One of the most common reasons that claims are denied have to do with the incorrect use of CPT codes. First, some basic questions and answers:

“What are CPT codes?” CPT (Current Procedural Terminology) codes come from the American Medical Association (AMA), working in close collaboration with the Center for Medicare and Medicaid Services (CMS), as well as psychologists, psychiatrists, social workers and nurses, who participate in CPT coding workgroups. They are the 5-digit codes used on claims and invoices/Superbills to let insurance plans know what type of service was provided. Don’t be confused -- they are not diagnosis codes, which come from the ICD (International Classification of Diseases) or the DSM (Diagnostic and Statistical Manual of Mental Disorders).

“Are these codes universal?” These codes should be used in all billing for private insurance plans as well as federal and state plans, including Medicare and Medicaid. They are the same across all states and plans.

“Why are they so confusing?” In 2013 there was a major overhaul to the CPT code list that therapists commonly use. AND THERE HAVE BEEN CHANGES EACH YEAR SINCE. Therefore, the codes many therapists are using are out of date, or they are using them incorrectly.

“If there is a code for something, does this mean insurance will pay for it?” No. Each plan will have different rules and reimbursement policies.

“How do I know the reimbursement rate for each CPT code?” Each plan sets their own reimbursement rates for each CPT code, and rates may vary based on factors including provider’s network participation, region, and licensure.

Here is a short list of COMMONLY-USED CPT CODES THAT HAVE NOT CHANGED SIGNIFICANTLY IN THE LAST 10 YEARS:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90845</td>
<td>Psychoanalysis</td>
</tr>
<tr>
<td>90846</td>
<td>Family or couples therapy w/o patient present, 50 min (time specification added in 2016)</td>
</tr>
<tr>
<td>90847</td>
<td>Family or couples therapy, 50 min (time specification added in 2016) -- this should be used for ongoing couples or family therapy sessions</td>
</tr>
<tr>
<td>90849</td>
<td>Multiple family group</td>
</tr>
<tr>
<td>90853</td>
<td>Group therapy other than a multiple family group</td>
</tr>
<tr>
<td>90875</td>
<td>Individual psychophysiological therapy incorporating biofeedback training with psychotherapy; 30 mins.</td>
</tr>
<tr>
<td>90876</td>
<td>Individual psychophysiological therapy incorporating biofeedback training with psychotherapy; 45 mins</td>
</tr>
<tr>
<td>90880</td>
<td>Hypnotherapy</td>
</tr>
<tr>
<td>90899</td>
<td>Unlisted psychiatric service</td>
</tr>
</tbody>
</table>

IN THE FOLLOWING PAGES, WE WILL DISCUSS CODES THAT HAVE CHANGED SIGNIFICANTLY IN THE LAST 10 YEARS, BEEN DELETED, OR ADDED.
CODES THAT HAVE CHANGED:

1. DIAGNOSTIC INTERVIEW CODES

The code previously used for a psychiatric diagnostic interview, 90801, was replaced in 2013 by two separate codes: 90791 is to be used for a diagnostic evaluation, while 90792 is used for a diagnostic evaluation with medical services, such as a medical exam, ordering/reviewing medical tests, taking vital signs, prescribing/change of medication/dose, and consideration of a differential diagnosis (medical providers: See Attachment A for important information).

<table>
<thead>
<tr>
<th>2012 Codes (DELETED)</th>
<th>Current Codes (effective 1/1/13, current as of 2/1/2019)</th>
</tr>
</thead>
<tbody>
<tr>
<td>90801, psychiatric diagnostic evaluation</td>
<td>90791, psychiatric diagnostic evaluation (no medical services) OR, FOR MEDICAL PROVIDERS: 90792, psychiatric diagnostic evaluation with medical services (or can use E/M new patient code)</td>
</tr>
</tbody>
</table>

a. 90791 can be used by all providers. 90792 should be used only by medical providers.
b. You can only report one evaluation unit in one day per patient. However, providers with different specialties can both use a diagnostic evaluation code with the same patient on the same day, if the plan allows this.
c. Medical providers can use E/M New Patient codes in lieu of 90791/90792, but E/M documentation requirements are different (For more on E/M codes, see Attachment A).
d. In some instances, family members, guardians, or significant others may be seen in lieu of the client.
e. Codes 90791 and 90792 may be reported more than once for the patient when separate diagnostic evaluations are conducted with the patient and other informants on different days. However, some insurance plans may only pay for one diagnostic evaluation per client.
f. Use the same codes, 90791 and 90792, for later reassessment, if indicated.

