Optum

Coding &
Payment Guide

Behavioral Health Services

An essential coding, billing and reimbursement guide for psychiatrists, psychologists, and clinical social workers

2027

optumcoding.com

Contents

Getting Started with Coding and Payment Guide

The *Coding and Payment Guide for Behavioral Health Services* is designed to be a guide to the specialty procedures classified in the CPT® book. It is structured to help coders understand procedures and translate physician narrative into correct CPT codes by combining many clinical resources into one, easy-to-use source book.

The book also allows coders to validate the intended code selection by providing an easy-to-understand explanation of the procedure and associated conditions or indications for performing the various procedures. As a result, data quality and reimbursement will be improved by providing code-specific clinical information and helpful tips regarding the coding of procedures.

CPT/HCPCS Codes

For ease of use, evaluation and mangement codes related to behavioral health are listed first in the *Coding and Payment Guide*. All other CPT and HCPCS Level II codes related to behavioral health are listed in ascending numeric order. Each CPT/HCPCS code is followed by its official code description.

Resequencing of CPT Codes

The American Medical Association (AMA) employs a resequenced numbering methodology. According to the AMA, there are instances where a new code is needed within an existing grouping of codes, but an unused code number is not available to keep the range sequential. In the instance where the existing codes were not changed nor had only minimal changes, the AMA has assigned a code out of numeric sequence with the other related codes being grouped together. The resequenced codes and their descriptions have been placed with their related codes, out of numeric sequence. Codes within the Optum *Coding and Payment Guide* series display in their resequenced order. **Resequenced codes are enclosed in brackets [ ] for easy identification.**

ICD-10-CM

The most current ICD-10-CM codes are provided, each listed with their full official description. Refer to the ICD-10-CM book for more ICD-10-CM coding information.

Detailed Code Information

One or more columns are dedicated to each procedure or service to a series of similar procedures/services. Following the specific HCPCS Level II and CPT code and its narrative, is a combination of features.

Appendix Codes and Descriptions

Some procedure codes are presented in a less comprehensive format in the appendix. The CPT and HCPCS Level II codes appropriate to the specialty are included in the appendix with the official code description, lay description and associated relative value units, and Medicare edits. The Relative Value Unit/Medicare Edits table will not be included with any CPT/HCPCS code with a "0" (zero) value. Note: CMS has not established relative values for Category II and III codes.

CCI Edits, RVUs, and Other Coding Updates

The *Coding and Payment Guide* includes the a list of codes from the official Centers for Medicare and Medicaid Services' *National Correct Coding Policy Manual for Part B Medicare Contractors* that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from version 32.3, the most current version available at press time. CCI edits are updated quarterly and will be posted on the product updates page listed below. The website address is http://www.optumcoding.com/ProductUpdates/. The 2027 edition password is: **XXXXX**. Log in frequently to ensure you receive the most current updates.

Index

A comprehensive index is provided for easy access to the codes. The index entries have several axes. A code can be looked up by its procedural name or by the diagnoses commonly associated with it. Codes are also indexed anatomically. For example:

Brain
Cortex
Magnetic Stimulation, 90867-90869
Mapping, 90867, 96020

General Guidelines

Providers

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, the service or procedure itself is not limited to use only by that specialty group. Additionally, the procedures and services listed throughout the book are for use by any qualified physician or other qualified health care professional or entity (e.g., hospitals, laboratories, or home health agencies). Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Supplies

Some payers may allow physicians to separately report drugs and other supplies when reporting the place of service as office or other nonfacility setting. Drugs and supplies are to be reported by the facility only when performed in a facility setting.

Professional and Technical Components

Some pathology codes have a technical and a professional component. When physicians do not own their own equipment and send their patients to outside testing facilities, they should append modifier 26 to the procedural code to indicate they performed only the professional component.

Sample Page and Key

The following pages provide a sample page from the book displaying the format of *Coding Guide* with each element identified and explained.

90785

1

+ ★**90785** Interactive complexity (List separately in addition to the code for primary procedure)

Explanation

2

This code is reported in addition to the code for a primary psychiatric service. It is reported when the patient being treated has certain factors that increase the complexity of treatment rendered. These factors are limited to the following: the need to manage disruptive communication that complicates the delivery of treatment; complications involving the implementation of a treatment plan due to caregiver behavioral or emotional interference; evidence of a sentinel event with subsequent disclosure to a third party and discussion and/or reporting to the patient(s); or use of play equipment or translator to enable communication when a barrier exists.

Coding Tips

3

Report this code with psychiatric evaluation services (90791–90792), psychotherapy services (90832–90834, 90836–90838), and group psychotherapy (90853). Do not report this code with psychotherapy for crisis (90839–90840), psychological and neuropsychological testing (96130–96134, 96136–96139, 96146), or adaptive behavior assessment/treatment services (97151–97158, 0362T, 0373T). Do not report this code with E/M services provided without psychotherapy.

