Coding & Documentation

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MENTAL HEALTH SCREENINGS

Q I administered both the PHQ-9 (screening for depression) and the GAD-7 (screening for anxiety) to a patient with a commercial health plan. What codes should I report?

A You should report CPT code 96127, "Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument," with one unit for each screening instrument completed, and be sure to document the instruments used and the scores obtained. Health plans using Medicare's National Correct Coding Initiative (NCCI) Medically Unlikely Edits will typically allow reporting of two units on the same date of service without a modifier, but distinct diagnosis codes should be linked to each service line.

Use screening diagnosis codes only if the assessment was purely preventive and not prompted by any signs or symptoms. For instance, use ICD-10 code Z13.31, "Encounter for screening for depression," when screening for depression in patients at least 12 years old without reported symptoms. This is a preventive service defined under the Affordable Care Act and covered by many health plans. On the other hand, if the assessment was given because the patient was showing signs of depression, you should use a diagnosis code that fits those symptoms, such as R45.3, "Demoralization and apathy," or R45.851, "Suicidal ideation."

ICD-10 code Z13.39, "Encounter for screening examination for other mental health and behavioral disorders," can be reported with CPT code 96127 when anxiety assessments are given to asymptomatic patients. But this is not currently a recommended preventive service and therefore may not be covered.

For patients showing signs of anxiety, a diagnosis code related to the symptoms should be reported instead, such as ICD-10 code R45.82, "Worries." Commercial payers may have different policies on coverage for behavioral health screenings, so check with payers in your area to find out what they cover and when.

REPORTING MULTIPLE MANAGEMENT SERVICES

Q Can you report providing both remote physiological monitoring treatment management and chronic care management services to the same patient in the same calendar month?

A Yes, as long as the time for each service is distinctly documented and all requirements for reporting are met. CPT instructs that code 99457, "Remote physiologic monitoring treatment management services, 20 minutes or more," may be reported in addition to chronic care management, transitional care management, or behavioral health integration services as long as the time of each service is distinct. However, CPT code 99091, "Collection and interpretation of physiologic data," is not reported in the same time period as chronic care management. Always check the reimbursement policies of individual health plans to determine if these services are separately paid by the plan.

TRANSFERRING PAPER NOTES TO THE MEDICAL RECORD

Q Can I write my visit notes on paper and have an employee make the entries in the electronic health record (EHR) after the visit?

A Yes. Your staff can transcribe from your paper record to the EHR. However, it is essential that you personally read the transcribed documentation and make any corrections or amendments and sign off on the documentation.

Your staff cannot enter under your log-in or sign the note for you. Ideally, your written note would also be scanned into the medical record to further support that your staff transcribed your documentation accurately.

It is also acceptable to dictate your note for a scribe to enter in the EHR during your visit. Payers may require scribes to note that they have entered the documentation and require you to sign off on the note stating that you have verified the accuracy of the scribe's documentation. FPM

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EDITOR'S NOTE

Reviewed by the *FPM* Coding & Documentation Review Panel. Some payers may not agree with the advice given. Refer to current coding manuals and payer policies.

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