2. PSYCHOTHERAPY CODES

Individual psychotherapy codes are below. Family members can join a client occasionally in session, or for part of a session as an informant to ongoing individual therapy, but the identified client must be present for some or all of the service. These codes should not be used for ongoing couples or family therapy. For more on when to use these codes with multiple persons in the session, see Frequently Asked Questions, Page 5. You can see from the chart that location of services inpatient/outpatient/home now all use the same code.

<table>
<thead>
<tr>
<th>2012 Codes (DELETED)</th>
<th>Current Codes (effective 1/1/13, current as of 2/1/2019)</th>
</tr>
</thead>
<tbody>
<tr>
<td>90804, outpatient psychotherapy 20-30 min 90816, inpatient psychotherapy 20-30 min</td>
<td>90832, Psychotherapy, 30 minutes with patient (16-37 minutes individual therapy)</td>
</tr>
<tr>
<td>90806, outpatient psychotherapy 45-50 min 90818, inpatient psychotherapy 45-50 min</td>
<td>90834, Psychotherapy, 45 minutes with patient (38-52 minutes individual therapy)</td>
</tr>
<tr>
<td>90808, outpatient psychotherapy 75-80 min 90821, inpatient psychotherapy 75-80 min</td>
<td>90837, Psychotherapy, 60 minutes with patient (53 minutes and more of individual therapy)</td>
</tr>
</tbody>
</table>

a. “What about other sessions less than 16 minutes? There is no code -- sessions less than 16 minutes cannot be reported with a CPT code.
b. For sessions 53 minutes and longer: Use code for 60 minutes. However, remember this code may require preauthorization for insurance reimbursement from some plans. These insurance plans look on the 90837 as an “extended session” that may be approved for crisis stabilization, EMDR, or Systematic Desensitization techniques. Keep in mind that even if you get preauthorization, no matter the session length, the plan will likely only pay for 60 minutes (90837). This means if you see a client for 120 minutes, you typically won’t be paid if you bill for 90837, 2 units. (For more options for billing for extended sessions, see Frequently Asked Questions on page 5).
3. Crisis Codes

<table>
<thead>
<tr>
<th>2012 Code</th>
<th>Current Codes (effective 1/1/13, current as of 2/1/2019)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No existing code</td>
<td>90839, psychotherapy for crisis, first 60 min.</td>
</tr>
<tr>
<td>No existing code</td>
<td>90840, crisis code add-on for each additional 30 min.</td>
</tr>
</tbody>
</table>

“What is a crisis session?” Crisis is defined as including situations such as: a potentially life-threatening or high stress situation or complex case requiring urgent assessment, possibly immediate psychotherapy to stabilize the client, mobilization of resources, and/or immediate intervention to reduce trauma.

a. Crisis sessions must be face-to-face, the client must be present for at least part of the service, and provider must be focused solely on this client.

b. Crisis is based on your definition (not your client’s) and what your documentation supports.

c. You may do a crisis session with a new client/family and at a later date do a diagnostic session.

d. Reimbursement rates for crisis sessions will be determined by individual insurance plans. Some payers may not reimburse for these codes. Some plans (including Magellan) require authorization.

e. Crisis codes cannot be billed on the same date with 90791 or 90792 (diagnostic services), 90832-90838 (psychotherapy), or 90785 (interactive complexity) codes, or any other psychiatric service.

f. These codes do not include medical services. In a crisis situation, psychiatrists may prefer the appropriate E/M code.

“How do you code crisis sessions on claims?” In Box 24 of the CMS-1500 claim form, use 90839 for the first 30 – 74 minutes, one unit daily. For sessions longer than 74 minutes, on the next row, repeat the date and Place of Service Code (11 = office), then add the crisis add-on code of 90840 and your fee for this extra time - - see example below. While add-on codes are often indicated with a plus sign in front of them (ex: +90840), do not use the plus sign on the claim (for more on coding of add-on codes, see Frequently Asked Questions).

```
<table>
<thead>
<tr>
<th>A.</th>
<th>B.</th>
<th>C.</th>
<th>D.</th>
<th>E.</th>
<th>F.</th>
<th>G.</th>
</tr>
</thead>
<tbody>
<tr>
<td>06</td>
<td>26</td>
<td>13</td>
<td>06</td>
<td>26</td>
<td>11</td>
<td>90839</td>
</tr>
<tr>
<td>06</td>
<td>26</td>
<td>13</td>
<td>06</td>
<td>26</td>
<td>11</td>
<td>90840</td>
</tr>
</tbody>
</table>
```

- For sessions 75 - 104 minutes long, report both 90839 and 90840.
- For sessions 105 - 134 minutes long, report 90839 and 2 units of 90840.

