CPT Code Use & Validation

Abstract

In 2019, CMS introduced two CPT codes to support its Behavioral Health Strategy to improve access to and quality of mental health care services for senior Americans. The objective for the use of these codes "*is to increase the detection, effective management, and recovery of mental health conditions through coordination and integration between primary and specialty care providers.*"

CMS recognized that 30 million more Baby Boomers would be entering Medicare over the next decade, and the costs to support these individuals were projected to increase its budget by over 35%. This demographic was living longer and experiencing increased mental and behavioral health issues, impacting their physical health. These senior citizens were not getting the proper mental and behavioral health evaluation and were unlikely to see psychologists, psychiatrists, and other behavioral health specialists. As a result, CMS introduced codes 96130 and 96132 to allow non-psych providers to increase the detection of psychiatric and neuropsychiatric disorders to support its Behavioral Health Strategy. These codes were intentionally created as non-psychiatric codes (90- codes) to allow PCPs and specialty care providers to identify patients who may require behavioral and mental health care and refer them out to the appropriate providers and services.

These codes are particularly applicable to physicians and providers who see patients with chronic pain, as there is an extremely high rate of comorbidity of severe depression among seniors with chronic pain. This demographic also has the highest rate of suicide in the United States, and the lethality of their suicides is over 400% higher than all other demographics combined.

Although these CPT codes could benefit patients and support CMS's Behavioral Health Strategy and Value-Based Medicine, the challenge for providers was implementing these codes into their practice effectively and meeting all CMS guidelines without increasing their costs. The Behavioral Response Evaluation (BRE) program was created to allow providers to implement a profitable comprehensive mental and behavioral health assessment strategy in their practices without the use of their staff.

CPT Code Descriptors and Use

The CPT codes used in the Behavioral Response Evaluation program include:

G0444 - Annual Depression Screening. The diagnostic instrument used is the depression module of the Patient Health Questionnaire (PHQ). The PHQ-9 scores each of the 9 DSM-IV criteria as “0” (not at all) to “3” (nearly every day). The BRE Clinical Case Manager (CCM) administers the PHQ-9 with the patient in a one-on-one interaction. The 15-minute time requirement for G0444 is met by the CCM, who administers the PHQ-9, records the patient's responses, and generates a comprehensive report with patient scores according to the instrument's guidelines. Note: G0444 can only be billed and reimbursed once per year for each patient. If a PCP had already administered an annual depression screening on a patient, the practice will not be reimbursed. However, BRE does not charge clients for the administration of the PHQ-9, but uses the instrument as part of the patient's overall mental health profile for clinical assessment by the provider.

G0396 - Medication and Opioid/Substance AbuseDisorder Screening. Substance abuse structured assessment (non-alcohol). The diagnostic instrument used is The Pain Medication Questionnaire (PMQ-R), which assesses the patient for medication abuse and misuse, including opioids. The BRE Clinical Case Manager (CCM) administers the PMQ-R with the patient one-on-one. The 15-minute time requirement for G0396 is met by the CCM, who administers the PHQ-9, records the patient's responses, and generates a comprehensive report with patient scores according to the instrument's guidelines.

CPT Codes

96130 - CPT Code 96130 is defined as "psychological testing evaluation services by physician or other qualified healthcare professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision-making, treatment planning, and reporting, and interactive feedback to the patient, family member or caregiver, when performed; first hour." The minimum time that can be spent and still bill CPT 96130 is 31 minutes (1/2 the defined time plus one minute: 1 Hour / 2 + 1 = 31 minutes).

The diagnostic instrument used is the Center for Epidemiologic Studies Depression Scale-Revised. This CMS-approve questionnaire was developed in 1977 depressive symptoms severity in the general population.

The time required to bill 96130 includes the integration of patient data, interpretation of standardized test results and clinical data, clinical decision-making, treatment planning and reporting, and face time with the patient. Face time with the patient must include interactive feedback to the patient, family member, or caregiver. The fulfillment of the required time includes all of the supporting staff working under the direct supervision of the billing provider in the execution of the requirements for 96130. This is comparative to the fulfillment of the time requirements for CPT Codes used for E&M encounters, such as 99213/99214. Much of this is accomplished with the integration of patient data. For example, the Provider makes a clinical decision to have the patient perform psychological testing and creates a referral order for the patient. That referral order is documented in the practice EMR and then sent to BRE for patient assessment by the CCM, who works under the provider's supervision. The CCM then needs to coordinate the time to assess the patient with the practice's patient schedule. Once the patient is assessed, the CCM creates an electronic copy of the test results and sends it to the practice so it can be input into the patient record in the practice EMR for interpretation, clinical decision-making, treatment planning, and discussion with the patient. Below is an example of the time elements that support 96130.

