2-no data
- 3-3 data points or historian
- 4-3 data points including historian
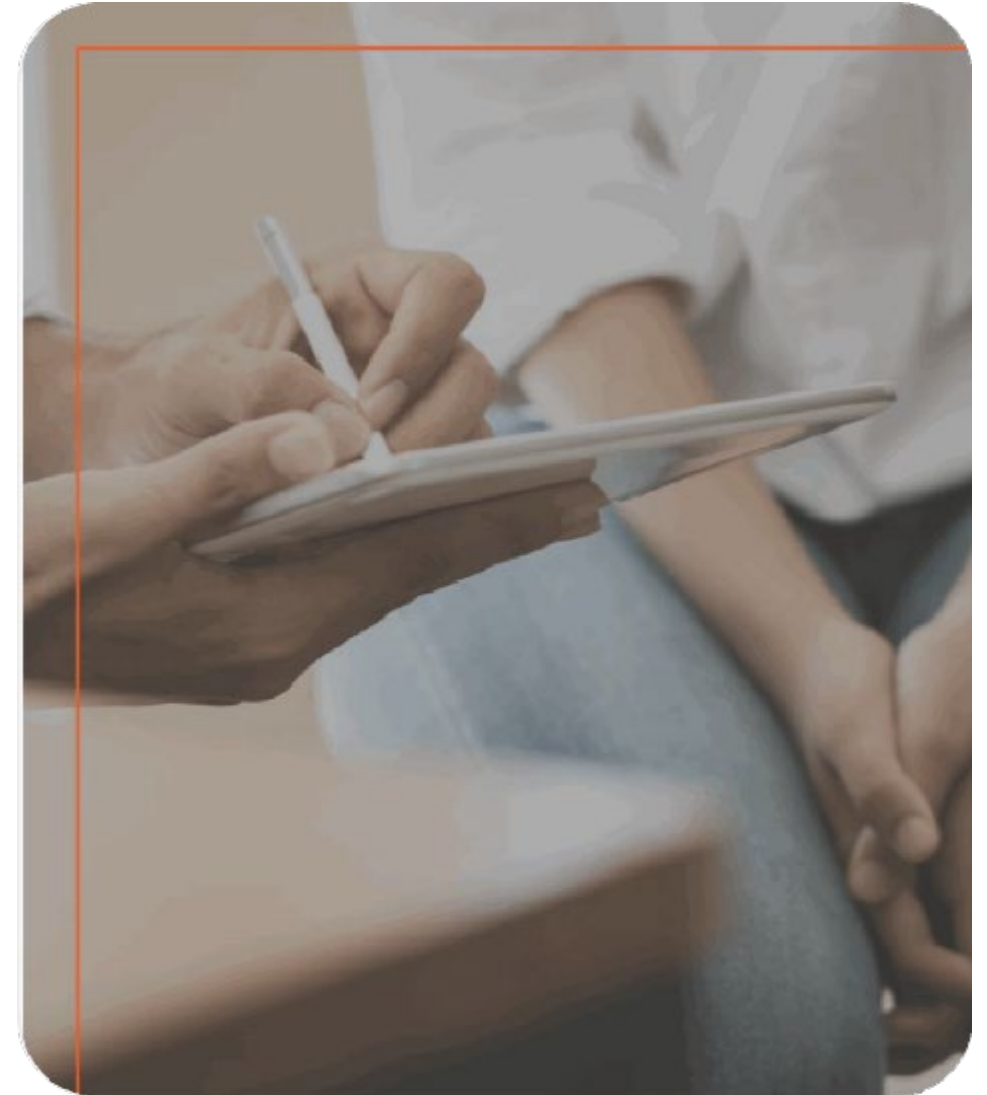- 5-2 out of 3 with historian, external interpretations or discussions

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Risk

- Really means Risk of Treatment or further testing
- Level 2-no advice or medication (Chicken Soup)
- Level 3-OTC meds only
- Level 4-Prescription medication or off-label use of OTC medication, SDOH
- Level 5-Medication mgmt. which requires frequent monitoring (e.g. seizure medication)