4. Interactive Complexity Add-On Code

“What is interactive complexity, and when would you use this add-on code?” Interactive complexity may be reported when at least one of the following factors is present in a session:

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

2. Caregiver emotions or behaviors that interfere with implementation of the treatment plan

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

4. Use of play equipment, physical devices, interpreter or translator to overcome barriers to diagnostic or therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language (this could include young/verbally underdeveloped clients).
The interactive complexity add-on code (continued):

<table>
<thead>
<tr>
<th>2012 Codes (DELETED)</th>
<th>Current Codes (effective 1/1/13, current as of 2/1/2019)</th>
</tr>
</thead>
<tbody>
<tr>
<td>90802, interactive psychiatric diagnostic evaluation</td>
<td>90791 or 90792, with 90785 (interactive complexity add-on)</td>
</tr>
<tr>
<td>90810, interactive psychotherapy, 20-30 min.</td>
<td>90832 psychotherapy, 30 min., and 90785, interactive complexity add-on code</td>
</tr>
<tr>
<td>90812, interactive psychotherapy, 45-50 min.</td>
<td>90834, psychotherapy, 45 min. and 90785, interactive complexity add-on code</td>
</tr>
<tr>
<td>90814, interactive psychotherapy, 75-80 min.</td>
<td>90837, psychotherapy, 60 min. and 90785, interactive complexity add-on code</td>
</tr>
<tr>
<td>90857, Interactive group psychotherapy</td>
<td>90853, group psychotherapy (other than of multi-family), and 90785, interactive complexity add-on code</td>
</tr>
</tbody>
</table>

Notes on the Interactive Complexity Add-On Code (90785)

- This code cannot be used alone.
- It can only be paired with diagnostic evaluation, psychotherapy, or group codes. It cannot be used in conjunction with E/M sessions, family psychotherapy (90846, 90847, 90849), or psychotherapy for crisis (90839 and 90840).
- The interactive complexity code (90785) relates ONLY to the increased work intensity of the psychotherapy. 90785 does NOT change the time for the psychotherapy service.
- This is often used when a child and parents are seen together in the session.
- This add-on code may NOT be reimbursed by some payers. Check with the plan.
- Doctors can use E/M codes instead. In this case, there is no need for the interactive complexity code.

How to Code Interactive Complexity Add-On Codes on Claims: On the CMS-1500 form, report the CPT code for the service provided on the white portion of one line with your fee, as you normally would. On the row beneath, repeat the date and Place of Service Code (11 if office), then add the interactive complexity add-on code 90785, and any extra fee, as you determine appropriate. The plan understands the information here refers to the session on the line above. While add-on codes are often signified with a plus sign (ex. +90785), don’t use this plus sign on the claim (see example below; for more on add-on codes, see Frequently Asked Questions).

FREQUENTLY ASKED QUESTIONS:

“I don’t take insurance. Do I have to be concerned with CPT codes?” Yes! If you are like most of us, and you give invoices/superbills to clients to turn into their insurance plan for reimbursement, you will need to use the new codes.

“Do I charge a separate amount for add-on codes?” Yes. In the example directly above, you would put your usual fee for the 45-minute session on the first line, and on the second line you would put your additional charge for the interactive nature of the session. Be aware that plans may choose not to pay this add-on fee, or may only pay a small amount (one plan’s rate sheet said they would only pay $3.00 more for interactive complexity.)
“I see that psychotherapy codes can be used when a family member comes to the session. So, when do I use the family session code 90847?” If an individual is the focus of treatment, and a family member comes for part of session, or occasionally joins the client in the session, you may use the individual psychotherapy codes 90832, 90834, or 90837 (as long as the client is present for part of the session). An example might be if you meet with a child’s mom (with or without the client) for the last 15 minutes of your individual session with the child. However, if the couple or family is the focus of ongoing treatment, use the 90847 family therapy code - but remember you still must have an identified patient with a diagnosis (usually other than a Z-code).

“Do 55-60 minute sessions with clients. Should I now use the 45 or 60-minute code?” Technically, if it is over 53 minutes, the correct code would be 90837, the 60-minute code. However, as I said earlier, some plans won’t pay for (or won’t pay MORE for) a 60-minute session without preauthorization, as these plans (most notably UBH/Optum) may see 90837 as equivalent to an extended session. If a plan does cover 90837 sessions without preauthorization, they might not cover them routinely. Having said that, I do know many plans that cover 90837 for regular, weekly sessions. It could be with some plans that using 90837 regularly might make the case more likely to be reviewed. As always, it’s a good idea to contact the plan to check their policy on covering 90837 sessions. (Read on for more about extended sessions).

