



E/M 101: Preparing Your Organization for 2013 CPT Code Changes

December 3, 2012

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Today's Agenda

- > CPT Codes in 2013: Changes for Behavioral Health
Nina Marshall, MSW; Director of Public Policy, National Council
- > Readiness for New Compliance Requirements
Adam J. Falcone, Esq.; Partner, Feldesman Tucker Leifer Fidell
- > Using Evaluation and Management Codes
David R. Swann, MA, LCAS, CCS, LPC, NCC;
Senior Healthcare Integration Consultant, MTM Services
- > Payers in Transition
Yanick "Nicky" Hazlewood, Esq.
Vice President, Provider Contracting, OptumHealth
- > Additional Resources
- > Q&A



CPT Codes in 2013: Changes for Behavioral Health

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CPT Codes are:

> **Procedure codes**

Diagnostic Codes
Rates
Policy Decisions

> **Established by the AMA, with CMS**

Individual Payers

> **Reviewed annually**, although biggest changes to psychiatry section since 1998

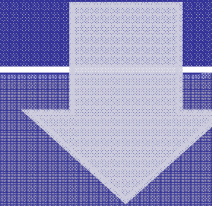
And tight timelines



Implementation of 2013 Changes

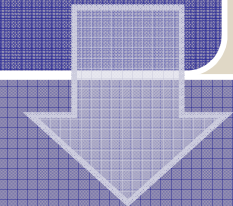
Code Changes

- Stakeholder input process
- Additions, deletions, modifications
- CMS approval and preliminary notification



Payer Valuation of Codes

- Independent decisions
- Often expressed in relation to Medicare rates
- For public agencies, may require regulatory changes



Provider and Other Stakeholder Preparation

- Alignment of HIT systems and charge sheets
- Amendments to contracts and provider agreements
- Documentation trainings for direct service providers and compliance staff



2013 and Behavioral Health Shift to Evaluation/Management

- > Removal of “combination codes” for psychotherapy and evaluation/management (90805, 90807)
- > Elimination of Medication Management codes in Psychotherapy section for providers who can use E/M codes for pharmacologic management

Additional changes:

- > New psychotherapy codes: time, place, number
- > Addition of codes for crisis services
- > Add-on codes for interactive complexity



Implementation on January 1, 2013

- > Effective date required under HIPAA
- > Implementation will not be formally delayed
- > Individual carriers are determining transition plans



Readiness for New Compliance Requirements

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Increased Scrutiny of Behavioral Health Organizations

- > Recoupments by New York's Office of Medicaid Inspector General (OMIG) in 2010:
 - \$2.1 million from 16 outpatient mental health providers
 - \$2.1 million from 15 outpatient chemical dependency providers
 - \$1.4 million from 3 inpatient chemical dependency providers
- > One substance abuse services provider had to pay back half of its Medicaid revenue in 2004 due to extrapolation of audit findings
- > OMIG has defined "abuse" as the failure to comply with professional standards for health care, medical necessity, medical records, and billing operations



Why is Proper Coding and Documentation Important?

1. Ensuring Management of Patient Care

- > Provides chronological history of patient's treatment and plan for care
- > Quality Assurance/Utilization Review
- > Peer Review/Case Conferences
- > Collection of Data for Research and Education



Why is Proper Coding and Documentation Important?

2. Impacts Upon Financial Performance

- > Ensures timely and appropriate payment of claims
- > Reduces denied claims
- > Undercoding can leave dollars on the table
- > Miscoding can result in financial penalties
- > Protects the organization in malpractice suits



Why is Proper Coding and Documentation Important?

3. Compliance with the Law

- > It's the law!
- > Significant penalties for false claims and failure to return overpayments
- > Laissez faire attitudes about improper coding may send message to employees that compliance is not important
- > Negative publicity can severely harm the organization's reputation among payers, regulators and patients
- > **BECAUSE YOU OWE IT TO YOUR PATIENTS!**



What Can You Do to Prevent Improper Coding?

- Educate Staff on Proper Coding, Billing and Data Capture
 - Most providers have not received formal coding training
 - Patient Access staff (e.g. registrars) require training on appropriate data capture
 - Billing staff require training on common billing guidelines by program
 - Training should include consequences of false claims submission
 - All training needs to be ongoing



What Can You Do to Prevent Improper Coding?

- ❑ Establish and Enforce Billing and Coding Policies and Procedures
 - Overcomes entrenched, improper practices
 - Formalizing policies and procedures ensures that no one staff person can leave taking all the knowledge with him/her
 - Should address all pertinent areas, such as:
 - Encounter Form Documentation
 - Staff Education and Training
 - Medical Necessity
 - Claims Review
 - Medical Record Retention
 - Third Party Billing Companies
 - Reporting of Overpayments
 - Auditing and Monitoring



What Can You Do to Prevent Improper Coding?