Documentation Tips

4

Documentation should clearly indicate the type of interactive methods used such as interpreter, use of play, or physical device used, and that the patient could not communicate through normal verbal means. Other catatonic states may be covered if documentation is submitted with the claim. Coverage also includes interactive examinations of patients with primary psychiatric diagnoses (excluding dementias and sleep disorders), and one of the following conditions must be clearly and concisely recorded in the medical record:

- Maladaptive communication complicating delivery of care
- Caregiver does not understand or has limited ability to assist in implementation of treatment plan
- Sentinel event (that may be reported to third party) disclosured and requires discussion
- Barriers to therapeutic or diagnostic interaction for patient who has limited or undeveloped receptive communication skills and is unable to use typical communication language

Time spent by the clinician providing interactive complexity services should be reflected in the timed service code for the psychotherapy or the psychotherapy add-on code provided in combination with an E/M service and must be connected only to the psychotherapy service.

Reimbursement Tips

5

Medicare and the CPT book has identified this code as a telehealth/telemedicine service that may also be an audio-only service. Medicare and commercial payers should be contacted regarding their coverage guidelines. Telemedicine services may be reported by the performing provider by adding modifier 93 or 95 to this procedure code and/or using the appropriate place-of-service indicator; POS 02 for telehealth when the originating site is not the patient's home and POS 10 for telehealth services when the originating site is the patient's home. Services at the origination site are reported with HCPCS Level II code Q3014.

According to instructions found in the Correct Coding Initiative, "Interactive services (diagnostic or therapeutic) are distinct services for patients who have lost, or have not yet developed either the expressive language communication skills to explain his/her symptoms and response to treatment…" Interactive complexity to psychiatric services is reported with add-on CPT code 90785.

Assignment of benefits is required when this service is provided by a clinical social worker.

Medicare payment is at 75 percent of the physician fee schedule when the service is provided by a clinical social worker.

ICD-10-CM Diagnostic Codes

6

This/these CPT code(s) are add-on code(s). See the primary procedure code that this code is performed with for your ICD-10-CM code selections.

Associated HCPCS Codes

7

H0001	Alcohol and/or drug assessment
H0002	Behavioral health screening to determine eligibility for admission to treatment program
H0006	Alcohol and/or drug services; case management
H0007	Alcohol and/or drug services; crisis intervention (outpatient)
H0031	Mental health assessment, by nonphysician
H1011	Family assessment by licensed behavioral health professional for state defined purposes

AMA: 90785 2022,Aug; 2022,Jan; 2020,Aug; 2018,Nov; 2018,Jul; 201

8

Relative Value Units/Medicare Edits

9

Non-Facility RVU	Work	PE	MP	Total
90785	0.33	0.1	0.01	0.44
Facility RVU	**Work**	**PE**	**MP**	**Total**
90785	0.33	0.05	0.01	0.39

	FUD	Status	MUE	Modifiers				IOM Reference
90785	N/A	A	3(3)	N/A	N/A	N/A	N/A	None

* with documentation

Terms To Know

10

aphasia. Partial or total loss of the ability to comprehend language or communicate through speaking, the written word, or sign language. Aphasia may result from stroke, injury, Alzheimer's disease, or other disorder. Common types of aphasia include expressive, receptive, anomic, global, and conduction.

dysarthria. Difficulty pronouncing words.

interactive psychotherapy. Use of physical aids and nonverbal communication to overcome barriers to therapeutic interaction between a clinician and a patient who has not yet developed or has lost either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the clinician if he or she were to use ordinary adult language for communication.

psychotherapy. Treatment for mental illness and behavioral disturbances in which the clinician establishes a professional contract with the patient and, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

1. CPT Codes and Descriptions

This edition of *Coding and Payment Guide for Behavioral Health Services* is updated with CPT codes for year 2027.

The following icons are used in the *Coding and Payment Guide*:

- ● This CPT code is new for 2027.
- ▲ This CPT code description is revised for 2027.
- ✚ This CPT code is an add-on code.

Add-on codes are not subject to bilateral or multiple procedure rules, reimbursement reduction, or appending modifier 50 or 51. Add-on codes describe additional intraservice work associated with the primary procedure performed by the same physician on the same date of service and are not reported as stand-alone procedures. Add-on codes for procedures performed on bilateral structures are reported by listing the add-on code twice.

- ★ This CPT code is identified by CPT as appropriate for audio-visual telemedicine services.

Documentation should include the type of technology used for the treatment in addition to the patient evaluation, treatment, and consents.

According to CPT guidelines, the codes listed below may be used for reporting audio-only telemedicine services when modifier 93 Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System, is appended. These procedures involve electronic communication using interactive telecommunications equipment that at a minimum includes audio.

90785	90791	90792	90832	90833	90834	90836
90837	90838	90839	90840	90845	90846	90847
92507	92508	92521	92522	92523	92524	96041
96110	96116	96121	96156	96158	96159	96160
96161	96164	96165	96167	96168	96170	96171
97802	97803	97804	99406	99407	99408	99409
99497	99498					

- [ ] CPT codes enclosed in brackets are resequenced and may not appear in numerical order.