“I like to do 60-120 minute sessions with clients. How do I bill for this?” The code for extended therapy session 75-80 minutes (90808) was deleted in 2013. So coding for longer sessions is tricky. As I said in the answer to the previous question, sessions over 52 minutes may only be reimbursed with preauthorization and in special circumstances. Some plans pay them without question, others may pay as long as they are not used too often.

So, when it comes to extended sessions, if the session meets the criteria for a crisis session, you might use these codes (check if authorization is needed – yes, some plans want authorization for crisis sessions!) If not a crisis, call the plan and tell them why you feel the need for extended sessions, and if approved, how they want you to code it. Possibilities include: 1) using the 60-minute therapy code for all sessions longer than 52 minutes, knowing that you or the client will only get reimbursed for the first 60 minutes, and keeping in mind that you may need preauthorization, or 2) bill one 45 or 60-minute session to insurance and contract privately with the client to pay any additional time out of pocket (have them agree in writing -- if it’s a Medicare client, the client should sign an Advance Beneficiary Notice). WARNING: If you did (for example) a 90-minute session, some therapists have told me they have gotten reimbursed when they listed it as two 45-minute sessions in the same day. However, it is NOT recommended, unless the plan tells you to do so, as many plans only allow one hour of therapy per day.

In addition to the code for 60 minutes and above (90837), there are new codes 99354 (60 minutes Prolonged Services) and 99355 (Prolonged Services, each additional 30 minutes) described by the AMA that could be paired with a 90837 to bill for an extended individual session (these can't be used for extended couples sessions). See my article at http://theinsurancemaze.com/extendedsessions/. HOWEVER, some plans may only pay these codes when used by medical providers, and when used in conjunction with an Evaluation/Management service. As always, call the plan first to check their reimbursement for these codes.

“What if I see two codes that seem to fit?” You can use whatever code you think fits the service provided.

“What if I am submitting a claim for sessions in two separate years?” Always bill using the codes that were in force when the session occurred, and bill each year on separate claims (ex. it is best not to mix 2018 and 2019 sessions on the same claim, as coverage and reimbursement rates may change).

GENERAL TIPS:
1. If you intend to provide service for any unusual session type or length, check if prior authorization is required (especially code 90837 for 60 minutes psychotherapy, crisis codes, and interactive add-on codes).
2. Get a complete list of the CPT codes, and download one of the free online “crosswalks” (which shows both old and new codes for the same service) for quick reference -- See the Resource page for different crosswalks.
3. Psychiatrists/Medical Providers: Read Attachment A of this report. But remember—this is just a quick overview — If you are not familiar with E/M coding and documentation, get training. The American Psychiatric Association has some online courses (see Resources).
4. Stay tuned — CPT codes change yearly, so I will try to keep you up to date with important changes via my email newsletter. To subscribe or to contact me with your questions, visit www.theinsurancemaze.com
RESOURCES

American Medical Association
www.ama-assn.org
Purchase the 2013 CPT codebook available at the AMA bookstore at https://catalog.ama-assn.org/Catalog/home.jsp or call the AMA at 800-621-8335. (Also available for purchase in bookstores or through online bookstores)

The National Council for Behavioral Health
www.thenationalcouncil.org

American Psychological Association
www.apapracticecentral.org
practice@apa.org
Practitioner Helpline: (800) 374-2723
CPT code section: http://www.apapracticecentral.org/reimbursement/billing/index.aspx
Helpful public and members-only billing and coding information for all disciplines, though aimed at psychologists

American Psychiatric Association
www.psych.org
Both public and member-only materials. Members with questions can call Practice hotline at 800-343-4671 or send an email to hsf@psych.org. To view their 2012 to 2013 code crosswalks, go to http://www.cphs.org/pdf/CPTCodes/cpt2013crosswalktonewcodestable.pdf

American Academy of Child and Adolescent Psychiatry
www.aacap.org
Webinars and online information

National Association of Social Workers
www.socialworkers.org Member-only information related to 2013 CPT codes for social workers

www.theinsurancemaze.com
barbgris@aol.com or 408.985.0846
The author has put together an easy-to-read, detailed overview of what every therapist should know about working with insurance. Provides consultations for therapists with insurance problems and questions. Join her mailing list to receive her free monthly insurance e-newsletter for regular updates on the ever-changing insurance world.
ATTACHMENT A: A BRIEF OVERVIEW OF CPT CODE CHANGES FOR PHYSICIANS, PSYCHIATRISTS AND MEDICAL PROVIDERS

Disclaimer: This is not intended to be a comprehensive outline of the CPT changes for medical providers or to discuss the very complicated world of Evaluation/Management Codes. This is only a quick overview, hoping that it will give you some basic facts, encourage you to find out more, and give you some resources (see previous page) for doing so.