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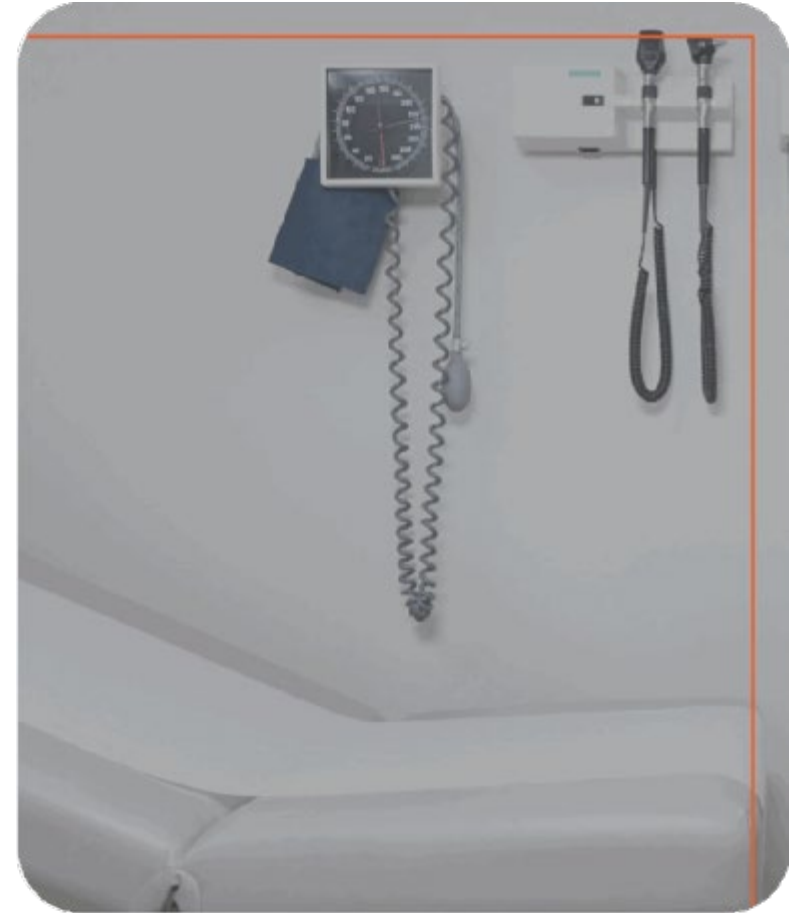
Applying New Rules to Mental Health

- Remember need 2 out of 3 for Level of service: Problems, Data, Risk
- Data-not generally needed
- Risk-will generally be: level 3 if not on meds, level 4 if patient is on medication, Level 5 if on a medication that requires frequent monitoring
- Assuming above, number and type of problems will drive level of service
- Use time only if needed to reflect the care you gave

Billing Well & Sick

- If you diagnose or treat a condition during a well visit, bill for a well and sick together

- use modifier -25

- This will trigger a copay, let the parent know

- Bill for the sick visit the same way as if it was done separately

- If you are too busy, have the patient come back the next day or do a telemedicine visit

Time Rules

New Patient:

Level	Time
Level 1	No time associated
Level 2	15 minutes
Level 3	30 minutes
Level 4	45 minutes
Level 5	60 minutes

Established Patient:

Level	Time
Level 1	No time associated
Level 2	10 minutes
Level 3	20 minutes
Level 4	30 minutes
Level 5	54 minutes

*99417 for each 15 min above 54min

○ example 55-69 min 99417 x 1, 69-83 min 99417 x 2 no modifier needed

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CPT Category II Codes

Provide more detailed information about a clinical service
May reduce request for more information

Important Mental Health Category II codes:

2014F -ADHD Mental health assessed
3085F - Depression Suicide Risk Assessed

Billing for Screening Tools

- 96127- Columbia, SCARED parent and child, ASQ, PSCY, Vanderbilt, Conners, Teen Screen