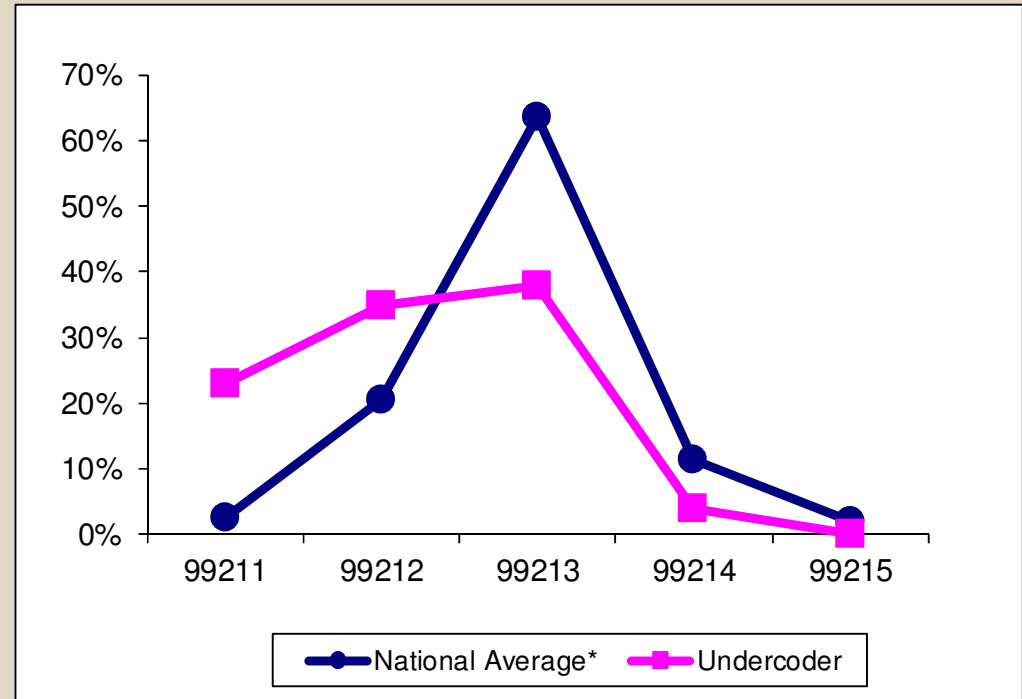
- Identify Specific Areas of Non-Compliance
 - Conduct internal audits
 - Ensure findings are documented, corrected and followed-up on/monitored in an ongoing way
 - Compare provider coding to national averages
 - Provide individual training to those who need it
 - Make other coding resources available to staff



How Can You Recognize Potential Improper Coding?

Graph the distribution of Evaluation and Management Codes and compare against national averages.