2. Explanation

Every CPT/HCPCS code or series of similar codes is presented with its official CPT/HCPCS code description. However, sometimes these descriptions do not provide the coder with sufficient information to make a proper code selection. In *Coding and Payment Guide for Behavioral Health Services*, a step-by-step clinical description of the procedure is provided, in simple terms. Technical language that might be used by the physician or other qualified health care provider is included and defined. *Coding and Payment Guide for Behavioral Health Services* describes the most common method of performing each procedure.

3. Coding Tips

Coding tips provide information on how the code should be used, provides related procedure codes, and offers help concerning common billing errors and modifier usage. This information comes from consultants and subject matter experts at Optum and from the coding guidelines provided in the CPT book.

4. Documentation Tips

Documentation tips provide code-specific tips to the coder regarding the information that should be noted in the documentation in order to support code assignment.

5. Reimbursement Tips

Medicare and other payer guidelines that could affect the reimbursement of this service or procedure are included in the Reimbursement Tips section.

6. ICD-10-CM Diagnostic Codes

ICD-10-CM diagnostic codes listed are common diagnoses or reasons the procedure may be necessary. This list in most cases is inclusive to the specialty. Some ICD-10-CM codes are further identified with the following icons:

- N Newborn: 0
- P Pediatric: 0-17
- M Maternity: 9-64
- A Adult: 15-124
- ☑ Laterality

Please note that in some instances the ICD-10-CM codes for only one side of the body (right) have been listed with the CPT code. The associated ICD-10-CM codes for the other side and/or bilateral may also be appropriate. Codes that refer to the right or left are identified with the ☑ icon to alert the user to check for laterality. In some cases, not every possible code is listed and the ICD-10-CM book should be referenced for other valid codes.

7. HCPCS Associated Codes

Medicare and some other payers require the use of HCPCS Level II codes and not CPT codes when reporting certain services. The HCPCS codes and their description are displayed in this field. If there is not a HCPCS code for this service, this field will not be displayed.

8. AMA References

The AMA references for *CPT Assistant* are listed by CPT code, with the most recent reference listed first. Generally only the last six years of references are listed.

9. Relative Value Units/Medicare Edits

Relative Value Units

In a resource based relative value scale (RBRVS), services are ranked based on the relative costs of the resources required to provide those services as opposed to the average fee for the service, or average prevailing Medicare charge. The Medicare RBRVS defines three distinct components affecting the value of each service or procedure:

- Physician work component, reflecting the physician's time and skill
- Practice expense (PE) component, reflecting the physician's rent, staff, supplies, equipment, and other overhead
- Malpractice insurance (MP) component, reflecting the relative risk or liability associated with the service
- Total RVUs are a sum of the work, PE, and MP RVUs

There are two groups of RVUs listed for each CPT code. The first group of RVUs is for nonfacilities, which includes provider services performed in physician offices, patients' homes, or other nonhospital settings. The second group of RVUs is for facilities, which represents provider services performed in hospitals, ambulatory surgical centers, or skilled nursing facilities.

Medicare Follow-Up Days (FUD)

Information on the Medicare global period is provided here. The global period is the time following a surgery during which routine care by the physician is considered postoperative and included in the surgical fee. Office visits or other routine care related to the original surgery cannot be separately reported if they occur during the global period.

Status

The Medicare status indicates if the service is separately payable by Medicare. The Medicare RBRVS includes:

- A Active code—separate payment may be made
- B Bundled code—payment is bundled into other service
- C Carrier priced—individual carrier will price the code
- I Not valid—Medicare uses another code for this service

99202-99205

99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

99205 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

Explanation

Providers report these codes for new patients being seen in the doctor's office, a multispecialty group clinic, or other outpatient environment. All require a medically appropriate history and/or examination. Code selection is based on the level of medical decision making (MDM) or total time personally spent by the physician and/or other qualified health care professional(s) on the date of the encounter. Factors to be considered in MDM include the number and complexity of problems addressed during the encounter, amount and complexity of data requiring review and analysis, and the risk of complications and/or morbidity or mortality associated with patient management. The most basic service is represented by 99202, which entails straightforward MDM. If time is used for code selection, a total time of 15 minutes must be met or exceeded on the day of the encounter. Report 99203 for a visit requiring a low level of MDM or meeting or exceeding 30 minutes of total time; 99204 for a visit requiring a moderate level of MDM or meeting or exceeding 45 minutes of total time; and 99205 for a visit requiring a high level of MDM or meeting or exceeding 60 minutes of total time.

Coding Tips

These codes are used to report office or other outpatient services for a new patient. A medically appropriate history and physical examination, as determined by the treating provider, should be documented. The level of history and physical examination are not considered when determining the level of service. Codes should be selected based upon the current CPT Medical Decision Making table. Alternatively, time alone may be used to select the appropriate level of service. Total time for reporting these services includes face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional on the date of the encounter. Medicare has identified these codes as telehealth/telemedicine services. CMS requires the use of a place of service (POS) indicator: POS 02 for telehealth services when the originating site is not the patient's home and POS 10 for telehealth services when the originating site is the patient's home. For prolonged services applicable to 99205, see 99417; for Medicare, see G2212. Medicare and commercial payers should be contacted regarding their coverage guidelines. For office or other outpatient services for an established patient, see 99211–99215.