Big changes:

1. **CPT code 90862, Pharmacological Management, used frequently by psychiatrists and other prescribing doctors, was eliminated and replaced by Evaluation/Management codes.**

2. **E/M codes are traditionally used by doctors, physician assistants, nurses, but have not historically been as widely used in the mental health community. Because of these CPT changes, doctors and nurses must now become familiar with E/M codes and documentation guidelines.** There are helpful webinars and trainings available (see “Resources” section of this report). Medicare always allowed psychiatrists to use E/M codes, but until 2010, few other payers reimbursed psychiatrists for E/M codes for outpatient services.

3. **Add-on psychotherapy codes:** Psychiatrists who also do therapy may now use an E/M code plus “add-on psychotherapy codes” to bill separately for psychotherapy time within the same visit. (For examples of how add-on codes should look on the claim, see below).

4. **A few quick notes about E/M codes:**
   a. May be reimbursed at higher rates than equivalent CPT codes.
   b. Start with a 99.
   c. Used by all physicians and other qualified health care professionals (including APN and PA).
   d. Categories of complexity start at level 1 (last digit 1) least complex, goes up to 5.
      a. Involves history, exam, and medical decision making. If vital signs, weight, blood pressure etc. are measured, they need not be taken by doctor – they can be taken by staff.
      b. Time cannot be used to choose E/M codes, unlike psychotherapy codes.
      c. If using an E/M code with a psychotherapy code add-on, the time spent providing E/M activities should not be considered in choosing the time-based psychotherapy code. When not using a separate therapy code, time spent doing psychotherapy can be considered when choosing the E/M Level of Care code.
      d. Interactive complexity codes cannot be billed with E/M codes – interactive complexity codes can only be paired with psychotherapy or diagnostic evaluation (see interactive complexity section, above).
   e. Some examples of changes:

<table>
<thead>
<tr>
<th>2012 Codes (DELETED)</th>
<th>Current Codes as of 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>90805, outpatient psychotherapy with E/M services 20-30 min.</td>
<td>Appropriate outpatient E/M code (not selected on basis of time), and 90833, 30-minute psychotherapy add-on code</td>
</tr>
<tr>
<td>90811, interactive psychotherapy with E/M services, 20-30 min.</td>
<td>Appropriate outpatient E/M code (not selected on basis of time), and 90833, 30-minute psychotherapy add-on code, and 90785, interactive complexity add on code</td>
</tr>
</tbody>
</table>

**Coding of E/M services on the CMS-1500 claim form:** E/M codes appear in CPT code column. Enter the correct E/M code. Add-on codes (if any) go in same column on the line below (repeating Date of Service and Place of Service Code information). In the example below, the code 90833 is used to reflect 30 minutes of psychotherapy in addition to the E/M code for medical services provided (note: 99XXX is not a valid E/M code).
“What if I have two add on codes?” If your session included E/M, psychotherapy, and interactive complexity, here is how that might look:

![Diagram of two add on codes]

**Definition of a New patient:** One that has never received any services from you or another doctor of the same specialty that belongs to your group in the last 3 years. A patient you cover while on-call for another doctor is not considered a new patient. Doctors with different specialties within the group can both use New Patient codes when seeing a patient for the first time.

**Definition of Established patient:** One who has received services from you or another doctor in the same specialty that belongs to your group in the last three years.

**Prescribing psychologists may use add-on code 90863 with a psychotherapy code.** This is for Pharmacologic Management, including prescription and review of medication, when performed with psychotherapy services. The code was designed for use by prescribing psychologists -- physicians should not use this code. However, Medicare has determined that they will not reimburse for this code, so other payers may follow suit. Be sure to check with the plan.

**What action you should take:** Take a training course or webinar on E/M Coding and Documentation, if you are not familiar with it. It is too complicated to cover in a brief overview like this. Contact your professional organization, or the resource list on the previous page will give you some places for very helpful trainings and webinars. See Page 5 for other actions you should take to prepare for the new CPT Codes.

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