UNDERCODER



*Source: Ingenix, 2001

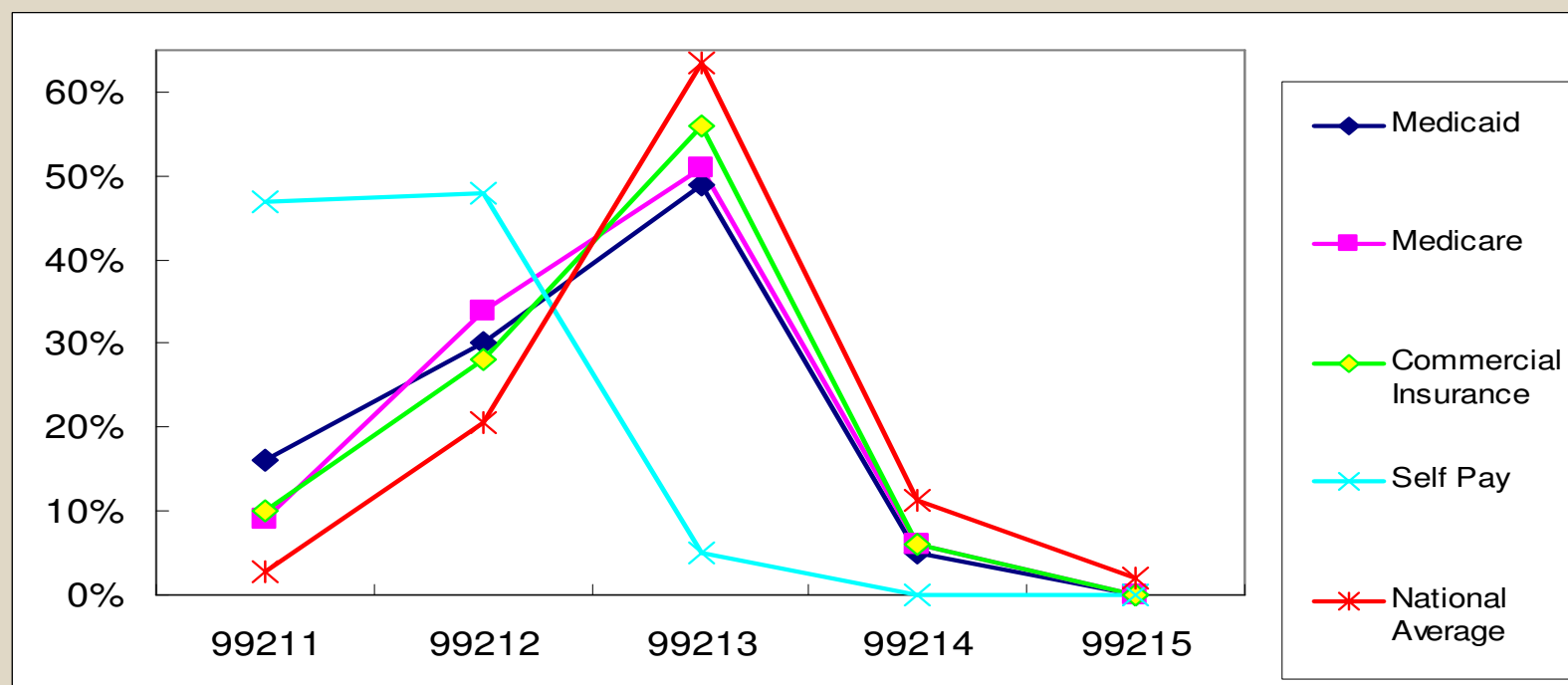
Established Patient Visits

E&M Codes	National Average*	Undercoder	
	% of Total	# Services	% of Total
99211	2.7%	2,300	23.0%
99212	20.6%	3,500	35.0%
99213	63.5%	3,800	38.0%
99214	11.3%	400	4.0%
99215	2.0%	-	0.0%

How Can you Recognize Improper Coding?

Perform Individual Payer Review

When depicted graphically, we can see that this organization is undercoding compared to the national average:





What Issues Should You Audit?

- > Improper coding
- > Unlicensed (or lapsed license) practitioner
- > Midlevel practitioner exceeding scope of license
- > No progress note or treatment plan
- > Missing signature on progress note or treatment plan
- > Services rendered do not match treatment plan
- > Time of service overlaps with other service rendered to same patient by different practitioner
- > Start and/or end time of session not recorded
- > Service not billable due to practitioner type
- > Employed or contracted “excluded” individual
- > Incorrectly identified practitioner on claim
- > Service not billable due to timeliness
- > Violation of Anti-Kickback Statute

What Do You Do If You Identify Wrongdoing?

- > If you discover irrefutable evidence of ongoing wrongdoing, take steps to cease the conduct immediately
 - Prevent on-going errors and violations – don't wait until the end of the investigation!
- > Investigate
 - Evaluate and plan
 - Gather the facts
 - Reach and report findings
 - Take corrective actions (if necessary)





Get it Right the First Time

- > Determine whether your State Medicaid program will cover new behavioral health CPT codes
- > Determine if your commercial payers will cover new behavioral health CPT codes
 - Review payer contracts to determine how “covered services” are described
 - Compare codes currently covered with those you will use after January 1, 2013
 - Contact payers to determine how they will pay for “covered services” that are not described under current codes



Behavioral Health Shift to Evaluation and Management Codes

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Evaluation/Management Codes

- > Psychiatrists, Physician Extenders, Nurse Practitioners and others who are licensed to perform medical activities must use E/M codes for services such as medication management
- > These codes are the same ones all physicians use for similar services, and use the numbers 99xxx
- > Documentation requirements are much more specific for these codes and require addressing various degrees of medical complexity
- > APA has a training program online for members in the use of these codes
- > Other mental health professionals do not use these codes



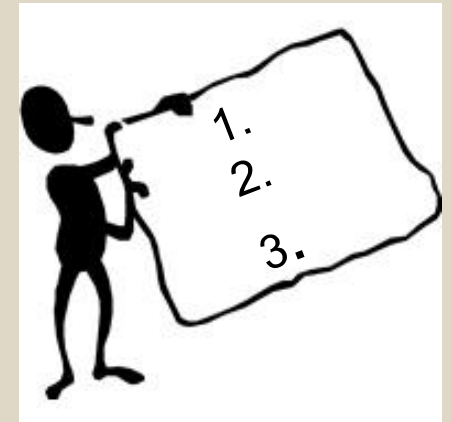
Evaluation/Management Codes, cont.

- > E/M codes, since they are a category of CPT codes, are comprised of five digits
- > E/M codes specifically begin with 99
- > E/M subsequent numbers depend on the type of E/M
 - A level 1 (last digit a 1) is the least complex
 - A level 2 (last digit a 2) is greater complexity
- > The highest code level will end in a 3 (an inpatient hospital admission), or a 5 (outpatient or consultations)

Code Selection for E/M

Each individual code listed has three components that qualify physicians to work for the specific code:

- 1) History
- 2) Examination
- 3) Medical Decision Making
(MDM)





Two Paths to E/M Selection

Path One

- Based on the **Elements** (History, Exam, and Medical Decision Making)

Path Two

- Basing the code on **Time** (Counseling and Coordination of Care).
- The only exception to this under the new 2013 criteria, if you are using an add on psychotherapy code, you cannot use time as the basis of selecting the code for the E/M portion of the work.