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

AMA: **99202** 2024,Sep; 2024,Jun; 2024,Jan; 2023,Dec; 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar **99203** 2024,Sep; 2024,Jun; 2024,Jan; 2023,Dec; 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar **99204** 2024,Sep; 2024,Jun; 2024,Jan; 2023,Dec; 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar **99205** 2024,Sep; 2024,Mar; 2024,Jan; 2023,Dec; 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99202	0.93	1.16	0.08	2.17
99203	1.6	1.59	0.16	3.35
99204	2.6	2.18	0.24	5.02
99205	3.5	2.79	0.33	6.62
Facility RVU	**Work**	**PE**	**MP**	**Total**
99202	0.93	0.4	0.08	1.41
99203	1.6	0.68	0.16	2.44
99204	2.6	1.13	0.24	3.97
99205	3.5	1.57	0.33	5.4

	FUD	Status	MUE	Modifiers				IOM Reference
99202	N/A	A	1(2)	N/A	N/A	N/A	80*	None
99203	N/A	A	1(2)	N/A	N/A	N/A	80*	
99204	N/A	A	1(2)	N/A	N/A	N/A	80*	
99205	N/A	A	1(2)	N/A	N/A	N/A	80*	

* with documentation

90785

+ ★**90785** Interactive complexity (List separately in addition to the code for primary procedure)

Explanation

This code is reported in addition to the code for a primary psychiatric service. It is reported when the patient being treated has certain factors that increase the complexity of treatment rendered. These factors are limited to the following: the need to manage disruptive communication that complicates the delivery of treatment; complications involving the implementation of a treatment plan due to caregiver behavioral or emotional interference; evidence of a sentinel event with subsequent disclosure to a third party and discussion and/or reporting to the patient(s); or use of play equipment or translator to enable communication when a barrier exists.

Coding Tips

Report this code with psychiatric evaluation services (90791–90792), psychotherapy services (90832–90834, 90836–90838), and group psychotherapy (90853). Do not report this code with psychotherapy for crisis (90839–90840), psychological and neuropsychological testing (96130–96134, 96136–96139, 96146), or adaptive behavior assessment/treatment services (97151–97158, 0362T, 0373T). Do not report this code with E/M services provided without psychotherapy.

Documentation Tips

Documentation should clearly indicate the type of interactive methods used such as interpreter, use of play, or physical device used, and that the patient could not communicate through normal verbal means. Other catatonic states may be covered if documentation is submitted with the claim. Coverage also includes interactive examinations of patients with primary psychiatric diagnoses (excluding dementias and sleep disorders), and one of the following conditions must be clearly and concisely recorded in the medical record:

- Maladaptive communication complicating delivery of care
- Caregiver does not understand or has limited ability to assist in implementation of treatment plan
- Sentinel event (that may be reported to third party) disclosured and requires discussion
- Barriers to therapeutic or diagnostic interaction for patient who has limited or undeveloped receptive communication skills and is unable to use typical communication language

Time spent by the clinician providing interactive complexity services should be reflected in the timed service code for the psychotherapy or the psychotherapy add-on code provided in combination with an E/M service and must be connected only to the psychotherapy service.

Reimbursement Tips

Medicare and the CPT book has identified this code as a telehealth/telemedicine service that may also be an audio-only service. Medicare and commercial payers should be contacted regarding their coverage guidelines. Telemedicine services may be reported by the performing provider by adding modifier 93 or 95 to this procedure code and/or using the appropriate place-of-service indicator; POS 02 for telehealth when the originating site is not the patient's home and POS 10 for telehealth services when the originating site is the patient's home. Services at the origination site are reported with HCPCS Level II code Q3014.

According to instructions found in the Correct Coding Initiative, "Interactive services (diagnostic or therapeutic) are distinct services for patients who have lost, or have not yet developed either the expressive language communication skills to explain his/her symptoms and response to treatment…" Interactive complexity to psychiatric services is reported with add-on CPT code 90785.

Assignment of benefits is required when this service is provided by a clinical social worker.

Medicare payment is at 75 percent of the physician fee schedule when the service is provided by a clinical social worker.

ICD-10-CM Diagnostic Codes

This/these CPT code(s) are add-on code(s). See the primary procedure code that this code is performed with for your ICD-10-CM code selections.

