

Coding Tips for Behavioral Health Visits

This document is not intended as coding education, but rather tips that have worked for our primary care practices and partners. For further information, please refer to the American Academy of Pediatrics (AAP) or the American Academy of Family Physicians coding resources. As always, if it is not documented, it was not done.

Billing for Standardized Screening: CPT 96127 (with Modifier 59)

When you perform a standardized screening such as the PHQ-A or PHQ-9, you should bill for it. This can be used whether you are using it with a well or evaluation and management (E&M) code for the visit.

- CPT 96127: Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/hyperactivity disorder scale), with scoring and documentation, per standardized instrument.

2021 E&M Visit Coding Guidelines

The new coding guidelines allow you to choose your E&M level based on time or based on medical decision-making (MDM). There are advantages to both, depending on the situation.

Time:

The time included in choosing your level includes all time spent by the provider (not staff time) on the day of service – preparing for the visit, time with the patient, time completing your note or time reaching out to another healthcare provider (the Virginia Mental Health Access Program, for example).

- The AAP recommends a statement in your plan that reads, “I personally spent a total of X minutes in patient care on the date of this encounter, regarding the following”

CPT Code	TIME	CPT Code (new pt.)	TIME (new pt.)
99214	30 – 39 minutes	99204	45 – 59 minutes
99215	40 – 54 minutes	99205	60 – 74 minutes

CPT 99417 (Bill with 99215 When Using Time)

Capture each 15 minutes of necessary provider work >54 minutes by billing number of units of 99417. It can be face-to-face or non-face-to-face work, but it must be on the same day of the visit.

MDM:

The three elements of MDM are:

- Problem number/complexity
- Data amount/complexity reviewed or analyzed
- Risk of complications

Two-thirds of MDM elements are used to determine level of service. See mdm2021.com for an excellent tool.

Diagnosis of moderate to severe depression or suicidality meets criteria for level 99215, based on complexity of problem and risk of complication of patient management. Some visits, and possibly some follow-up visits, may be a level 4 visit, based on the status of the patient.

The Well Visit (Screening for Mental Health):

- Always bill for all screenings performed at well visit (96127)
 - If moderate to severe depression or suicidality is discovered, consider:
 - Changing the well visit code to an E&M visit (99215) and bringing patient back for a well visit at another time
 - If the patient is safe, opt to bring the patient back in person or by telemedicine for a follow-up visit within a few days
 - Adding modifier 25 for both sick and well visits – must notify family that they will get a copy and must document all components of the well visit as well as assessment/plan for the behavioral health visit
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The codes below are beyond the scope of this document and will require additional research if you decide to use them.

CPT 99452: Interprofessional Phone/Internet/EHR

- Consultation for assessment or management (billed by treating primary care physician, NP, PA)
- Requires verbal consent from the patient, documented in the chart
- 16 – 30 minutes of time (low RVU value for 30 minutes of time)
- Can be used on a different day than the visit
- May not be reported more than once in a 14-day period

CPT 99491: Care Coordination

This is a way to bill for care coordination over a month. It is time spent on the patient's care outside of an office visit. Care coordination is expected to take at least 30 minutes per calendar month, if patient has multiple chronic conditions expected to last at least 12 months.

- Can be staff – hospital follow-up, coordination with insurance, care planning and referrals
- Must document time – ours are done in our phone notes or inside our care coordination order, but make sure to pick a single place to document so that you can easily count the time
- Requires consent from the patient every 30 days for Medicaid (varies by payor)
- Must review regulations by payer, but the code may be useful for Medicaid, especially if you have someone who serves as a care coordinator