SELECTING E/M CODES

Path One



Based on the Elements



How To Select E/M Service Codes

- > Selecting code from proper category or subcategory, for example:
 - Office or Other Outpatient Services
 - New patient
 - Established patient
 - Hospital Inpatient Services
- > Selecting appropriate level of service
- > Supporting selection with documentation
- > Meets CPT definitions
- > Meets CMS Documentation Guidelines



How To Select E/M Service Codes

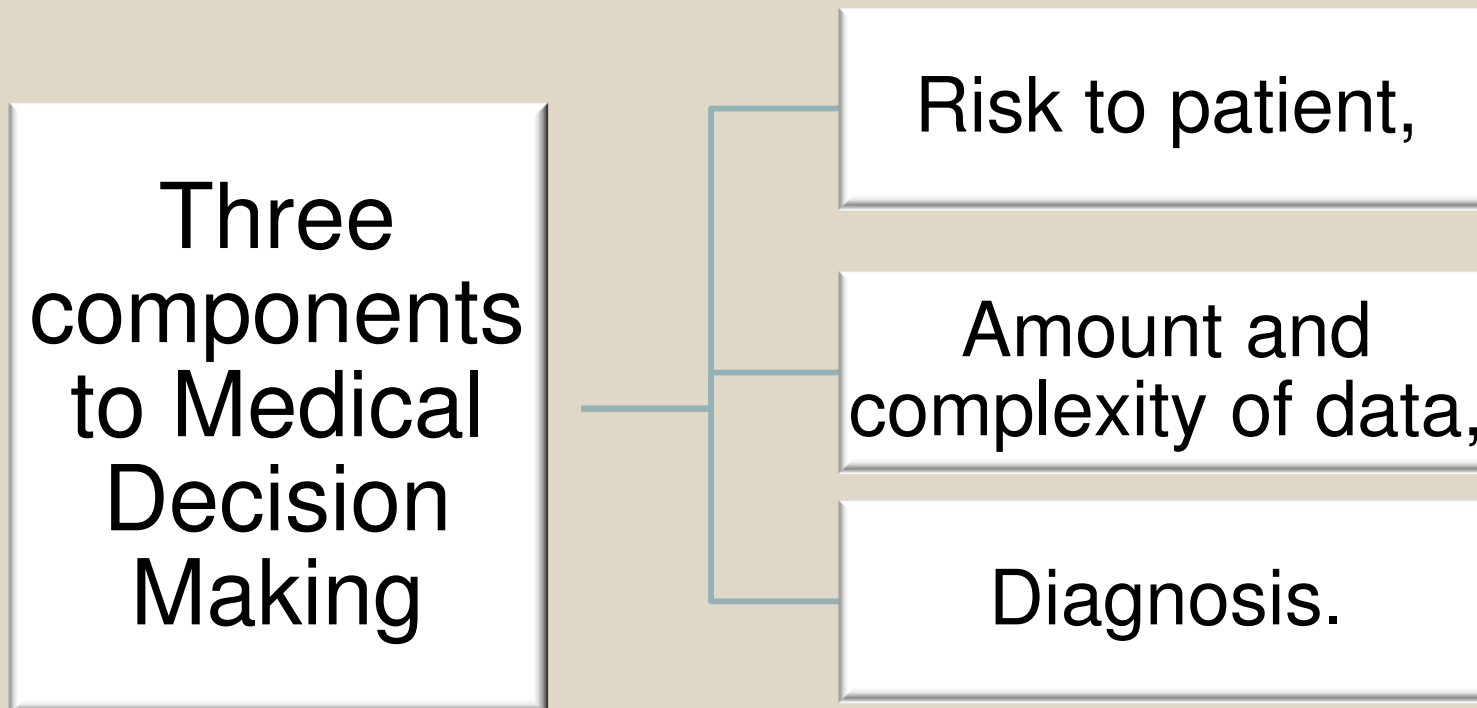
Includes services medically necessary to evaluate/tx the patient

Code selection must be supported by “work” and “medical necessity”

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code



Medical Decision Making



The complexity of MDM (straightforward, low, moderate or high) is determined by the lowest of the two highest components



Medical Decision Making

Case Example: Established patient with suicidal ideation and diagnosis of major depression.

Type of Medical Decision Making	Risk to Patient	Amount and Complexity of Data	Number of Diagnoses or Management Options
Straightforward	Minimal	Minimal or None	Minimal
Low Complexity	Low	Limited	Limited
Moderate Complexity	Moderate	Moderate	Multiple
High Complexity	High	Extensive	Extensive



Two highest components in this example.



Type of Medical Decision Making, because it's the lowest of the two highest components.