- may bill up to 5 units

- use -25 modifier if during a visit

- may bill standing alone without a visit

- Must score, and interpret results in chart

Diagnosis Codes

- ADHD Combined F90.2

- Major Depression F32.9
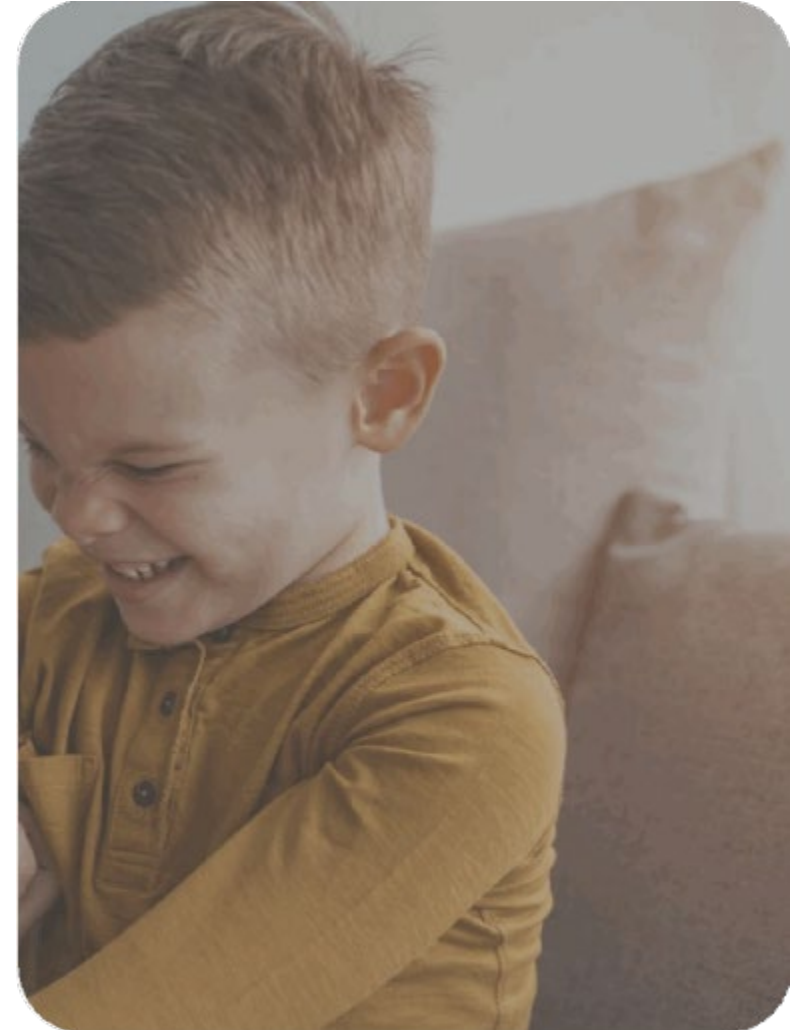
- Anxiety Disorder F31.9

- Most insurers in the Downstate area accept these diagnosis codes, no need to get creative

ADHD Case 1

- Mom comes in concerned about Johnny, a 6 yr old with hyperactivity. She doesn't know if he has ADHD. He has no other problems.
- You collect HPI, Family Hx, Social History, School History.
- You determine he needs a Psyhoed, Vanderbilts, review report cards.
- Will meet again when these are in.
- How do you code?

ADHD Case 1

- **If Billed Without Time:**

    - 1 Diagnosis (Level 3)

    - Data (Level 3)

    - Risk No Rx (Level 3)

   - Bill by time to better reflect care

ADHD Case 2

- Louisa is diagnosed with ADHD comorbid with Anxiety Disorder.
- HPI: doing poorly in school. On stimulant, review Vanderbilts.
- Review how she is doing with appetite, sleep, grades, home life, social life.
- DX ADHD with Anxiety.
- You decide to increase her concerta, make sure she is seeing a therapist for anxiety and give mom behavioral management techniques.
- How do you code?

 - Level 4: 2 chronic problems, Medication management.

ADHD Case 2

- Johnny has been on his ADHD medication for 6 months.
- He is doing great. Weight is stable.
- Your review Vanderbilts from school.
- His concerta dose does not need to be changed.

- How do you code?

  - Level 3
  - Stable chronic illness (3), Medication mgmt. (4)
  - Increase to level 4 if he has a co-morbid condition you are managing.

  - Increase to level 4 if he has weight loss or needs a dose change.
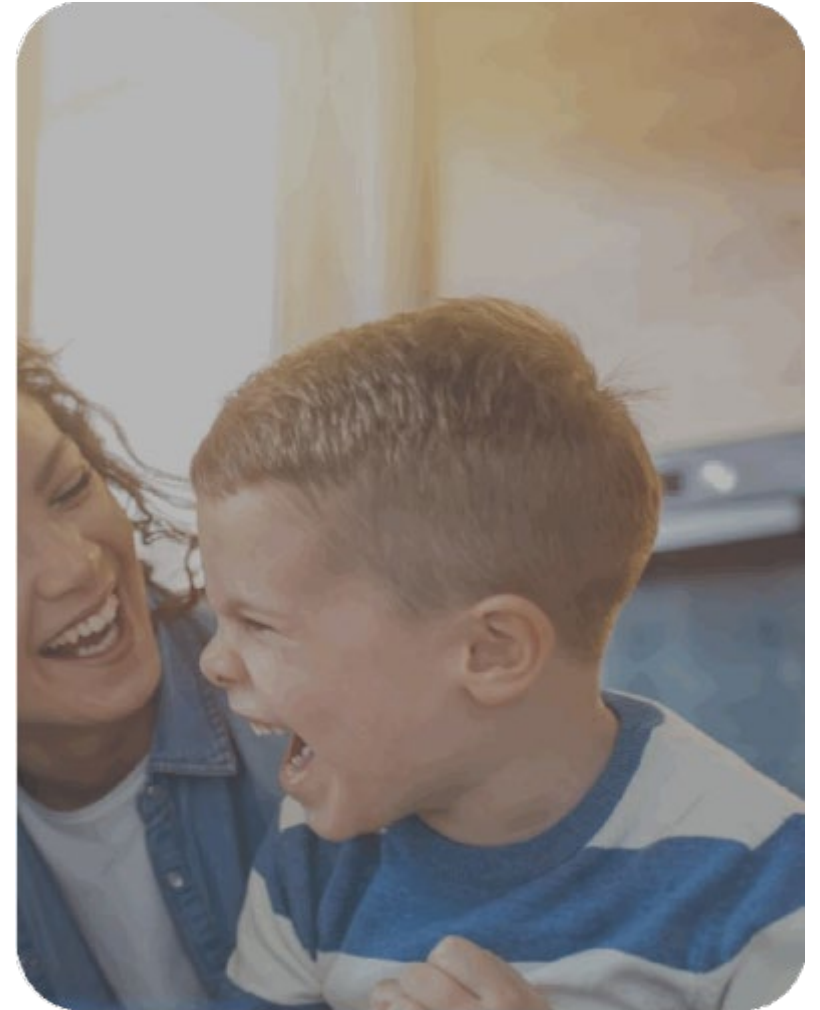
Depression/Anxiety