Associated HCPCS Codes

H0001	Alcohol and/or drug assessment
H0002	Behavioral health screening to determine eligibility for admission to treatment program
H0006	Alcohol and/or drug services; case management
H0007	Alcohol and/or drug services; crisis intervention (outpatient)
H0031	Mental health assessment, by nonphysician
H1011	Family assessment by licensed behavioral health professional for state defined purposes

AMA: 90785 2022,Aug; 2022,Jan; 2020,Aug; 2018,Nov; 2018,Jul; 2018,Apr

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
90785	0.33	0.1	0.01	0.44
Facility RVU	**Work**	**PE**	**MP**	**Total**
90785	0.33	0.05	0.01	0.39

	FUD	Status	MUE	Modifiers				IOM Reference
90785	N/A	A	3(3)	N/A	N/A	N/A	N/A	None

* with documentation

Terms To Know

aphasia. Partial or total loss of the ability to comprehend language or communicate through speaking, the written word, or sign language. Aphasia may result from stroke, injury, Alzheimer's disease, or other disorder. Common types of aphasia include expressive, receptive, anomic, global, and conduction.

dysarthria. Difficulty pronouncing words.

interactive psychotherapy. Use of physical aids and nonverbal communication to overcome barriers to therapeutic interaction between a clinician and a patient who has not yet developed or has lost either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the clinician if he or she were to use ordinary adult language for communication.

psychotherapy. Treatment for mental illness and behavioral disturbances in which the clinician establishes a professional contract with the patient and, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

90863

+ ★**90863** Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure)

Explanation

The patient's medications are managed during a psychiatric service, including the patient's current use of medicines, a medical review of the benefits and treatment progression, management of side effects, and review or change of prescription. This is a pharmacologically related service and is reported in addition to noncrisis-related psychotherapy when there is no other evaluation and management service performed during the encounter.

Coding Tips

This procedure may be performed by a physician or other qualified health care professional.

The appropriate psychotherapy code without evaluation and management (E/M) service (90832, 90834, or 90837) should be reported in addition to 90863. Do not report with an evaluation and management code as the service is included as part of the E/M code. When determining the appropriate psychotherapy code to be reported with this procedure, any time spent providing the medication management should be excluded. For example, if the patient is seen for 45 minutes, and 15 minutes is spent performing medication management, 90832 Psychotherapy, 30 minutes with patient and/or family, and 90863 are reported.

For pharmacologic management with psychotherapy services performed by a physician or other qualified health care professional who may report E/M services, report 99202–99255, 99281–99385, 99304–99310, or 99341–99350 with 90833, 90836, or 90838.

Documentation Tips

The written plan for care should include treatments and medications—specifying frequency and dosage, any referrals and consultations, patient and family education, and specific instructions for follow-up.

Reimbursement Tips

The CPT code book has identified this code as a telehealth/telemedicine service. Telemedicine services may be reported by the performing provider by adding modifier 95 to the procedure code and using the appropriate place-of-service (POS) indicator. Services at the origination site are reported with HCPCS Level II code Q3014.

ICD-10-CM Diagnostic Codes

This/these CPT code(s) are add-on code(s). See the primary procedure code that this code is performed with for your ICD-10-CM code selections.

Associated HCPCS Codes

H0034 Medication training and support, per 15 minutes

AMA: 90863 2022,Jan; 2020,Aug; 2018,Nov; 2018,Jul

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
90863	0.48	0.24	0.03	0.75
Facility RVU	**Work**	**PE**	**MP**	**Total**
90863	0.48	0.19	0.03	0.7

	FUD	Status	MUE	Modifiers				IOM Reference
90863	N/A	I	1(3)	N/A	N/A	N/A	N/A	None

* with documentation

Terms To Know

medication management. Monitoring and adjusting the use of medications for the treatment of a mental disorder.

medications. Drugs and biologicals that an individual is already taking, that are ordered for the individual during the course of treatment, or that are ordered for an individual after treatment has been provided.

pharmacological agent. Drug used to produce a chemical effect.

psychotherapy. Treatment for mental illness and behavioral disturbances in which the clinician establishes a professional contract with the patient and, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

90901

90901 Biofeedback training by any modality

Explanation

Biofeedback trains patients to control their autonomic or involuntary nervous system responses to regulate vital signs such as heart rate, blood pressure, temperature, and muscle tension. Monitors of various types are used to indicate body responses, which the patient learns to associate with related stimuli and also control in serial sessions. This code applies to any of several modalities of biofeedback training. Biofeedback is used for treatment of conditions including high blood pressure, incontinence, Raynaud's syndrome, and anticipatory nausea due to chemotherapy.

Coding Tips

The anatomical location, as well as the condition necessitating the treatment, should be clearly identified in the medical record. For biofeedback of perineal, anorectal, or urethral sphincter, see 90912-91913.

Do not use code 90875 or 90876; these two codes are for individual psychophysiological therapy. Treatment of incontinence by pulsed magnetic neuromodulation should be reported using 53899.

Documentation Tips

The anatomical location, as well as the condition necessitating the treatment, should be clearly identified in the medical record.

Reimbursement Tips

Medicare provides benefits for these procedures only when medically necessary for the re-education of specific muscle groups or for the treatment of pathological muscle conditions not able to be treated using conventional methods. Biofeedback is not covered for muscle tension and for psychosomatic conditions. Be sure to check coverage guidelines with each individual payer.