Evaluation/Management Levels

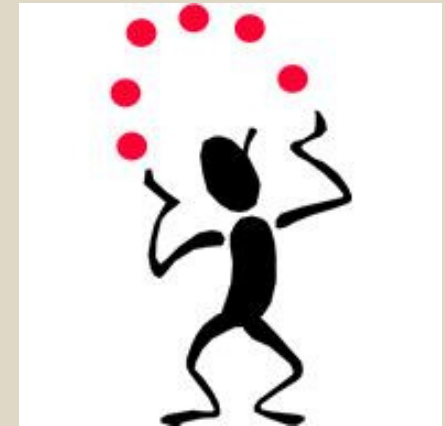
Level Of Exam

Problem Focused

Expanded Problem Focused

Detailed

Comprehensive





Major Changes – Psychotherapy and E/M Procedures

- > If patient receives medical E/M service and psychotherapy service on the same day by the same provider, report:
 - E/M code at the appropriate level AND
 - Psychotherapy add-on code (90833, 90836, 90838)

- > The two services must be significant and separately identifiable

- > A separate diagnosis is not required



Major Changes – Psychotherapy and E/M Procedures

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The two services must be significant and separately identifiable

A separate diagnosis is not required



Major Changes – Psychotherapy and E/M Procedures

- > Reporting both E/M and psychotherapy codes
 - Type and level of E/M is selected first based on the key components (history, exam, MDM)
 - Time may not be used as basis of E/M code selection
 - Psychotherapy service code based on time providing psychotherapy
 - Time providing E/M activities is not considered in selection of time-based psychotherapy code



Major Changes – Psychotherapy Procedures: Add-On Codes with E/M

- > When psychotherapy is done in the same encounter as an E/M service and by the same provider, there are timed add-on codes for psychotherapy
- > Add-on codes are indicated in CPT by the + symbol
- > Add-on psychotherapy codes are to be used by psychiatrists to indicate both services were provided (+90833 for 30 minutes, +90836 for 45 minutes, +90838 for 60 minutes). Each procedure can be with the patient and/or family member.
- > Both services must be separately identifiable



SELECTING E/M CODES

Path Two



Based on Time



E/M Codes and Time

Time shall be the key controlling factor used for the selection of the Level of the E/M Service when counseling or coordination of care dominates the encounter more than 50 percent EXCEPT when done in conjunction with a psychotherapy visit.



Counseling and E/M

When Discussing with the Patient or Family any of the following:

Prognosis

Test Results

Compliance/Adherence

Education

Risk Reduction

Instructions



E/M Outpatient Services: Codes & Time

NEW PATIENT VISIT TIME		ESTABLISHED PATIENT VISIT TIME		OFFICE CONSULTATION TIME	
CODE	MINUTES	CODE	MINUTES	CODE	MINUTES
99201	10	99211	5	99241	15
99202	20	99212	10	99242	30
99203	30	99213	15	99243	40
99204	45	99214	25	99244	60
99205	60	99215	40	99245	80



E/M New Patient Visit

Level	E/M Code	History	Exam	MDM	Time
1	<u>99201</u>	<u>Problem Focused</u>	<u>Problem Focused</u>	<u>Straightforward</u>	<u>10</u>
2	<u>99202</u>	<u>EPF</u>	<u>EPF</u>	<u>Straightforward</u>	<u>20</u>
3	<u>99203</u>	<u>Detailed</u>	<u>Detailed</u>	<u>Low</u>	<u>30</u>
4	<u>99204</u>	<u>Comprehensive</u>	<u>Comprehensive</u>	<u>Moderate</u>	<u>45</u>
5	<u>99205</u>	<u>Comprehensive</u>	<u>Comprehensive</u>	<u>High</u>	<u>60</u>



CPT E/M New Patient Definition

Solely for the purposes of distinguishing between new and established patients, professional services are those face to face services rendered by a physician and reported by a specific CPT code(s).

A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.



E/M Established Patient Visit

L e v e l	E/M Code	History	Exam	MDM	Time
1	<u>99211</u>	None	None	None	<u>5</u>
2	<u>99212</u>	<u>Problem Focused</u>	<u>Problem Focused</u>	<u>Straightforward</u>	<u>10</u>
3	<u>99213</u>	<u>EPF</u>	<u>EPF</u>	<u>Low</u>	<u>15</u>
4	<u>99214</u>	<u>Detailed</u>	<u>Detailed</u>	<u>Moderate</u>	<u>25</u>
5	<u>99215</u>	<u>Comprehensive</u>	<u>Comprehensive</u>	<u>High</u>	<u>40</u>



CPT E/M Established Patient Definition

An established patient is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past 3 years.

In the instance where a physician is on call for or covering for another physician, the patient's encounter will be classified as it would have been by the physician who is not available.



CPT E/M Consultation Definition

A service provided by a physician at the request of another physician or other appropriate source:

- To recommend care for a specific condition, or problem OR
- To determine whether to accept responsibility for the ongoing management of the patient's entire care or care of a specific condition or problem.