• Clinical evaluation/decision to have the patient perform psychological testing	2-4 mins
• Creating the associated referral order	2-3 mins
• Submission of order to BRE	2-3 mins
• Downloading and documentation of referral order by BRE	4-7 mins
• Cross referencing the patient order with the appropriate patient schedule in EMR	4-7 mins
• Scheduling patient call for testing	4-7 mins
• Sending patient testing data electronically to the practice and uploading into EMR	4-7 mins
• Review of patient testing data by the Provider and interpretation of results	5-7 mins
• Formulation of a treatment plan for the patient	5-7 mins
• Discussion with patient and/or family member/caretaker on a recommended treatment plan	3-10 mins
• Documentation of above in EMR	2-4 mins
Total Time	**36-64 mins**

96130 is a repetitive use code, meaning CMS does not have a restriction on the number of times the code can be used on a patient. CMS and other commercial Medicare plans support the psychological testing of high-risk patients on a monthly basis. Even commercial Medicare plans that require prior authorizations will approve the patient for monthly testing for the remainder of the calendar year. The CMS-approved assessments used in the BRE program are intentionally repetitive to see changes in responses over time. It is recommended that seniors with chronic pain be assessed monthly for the first year. This is particularly relevant for any patients on medication management. After the first year, if the patient is well-managed and the provider feels confident in their mental/behavioral health, you can move to bi-monthly or quarterly. One trigger event can skew patient results that you might otherwise not know, thus the need for frequency and repetitiveness.

CPT CODES - *Continued*

96132 - CPT Code 96132 is defined as "neuropsychological testing evaluation services by physician or other qualified healthcare professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision-making, treatment planning, and reporting, and interactive feedback to the patient, family member or caregiver, when performed; first hour." The minimum time that can be spent and still bill CPT 96132 is 31 minutes (1/2 the defined time plus one minute: 1 Hour / 2 + 1 = 31 minutes).

The diagnostic instrument used is the General Practitioner assessment of Cognition (GPCOG). This CMS-approve questionnaire was developed in 2002 as a screening tool for cognitive impairment. It was specifically developed for use in primary care and specialty care settings to be administered by a non-psych provider.

The time required to bill 96132 includes the integration of patient data, interpretation of standardized test results and clinical data, clinical decision-making, treatment planning and reporting, and face time with the patient. Face time with the patient must include interactive feedback to the patient, family member, or caregiver. The fulfillment of the required time includes all of the supporting staff working under the direct supervision of the billing provider in the execution of the requirements for 96130 This is comparative to the fulfillment of the time requirements for CPT Codes used for E&M encounters, such as 99213/99214. Much of this is accomplished with the integration of patient data. For example, the Provider makes a clinical decision to have the patient perform psychological testing and creates a referral order for the patient. That referral order is documented in the practice EMR and then sent to BRE for patient assessment by the CCM, who works under the provider's supervision. The CCM then needs to coordinate the time to assess the patient with the practice's patient schedule. Once the patient is assessed, the CCM creates an electronic copy of the test results and sends it to the practice so it can be input into the patient record in the practice EMR for interpretation, clinical decision-making, treatment planning, and discussion with the patient. Below is an example of the time elements that support 96132.

• Clinical evaluation/decision to have the patient perform psychological testing	2-4 mins
• Creating the associated referral order	2-3 mins
• Submission of order to BRE	2-3 mins
• Downloading and documentation of referral order by BRE	4-7 mins
• Cross referencing the patient order with the appropriate patient schedule in EMR	4-7 mins
• Scheduling patient call for testing	4-7 mins
• Sending patient testing data electronically to the practice and uploading into EMR	4-7 mins
• Review of patient testing data by the Provider and interpretation of results	5-7 mins
• Formulation of a treatment plan for the patient	5-7 mins
• Discussion with patient and/or family member/caretaker on a recommended treatment plan	3-10 mins
• Documentation of above in EMR	2-4 mins
Total Time	**36-64 mins**

96132 is a repetitive use code, meaning CMS does not have a restriction on the number of times the code can be used on a patient. CMS and other commercial Medicare plans support the psychological testing of high-risk patients on a monthly basis. Even commercial Medicare plans that require prior authorizations will approve the patient for monthly testing for the remainder of the calendar year. The CMS-approved assessments used in the BRE program are intentionally repetitive to see changes in responses over time. It is recommended that seniors with chronic pain be assessed monthly for the first year. This is particularly relevant for any patients on medication management. After the first year, if the patient is well-managed and the provider feels confident in their mental/behavioral health, you can move to bi-monthly or quarterly. One trigger event can skew patient results that you might otherwise not know, thus the need for frequency and repetitiveness.