ICD-10-CM Diagnostic Codes

G04.1 Tropical spastic paraplegia
G81.01 Flaccid hemiplegia affecting right dominant side ☑
G81.02 Flaccid hemiplegia affecting left dominant side ☑
G81.03 Flaccid hemiplegia affecting right nondominant side ☑
G81.04 Flaccid hemiplegia affecting left nondominant side ☑
G81.11 Spastic hemiplegia affecting right dominant side ☑
G81.12 Spastic hemiplegia affecting left dominant side ☑
G81.13 Spastic hemiplegia affecting right nondominant side ☑
G81.14 Spastic hemiplegia affecting left nondominant side ☑
G82.21 Paraplegia, complete
G82.22 Paraplegia, incomplete
G82.51 Quadriplegia, C1-C4 complete
G82.52 Quadriplegia, C1-C4 incomplete
G82.53 Quadriplegia, C5-C7 complete
G82.54 Quadriplegia, C5-C7 incomplete
G83.0 Diplegia of upper limbs
G83.4 Cauda equina syndrome
K59.01 Slow transit constipation
K59.02 Outlet dysfunction constipation
K59.03 Drug induced constipation
K59.04 Chronic idiopathic constipation
K59.09 Other constipation
K59.4 Anal spasm
M62.3 Immobility syndrome (paraplegic)
M62.411 Contracture of muscle, right shoulder ☑
M62.412 Contracture of muscle, left shoulder ☑
M62.421 Contracture of muscle, right upper arm ☑
M62.422 Contracture of muscle, left upper arm ☑
M62.431 Contracture of muscle, right forearm ☑
M62.432 Contracture of muscle, left forearm ☑
M62.441 Contracture of muscle, right hand ☑
M62.442 Contracture of muscle, left hand ☑
M62.451 Contracture of muscle, right thigh ☑
M62.452 Contracture of muscle, left thigh ☑
M62.461 Contracture of muscle, right lower leg ☑
M62.462 Contracture of muscle, left lower leg ☑
M62.471 Contracture of muscle, right ankle and foot ☑
M62.472 Contracture of muscle, left ankle and foot ☑
M62.48 Contracture of muscle, other site
M62.49 Contracture of muscle, multiple sites
M62.511 Muscle wasting and atrophy, not elsewhere classified, right shoulder ☑
M62.512 Muscle wasting and atrophy, not elsewhere classified, left shoulder ☑
M62.521 Muscle wasting and atrophy, not elsewhere classified, right upper arm ☑
M62.522 Muscle wasting and atrophy, not elsewhere classified, left upper arm ☑
M62.531 Muscle wasting and atrophy, not elsewhere classified, right forearm ☑
M62.532 Muscle wasting and atrophy, not elsewhere classified, left forearm ☑
M62.541 Muscle wasting and atrophy, not elsewhere classified, right hand ☑
M62.542 Muscle wasting and atrophy, not elsewhere classified, left hand ☑
M62.551 Muscle wasting and atrophy, not elsewhere classified, right thigh ☑
M62.552 Muscle wasting and atrophy, not elsewhere classified, left thigh ☑
M62.561 Muscle wasting and atrophy, not elsewhere classified, right lower leg ☑
M62.562 Muscle wasting and atrophy, not elsewhere classified, left lower leg ☑
M62.571 Muscle wasting and atrophy, not elsewhere classified, right ankle and foot ☑
M62.572 Muscle wasting and atrophy, not elsewhere classified, left ankle and foot ☑
M62.58 Muscle wasting and atrophy, not elsewhere classified, other site
M62.59 Muscle wasting and atrophy, not elsewhere classified, multiple sites
M62.5A0 Muscle wasting and atrophy, not elsewhere classified, back, cervical
M62.5A1 Muscle wasting and atrophy, not elsewhere classified, back, thoracic
M62.5A2 Muscle wasting and atrophy, not elsewhere classified, back, lumbosacral

G0442-G0443

G0442 Annual alcohol misuse screening, 5 to 15 minutes

G0443 Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes

Explanation

Screening and behavioral counseling interventions are used to identify and reduce alcohol misuse. Alcohol misuse includes risky/hazardous and harmful drinking that puts individuals at risk for future problems. Risky or hazardous drinking is defined by the United States Preventive Services Task Force (USPSTF) as "more than seven standard drinks per week or more than three drinks per occasion for women and anyone over the age of 65; more than 14 standard drinks per week or more than four drinks per occasion for men 65 years of age or younger; and alcohol use by pregnant women." Lower limits are recommended for patients taking medication that may interact with alcohol or who are performing activities that require attention, skill, or coordination, such as driving or operating heavy machinery or someone who has a medical condition that may be worsened by alcohol use. Harmful drinking is defined as drinking by anyone who is currently experiencing physical, social, or psychological harm from alcohol use but does not meet the criteria for dependence. Alcohol dependence can be defined as at least three of the following: tolerance; withdrawal symptoms; impaired control; preoccupation with acquisition or use; persistent desire or unsuccessful efforts to quit; sustaining social, occupational, or recreational disability; or continual use despite adverse conditions. The face-to-face counseling code is reported for visits for patients, including pregnant women, who misuse alcohol but do not meet the criteria for alcohol dependence, who are competent and alert at the time counseling is provided, and whose counseling is furnished by a primary care health care professional in the primary care setting.