Case Examples

- > Dr. Smedley is providing medication check services to Ms. Jones. He spends 15 minutes with patient.
 - Code to report: **E/M 99212**
- > Dr. Smedley evaluates a new patient who does not speak English and he uses an interpreter.
 - Code to report: **Dx. Eval 90792 + 90785**
- > Dr. Smedley provides medication check services to Mr. Jones for 15 minutes and provides an additional 30 minutes of psychotherapy.
 - Code to report: **E/M 99212 + 90833 (30 min. add-on psychotherapy code)**



Pharmacological Management

- > Pharmacologic Management Code 90862 has been eliminated.
- > Psychiatrists must now use the appropriate E/M code for pharmacologic management when both psychotherapy and E/M is provided.
- > If reporting psychotherapy and E/M, pharmacologic management is considered part of E/M service
- > Do not count time of pharmacologic management in psychotherapy codes.
- > If providing only pharmacologic management, report only E/M service codes.
- > These changes will result in an increase use of E/M codes by psychiatrists.



Pharmacological Management – HCPCS Code

- > Healthcare Common Procedure Coding System Used by Medicare – HCPCS
- > **M0064** – Brief Office Visit for Monitoring or Changing Drug Prescriptions for the Treatment of Mental, Psychoneurotic, and Personality Disorders



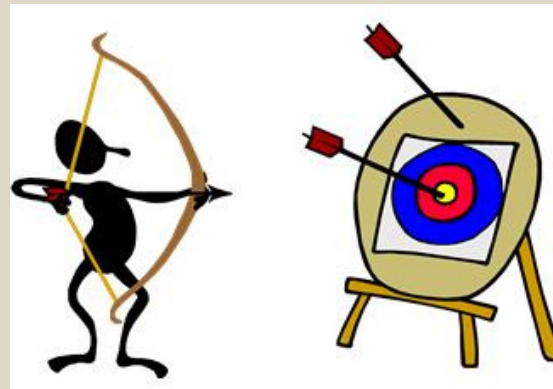
E/M CPT Behavioral Health Codes By Site

- > Subsequent Hospital Services (beyond initial)
99231-99233
- > New Nursing Facility Evaluations 99304-
99306
- > Established Nursing Facility 99307-99310
- > Nursing Facility D/C 99315-99316
- > New Patient Home Visit 99341-99345
- > Established Patient Home Visit 99347-99350

CPT Documentation – Getting it Right

Two sets of guidelines in place:

- > AMA's CPT Documentation Guidelines
- > CMS Documentation Guidelines





Documentation Guidelines

- > Use the guidelines that are designated by the payer.
- > The CMS Documentation Guidelines are used for most Medicaid (depending on the State) and all Medicare.



Documentation Guidelines

1997 Content & Documentation Requirements for Psychiatric Examination is recommended because of single organ systems.



Documentation Guidelines – **History:** Four Types

1. Problem-focused
2. Expanded problem-focused
3. Detailed
4. Comprehensive



Documentation Guidelines Components of History

- Chief Complaint (CC)
- History of Present Illness (HPI)
- Review of Systems (ROS)
- Past, Family, and/or Social History (PFSH)



Content and Documentation Requirements for **Psychiatric Evaluation***

LEVEL OF EXAM	PERFORM AND DOCUMENT
Problem Focused	1-5 Elements Identified by a Bullet
Expanded Problem Focused	At least 6 Elements Identified by a Bullet
Detailed	At least 9 Elements Identified by a Bullet
Comprehensive	Perform all Elements by a Bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.
<p>Reference: CMS Documentation Guidelines for E/M Services – 1997 Pages 39-40</p>	



Selecting and Documenting the Level of Medical Decision Making

Base Level of MDM on two of the three areas

Level of MDM	# Diagnoses of Management Options	Amount of/or Complexity of Data to Be Reviewed	Risk of Complications and/or Morbidity of Mortality
Straightforward	Minimal	Minimal or None	Minimal
Low Complexity	Limited	Limited	Low
Moderate Complexity	Multiple	Moderate	Moderate
High Complexity	Extensive	Extensive	High



Documenting Medical Decision Making

> Documentation should indicate:

- Assessment, impression, diagnosis
- Status of established diagnosis
- Differential dx, probable, etc. for undiagnosed
- Initiation/changes in treatment
- Referrals, requests, advice



Documenting Medical Decision Making

> Documentation should indicate:

- Type of tests
- Review and findings of tests
- Relevant findings from records
- Discussion of test results
- Direct visualization of specimen, images, etc.



Documenting Medical Decision Making

> Documentation should indicate:

- Co-morbidities/underlying conditions
- Type of surgical or invasive procedure
- Referral for or decision to perform procedure on an urgent basis



Outpatient E/M for New Patient

New Patient	99201	99202	99203	99204	99205
HISTORY					
Chief Complaint	Required	Required	Required	Required	Required
History of Present Illness	1-3 Elements	1-3 Elements	4 + Elements	4+ Elements	4+ Elements
ROS*	NA	Pertinent	2-9 Systems	10-14 Systems	10-14 Systems
PFSH**	NA	NA	1 of 3 Elements	3 of 3 Elements	3 of 3 Elements
PHYSICAL EXAMINATION					
1997 CMS Doc. Guidelines	1-5 Bulleted Elements	6-8 Bulleted Elements	9 or More Bulleted Elements	Comprehensive	Comprehensive
MEDICAL DECISION MAKING					
	Straight Forward	Straight Forward	Low	Moderate	High
TIME					
Face-to- Face	10 min	20 min	30 min	45 min	60 min