- 16 yr old who is depressed and admits to suicidal thoughts.
- You increase her Lexapro from 10 to 20mg.
- You decide she is not an imminent risk. Go over with parents how to keep home safe and patient agrees to an oral contract how to manage suicidal thoughts, or you decide she is a risk and send her to the ED immediately.
- How do you code?

  - Level 5 Depression with suicidality (5), Risk (5).
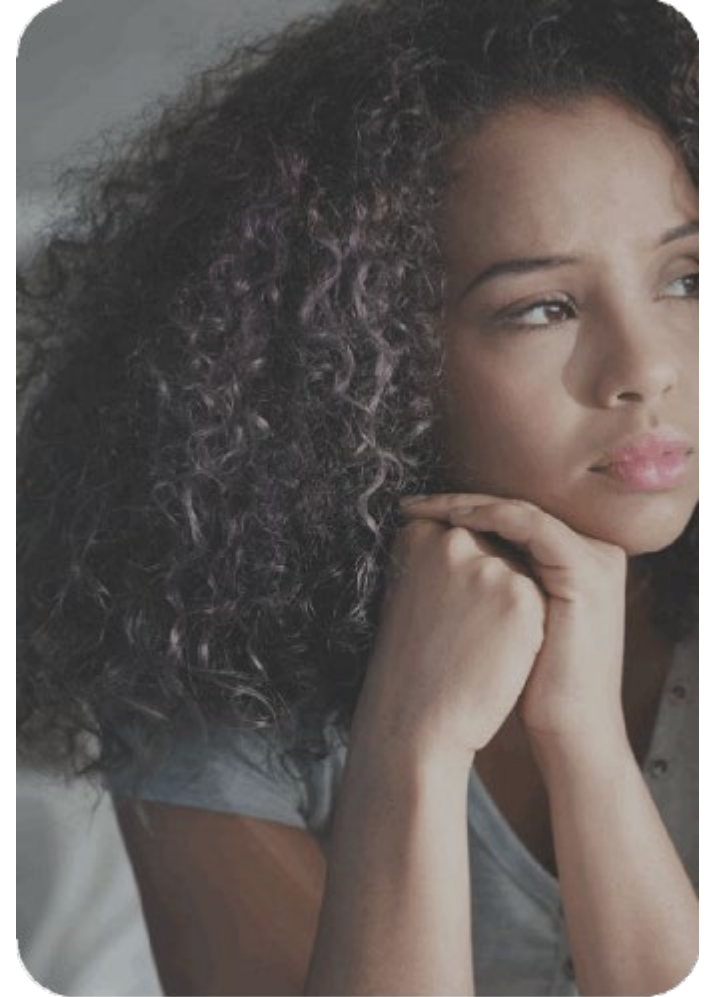
Depression/Anxiety

- 16 yr old with Depression without SI.
- He is on Lexapro. He is still somewhat depressed. He refuses to see a therapist and just wants his medication. You changed his Lexapro to 20mg 3 weeks ago and you want to sit at this dose a bit longer before changing.
- How do you code?

  - Level 4
  - Depression – unstable (4), Risk-medication mgmt. (4)
  - Drop to a level 3 if his symptoms are stable and needs only routine follow up, increase to level 4 if he has co-morbid anxiety and advice is given on managing anxiety.

Example With Social Determinant of Health (SDOH) As A Factor

- Brad has ADHD combined type. He is on Vyvanse but teacher reports he is erratic. On history you find both parents are working and he is often cared for by his older sister who sometimes forgets to give him his medication. You work with the school nurse to have his medication given at school.

- How do you code?

  - Level 4
  - ADHD unstable (4), Risk due to SDOH (4).

Thank You

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