Coding Tips

For alcohol abuse structured assessment, see 99408–99409 or HCPCS Level II codes G0396–G0397. For alcohol assessment, see H0001. Code H0001 is not valid for payment under the Medicare physician fee schedule.

Documentation Tips

Alcohol dependence (i.e., alcoholism) is a chronic disorder characterized by large or frequent consumption of ethanol to the point that the individual becomes physically and mentally dependent upon alcohol to function. Long-term consequences are physical, psychological, and behavioral, some of which are liver disease, undernutrition with electrolyte disorders and vitamin deficiencies, coagulopathy, depression, dementia, psychosis, heart disease, and violent behavior. Criterion denoting dependence is increased tolerance and continued use despite impairment of health, social life, and job performance. Cessation results in withdrawal symptoms, including early seizures.

The provider must state the pattern of harmful usage (i.e., dependence, abuse, or use) and its current clinical state (e.g., uncomplicated, intoxication, remission, etc.) and indicate the relationship to any identified mental, behavioral, or physical disorder, or its relevance to the patient's status or encounter including its clinical significance.

Reimbursement Tips

Medicare has identified these codes as telehealth/telemedicine services that may also be audio-only services. Commercial payers should be contacted regarding their coverage guidelines. Telemedicine services may be reported by the performing provider by adding modifier 93 or 95 to these procedure codes and/or using the appropriate place-of-service indicator; POS 02 for telehealth when the originating site is not the patient's home and POS 10 for telehealth services when the originating site is the patient's home. Services at the origination site are reported with HCPCS Level II code Q3014.

Check with third-party payers to determine their reporting requirements.

ICD-10-CM Diagnostic Codes

F10.10	Alcohol abuse, uncomplicated
F10.11	Alcohol abuse, in remission
F10.120	Alcohol abuse with intoxication, uncomplicated
F10.121	Alcohol abuse with intoxication delirium
F10.130	Alcohol abuse with withdrawal, uncomplicated
F10.131	Alcohol abuse with withdrawal delirium
F10.132	Alcohol abuse with withdrawal with perceptual disturbance
F10.14	Alcohol abuse with alcohol-induced mood disorder
F10.150	Alcohol abuse with alcohol-induced psychotic disorder with delusions
F10.151	Alcohol abuse with alcohol-induced psychotic disorder with hallucinations
F10.180	Alcohol abuse with alcohol-induced anxiety disorder
F10.181	Alcohol abuse with alcohol-induced sexual dysfunction
F10.182	Alcohol abuse with alcohol-induced sleep disorder
F10.188	Alcohol abuse with other alcohol-induced disorder
F10.20	Alcohol dependence, uncomplicated
F10.21	Alcohol dependence, in remission
F10.220	Alcohol dependence with intoxication, uncomplicated
F10.221	Alcohol dependence with intoxication delirium
F10.230	Alcohol dependence with withdrawal, uncomplicated
F10.231	Alcohol dependence with withdrawal delirium
F10.232	Alcohol dependence with withdrawal with perceptual disturbance
F10.24	Alcohol dependence with alcohol-induced mood disorder
F10.250	Alcohol dependence with alcohol-induced psychotic disorder with delusions
F10.251	Alcohol dependence with alcohol-induced psychotic disorder with hallucinations
F10.26	Alcohol dependence with alcohol-induced persisting amnestic disorder
F10.27	Alcohol dependence with alcohol-induced persisting dementia
F10.280	Alcohol dependence with alcohol-induced anxiety disorder
F10.281	Alcohol dependence with alcohol-induced sexual dysfunction
F10.282	Alcohol dependence with alcohol-induced sleep disorder
F10.288	Alcohol dependence with other alcohol-induced disorder

Associated CPT Codes

99408	Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes
99409	Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes

H0008-H0014

H0008 Alcohol and/or drug services; subacute detoxification (hospital inpatient)

H0009 Alcohol and/or drug services; acute detoxification (hospital inpatient)

H0010 Alcohol and/or drug services; subacute detoxification (residential addiction program inpatient)

H0011 Alcohol and/or drug services; acute detoxification (residential addiction program inpatient)

H0012 Alcohol and/or drug services; subacute detoxification (residential addiction program outpatient)

H0013 Alcohol and/or drug services; acute detoxification (residential addiction program outpatient)

H0014 Alcohol and/or drug services; ambulatory detoxification

Explanation

These codes are for acute and subacute detoxification services in which the differentiating factor is the setting where the patient is monitored for the long-term symptoms associated with the withdrawal from alcohol and/or drugs. Subacute detoxification deals with severe symptoms, such as alcohol and drug cravings, that do not require immediate intervention. Acute detoxification services are those in which the patient is medically managed and stabilized on an inpatient hospitalization basis for severe withdrawal syndrome associated with the withdrawal from alcohol/drugs. Acute withdrawal begins within hours and includes severe physical and psychological symptoms that may require medical management with medications such as methadone.