Outpatient E/M for Established Patients

Estab. Patient	99211	99212	99213	99214	99215
HISTORY					
Chief Complaint	NA	Required	Required	Required	Required
History of Present Illness	NA	1-3 Elements	1-3 Elements	4+ Elements	4+ Elements
ROS*	NA	NA	Pertinent	2-9 Systems	10-14 Systems
PFSH**	NA	NA	NA	1 of 3 Elements	2 of 3 Elements
PHYSICAL EXAMINATION					
1997 CMS Doc. Guidelines	NA	1-5 Bulleted Elements	6-8 Bulleted Elements	9 or more Elements	Comprehensive
MEDICAL DECISION MAKING					
	NA	Straight Forward	Low	Moderate	High
TIME					
Face-to- Face	5 min	10 min	15 min	25 min	40 min



Beyond E/M: Additional Changes to Behavioral Health Codes

- > Addition of an add-on code for “interactive complexity”
- > New codes for psychotherapy for a patient in crisis
- > All psychotherapy codes to be reported in all settings without regard to site
- > Hospital care for psychiatric inpatient or partial hospitalization may be reported using E/M codes (99221-99233) Site Specific
- > If services such as ECT or psychotherapy are provided in addition to hospital E/M services, both E/M and other service can be reported.



Interactive Complexity

- > Add-on code for interactive complexity which may be used when the patient encounter is made more complex by the need to involve people other than the patient (+90785).
- > +90785 Interactive complexity
- > Add-on code to be reported with:
 - Diagnostic Evaluations (90791-90792)
 - Psychotherapy (90833-90838)
 - Group Psychotherapy (90853)
 - E/M codes (99201-99255; 99304-99377;99341-99350) when E/M provided in conjunction with psychotherapy



Interactive Complexity

- > Refers to specific communication factors complicating delivery of psychiatric service
- > Common factors include:
 - Discordant or emotional family members
 - Young and verbally undeveloped
 - Impaired patients



Interactive Complexity – Conditions

- > Factors typically present with patients who:
 - Have others legally responsible for their care
 - Request others to be involved in care during visit
 - Require the involvement of other third parties



Interactive Complexity – Requirements

Code can be reported when **at least one** of the following is present:

Need to manage maladaptive communication that complicates care delivery

Caregiver's emotions or behaviors interferes with ability to assist in treatment plan

Evidence or disclosure of sentinel event and mandated report to state agency with initiation of discussion of event and/or report

Use of play equipment, or other physical devices, interpreter, or translator for communication with patient



Interactive Complexity

Time spent on Interactive Complexity service is to be reflected in time of psychotherapy code reported

Interactive Complexity service is not a factor for selecting E/M code except as it affects key components



Psychotherapy for Crisis

- > A new code has been added for psychotherapy for a patient in crisis (90839)
- > 90839 is used to report the first 30-74 minutes of psychotherapy for crisis on a given date
- > When a crisis encounter goes beyond 74 minutes there is an add-on code for each additional 30 minutes (+90840)
- > Time does not have to be continuous
- > Must be face-to-face with patient and/or family
- > Provider must devote full attention to patient; cannot provide services to other patients during time period



Psychotherapy for Crisis Services

Codes for crisis services cannot be reported in combination with:

- 90791, 90792 (diagnostic services)
- 90832-90838 (psychotherapy)
- 90785 (interactive complexity)



Psychotherapy for Crisis Services

Presenting problem typically life-threatening or complex and requires immediate attention to a patient in high distress

Codes include:

- Urgent assessment and history of crisis state
- Mental status exam
- Disposition



Psychotherapy for Crisis Services

- > Treatment includes:
 - Psychotherapy
 - Mobilization of resources to diffuse crisis and restore safety
 - Implementation of psychotherapeutic interventions to minimize potential for psychological trauma



Crisis Services: Example

- > 90839 (60 min) used for first 30-74 minutes
- > Reported only once per day
- > 90840 (each additional 30 min) report for up to 30 minutes each beyond 74 minutes
- > Example: 120 min of crisis therapy reported:
 - 90839 X 1
 - 90840 X 2
- > Less than 30 minutes reported with codes 90832 or 90833 (psychotherapy 30 min)

Revenue Cycle Management



**Admission Eligibility
Authorization
Verification
Open to Schedule**



**Treatment
Co-Pay Collections
Post Session
Scheduling**



**Post Discharge
Account Receivable
Management
Billing
Cash Posting
Consumer Follow-Up**





Revenue Cycle Management

- > A greater understanding of cash flows and management of billing practices will be needed in the new environment
 - How long is your billing process?
 - Are you billing weekly?
 - Can you process third party claims daily?
 - What is your percent of denials?
 - What is your performance standard on reconciliation of billing errors?
 - What percent of co-pays and self pay amounts are you collecting daily
 - Do you establish a daily collection figure for your front desk?