CPT CODES - *Continued*

96138 - CPT Code 96138 is defined as "Psychological and neuropsychological test administration and scoring by a technician, two or more tests, any method, first 30 minutes."

The fulfillment of the requirements of 96138 are performed by the BRE Clinical Case Manager (CCM), who works under the direct/indirect supervision of the referring provider. Although the CCM is not required to be a QHCP, many of BRE's CCMs are CNAs, RNs, LPNs, and LVNs with a geriatric care background. Although CCMs do not diagnose or prescribe patient treatment, having geriatric care experience is valuable when working with senior chronic pain patients who are depressed. BRE hires CCMs specific for each practice so the patient speaks to the same person each month.

The CCM administers the CESD-R, GP-COG, PMQ-R, and a suicide ideation assessment with the patient one-on-one over the phone. The minimum time that can be spent and still bill CPT 96138 is 16 minutes (1/2 the defined time plus one minute: 30 minutes / 2 + 1 = 16 minutes). The minimum time is easily exceeded with the administration of the assessment tools indicated above, and often the 30 minutes is exceeded, in which case CPT code 96139 can be added.

BILLING

The CPT Codes used in the BRE program (96130, 96132, 96138, G0396 & G0444) must be billed in conjunction with a qualifying E&M patient visit. The ICD-10 codes used do not have to be mental health-related (Codes beginning with F). They can be dx codes for conditions/symptoms comorbid to mental health conditions, which are prevalent in the patient population of pain management practices. In pain management specialties, the ICD-10 codes used are the patient's primary diagnosis as charted by the provider for the E&M visit. This would also include any BH or medication-related codes already included in the patient's medical dx. (example: F11.90 opioid use). The ICD-10 codes used are the patient's primary diagnosis as charted by the provider for the E&M visit. Example:

05/20/2020	Follow Up on chronic low back pain	Chronic Pain, Other (G89.29) Hip Pain (M25.559) Lumbar Radiculopathy (M54.16) High Risk Medication Monitoring Narcotics (Z79.891) Spinal Stenosis, Lumbar, Without Neurogenic Claudication (M48.061) Chronic Low Back Pain (M54.51)	Final

When 96130, 96132, 96138, G0396, and G0444 are billed with an E&M code, the E&M code should be billed first with a modifier 25. 96130, 96132, 96138, G0396, and G0444 should be billed last with a modifier 59.

When billing for multiple services on the same date or the same encounter, you may be required to document the medical necessity of performing separate, non-overlapping test administration, scoring, and/or evaluation services in close proximity with other services (e.g., health behavior assessment or reassessment), over and above the medical necessity of the assessments themselves. Note that the latest CPT code guidelines recognize that test evaluation includes time spent by doctors aside from in-person sessions with patients. Time spent reviewing patient information, choosing tasks to use, and documenting the test results are part of test evaluation. The NCCI and many insurers have recognized that these steps billed using code 96132 may take place over several days (see the APA's guidance for more detail), and most of our clients have billed for the code on the date of the final activity.

BILLING - *Continued*

Aside from direct reimbursement for an assessment, BRE can play a key role in making billing easy, such as:

- Providing a report that documents the results of an assessment, as well as metadata such as the time an assessment was administered for easy documentation in an EHR or future reference.
- Generating easy-to-read reports that aid in the interpretation of standardized results, interactive feedback with the patient, clinical decision-making, and treatment planning, all of which fall under the time billed for CPT codes 96130/32.
- Complementing other assessment results in order to aid in the diagnosis, thereby proving medical necessity for other services that may be billed during the same session or at a later date.
- Combining mental health assessments for depression and anxiety in the same platform as cognitive assessments so that mental health questionnaires can justify the need for cognitive testing.

COMPLIANCE

The CPT codes used in the BRE program have been successfully billed and reimbursed by Medicare and commercial Medicare payers over half a million times without incident. The BRE program's use of the codes and implementation of the program meets and exceeds CMS requirements for documentation and fulfillment. In many cases, Medicare or a commercial Medicare Payer has requested documentation on the use of these codes prior to payment (RFDs). In every instance, the reimbursements were promptly processed. We have had many clients go through a variety of audits by CMS (RAC, Integrity, Post-Payment). Other than Post-Payment Audits, the other audits were generated for reasons unrelated to these codes; however, these codes were part of the audit process and always met CMS requirements. This is due to BRE's strict adherence to CMS policies and the fact that our program does not allow for misuse or abuse of the related CPT codes.