H0015

H0015 Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education

Explanation

This code reports alcohol and drug related services within an intensive outpatient treatment program requiring the patient to participate at least 3 hours per day for at least 3 days per week. The patient is assessed medically and psychologically, provided counseling, intervention, and activity therapy or education, according to the needs of the patient and the individual's treatment plan.

H0016

H0016 Alcohol and/or drug services; medical/somatic (medical intervention in ambulatory setting)

Explanation

This service includes the supervision of medication, physical examinations, or other medical needs required to maintain the physical health of the patient receiving medical intervention treatment for alcohol and drug related problems in an ambulatory setting.

H0017

H0017 Behavioral health; residential (hospital residential treatment program), without room and board, per diem

Explanation

Residential treatment on a per diem basis for behavior health issues in a hospital residential treatment program is designed to provide a 24-hour group living situation in which the patient receives treatment under the care of a physician. This code does not include daily room and board.

H0018

H0018 Behavioral health; short-term residential (nonhospital residential treatment program), without room and board, per diem

Explanation

Short-term residential treatment is typically less than 30 days. This code applies to a residential treatment program for behavior health issues that is not part of a hospital but provides a 24-hour group living situation in which the patient receives treatment and does not include daily room and board.

H0019

H0019 Behavioral health; long-term residential (nonmedical, nonacute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem

Explanation

Long-term residential treatment is typically more than 30 days. This code applies to a residential treatment program for behavioral health issues that are neither medical nor acute in nature. This code is per diem, not including daily room and board.

H0020

H0020 Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)

Explanation

Methadone administration and/or service programs provide opioid replacement treatment (ORT) or opioid maintenance treatment (OMT), including the administration of methadone to an individual for detoxification from opioids and/or maintenance treatment. Overall treatment must be delivered, which should include counseling/therapy, case review, and medication monitoring. ORT/OMT is delivered by providers functioning under a defined set of policies and procedures, including admission, discharge, and continued service criteria stipulated by state law and regulations, Substance Abuse and Mental Health Services Administration (SAMHSA) regulations, and Drug Enforcement Agency (DEA) regulations. The ORT must be licensed by the Drug Enforcement Agency. The ORT should also have accreditation from the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), Committee for Accreditation (COA), and/or the Commission on the Accreditation of Rehabilitation Facilities (CARF). The ORT/OMT must meet the requirements of the Substance Abuse and Mental Health Administration.

H0021

H0021 Alcohol and/or drug training service (for staff and personnel not employed by providers)

Explanation

This code is used to report developing alcohol and/or drug service skills of staff and personnel that are not employed by an agency, such as training a counselor/clinician on proper techniques and approaches or sessions for clinicians on the effects of various types of drugs.

H0022

H0022 Alcohol and/or drug intervention service (planned facilitation)

Explanation

Alcohol and drug intervention services provide treatment services and activities that assist the professionally trained interventionalist to pursue and detect alcohol and or drug addictions and to intercede to halt the progress of the addictions. These services also include early interventions.

Correct Coding Initiative Update 32.3

❖Indicates Mutually Exclusive Edit

0362T 0403T, 0488T, 36591-36592, 96105-96110, 96125-96127, 96160-96161, 96523, 97152

0373T 0403T, 0488T, 36591-36592, 96105-96110, 96116, 96125-96127, 96523

0591T 0362T, 0373T, 0403T, 0469T, 0488T, 36591-36592, 90839, 90845, 92002-92014, 93000-93010, 93040-93042, 93792, 93793, 94002-94004, 94660-94662, 95851-95852, 96116, 96127, 96158-96159, 96164-96171, 96523, 97151, 97153-97172, 97802-97804, 99091, 99172-99173, 99174, 99177, 99202-99215❖, 99281-99285❖, 99304-99310❖, 99315-99316❖, 99341-99342❖, 99344-99350❖, 99446-99449, 99451-99452, G0250, G0270-G0271, G0380-G0384❖, G0444, G0459, G0463❖

0592T 0362T, 0373T, 0403T, 0469T, 0488T, 0591T, 36591-36592, 90839, 90845, 92002-92014, 93000-93010, 93040-93042, 93792, 93793, 94002-94004, 94660-94662, 95851-95852, 96116, 96127, 96164-96171, 96523, 97151, 97153-97172, 97802-97804, 99091, 99172-99173, 99174, 99177, 99202-99215❖, 99281-99285❖, 99304-99310❖, 99315-99316❖, 99341-99342❖, 99344-99350❖, 99446-99449, 99451-99452, G0250, G0270-G0271, G0380-G0384❖, G0444, G0459, G0463❖

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0820T 36591-36592, 96523

0821T No CCI edits apply to this code.

0822T No CCI edits apply to this code.

0889T No CCI edits apply to this code.

0890T No CCI edits apply to this code.

0891T No CCI edits apply to this code.

0892T No CCI edits apply to this code.

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