Pre-Visit

1. Contract management
2. Patient Scheduling
3. Medical Necessity
4. Eligibility/Benefits Management
5. Registration
6. Point of Service



Visit

1. Collection of Co-Pays
2. Clinical Care Documentation
3. Charge capture
4. Coding
5. Utilization Management



Post visit

1. Billing
2. Collections Management
3. Denial Management
4. Data Warehouse Analytics

Presented By: MTM Services



Considerations

1. Many issues can impact coding and billing for behavioral health services:
 - Payer
 - Type of Provider
 - Specific Services (CPT, HCPCS)
 - Business Relationships between providers
 - Reporting Methodology
2. You must consider each of these areas when billing for integrated care services



Basics of Reimbursement

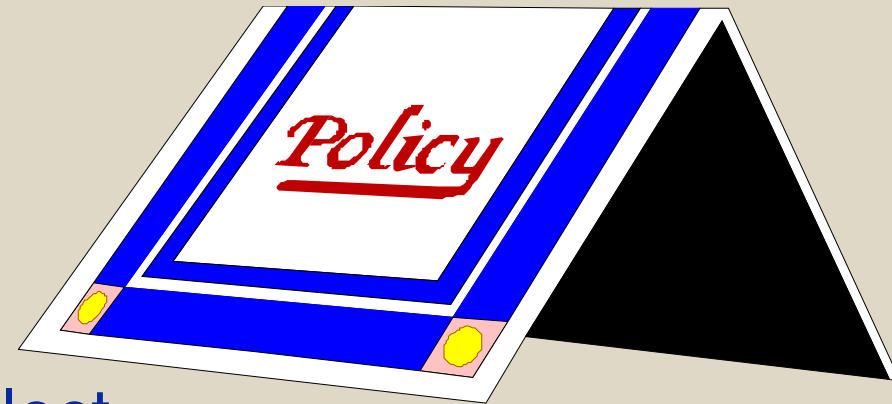
> Services must be:

- Covered
- Medically necessary
- Coded correctly and supported by the documentation in the medical record



Covered Services

- Payable within the patient's benefit plan
- A single payer may have numerous benefit plans
- Patients and/or employers select
- Government payers have own guidelines





Medically Necessary Services-AMA

- > American Medical Association's (AMA) Model Managed Care Contract definition of Medical Necessity:
- > “Health care services or procedures that a *prudent physician would provide to a patient* for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is:



Medically Necessary Services-AMA, cont.

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate in terms of type, frequency, extent, site and duration; and
3. Not primarily for the economic benefit of the health plans and purchasers or the convenience of the patient, treating physician, or other health care provider.



Medically Necessary-CMS

- The Center for Medicare and Medicaid (CMS) defines medically necessary services as those that are *“reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member”*
- In short, services must be clinically appropriate for the patient’s condition



Payers in Transition

Yanick Hazlewood, Esq.
Vice President, Provider Contracting
OptumHealth Behavioral Solutions

www.optumhealth.com

www.providerexpress.com



Optum, Preparing for 2013

> WHO

- One of the largest behavioral healthcare companies in the country with a diverse customer base — small businesses, Fortune 100 companies, health plans, universities, public sector entities
- Each member has distinct needs and priorities.
- OptumHealth has a robust network of individual practitioners, group practices and facilities.



Optum, Preparing for 2013, cont.

- > **WHAT** are some of the challenges Optum is encountering to assure compliance with the 2013 CPT code changes?
 - Setting up our clinical and claim system platforms
 - Preparing provider communications
 - Developing and implementing a provider communication campaign - let's get the word out!
 - Provider readiness
 - Internal training



Optum, Preparing for 2013, cont.

- > **WHERE** can you find Optum information related to the 2013 CPT code changes?
 - www.providerexpress.com
- > **WHEN** will Optum send out formal notices?
 - On or before December 10, 2012
- > **HOW** will Optum providers be notified?
 - By mail, email or fax



Resources

- > AMA Code Book www.amabookstore.com or 1-800-621-8335
- > [National Council webpage](#) dedicated to the CPT changes with resources such as:
 - 2012-2013 Crosswalk
 - Frequently Asked Questions
 - Free training resources
 - Information on rate-setting
- > *Compliance Watch*, new CPT series
 - www.TheNationalCouncil.org/CS/Compliance_Watch_Newsletter



Resources

- > Center for Medicare and Medicaid Services (CMS)
<http://www.cms.gov/Medicare/Medicare.html?redirect=/home/medicare.asp>
- > American Psychiatric Association
<http://www.psych.org/practice/managing-a-practice/cpt-changes-2013>
- > 1997 Documentation Guidelines for Evaluation and Management Services
<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf>



2013 National Council Conference

April 8 – 10, 2013

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3000



ATTENDEES



Q&A

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National Council

CPT Resource Page: www.TheNationalCouncil.org/CS/CPT_Codes
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