Mental Health Guidance on Workload Capture
Primary Care-Mental Health Integration (PC-MHI)

Background

Veterans Health Administration (VHA) facilities utilize a variety of software packages to capture outpatient and inpatient delivery of care, including outpatient encounters, inpatient appointments in outpatient clinics, all inpatient professional encounters not captured elsewhere and all inpatient mental health professional services. Accurate capture of workload informs budget allocation models (i.e. VERA) and is necessary for mental health provider productivity metrics that may help identify where staff shortages exist relative to the workload being generated.

All encounter data must pass or be transferred into Patient Care Encounter (**PCE**), and ultimately into the National Patient Care Database (NPCD). Use of electronic encounter forms and documentation templates were mandated in May 2003. These encounter forms and templates meet compliance criteria and if used, help to avoid omission of appropriate information which supports quality documentation and coding. VHA information systems were modified in January 2005 to enable the transmission of all encounters (**Inpatient and Outpatient**) from PCE to the NPCD (or current data warehouse).

VHA Directive 1082, **PATIENT CARE DATA CAPTURE,** requires the capture of all outpatient encounters, billable inpatient appointments in outpatient clinics, and **all inpatient (including MH RRTPs) billable encounters** not captured elsewhere. This Directive expanded current policy for patient care data capture by including the capture of all inpatient mental health professional services. It can be found at VHA Directive 1082.

KEY TERMS

Veterans Equitable Resource Allocation (VERA)

The Veterans Equitable Resource Allocation (VERA) model is used to allocate VHA General Purpose funds to the Veterans Integrated Service Networks (VISN's) in VHA. The underlying data components of the VERA Model rely on comprehensive data systems that track and analyze the many management information systems used in VHA health care administration. Historically, at least 90% of the funds allocated by the VERA Model are directly attributed to patient care practice. All workload that is appropriately documented and successfully transmitted to Austin is accounted for in the VERA Patient Classification process, which is the official data source for funding patient care practices in VHA.

See the VERA link for more information on the Patient Classification process on the **VERA 2016 Patient Classification Handbook**

Two changes in VERA for 2016 impact mental health. First, the bed days of care (BDOC) for the Residential Rehabilitation patient class in Price Group 8 is reduced to a minimum of 41 , but less than 84, BDOC for all residential treating specialties. Second, Substance Abuse patient class (51) in Price Group 9 is renamed Substance Abuse/Extensive Residential Rehab, and will include patients with 84 or greater BDOC, or 84+ BDOC with a qualifying Substance Abuse diagnosis code.

Stop Codes

Stop Codes (formerly known as DSS Identifiers) are built into each clinic and identify workload for all outpatient encounters, inpatient appointments in outpatient clinics, and inpatient professional services. They are the single and critical designation by which VHA defines clinical work units for cost purposes. Stop Codes assist VA medical centers in defining workload to support patient care, resource allocation, performance measurement, quality management, and third party collections. They are a six-character descriptor composed of a primary stop code and a credit (secondary) stop code. Primary stop codes indicate the workgroup responsible for providing the specific set of clinic products while the Credit or secondary stop code further defines the primary workgroup, such as the type of services provided or the type of provider.

Additional information on Stop Codes can be found at VHA Directive 1731 *Decision Support System Outpatient Identifiers.*

Current Procedural Terminology (CPT)

The American Medical Association (AMA), in conjunction with the Centers of Medicare and Medicaid Services (CMS), has defined codes for each service or procedure. Level 1 Healthcare Common Procedure Coding System (HCPCS), also known as Current Procedural Terminology (CPT) codes are five digit numeric and alpha-numeric codes updated annually by the AMA. Another category of alpha numeric codes, Level II HCPCS, may also be used in mental health settings for services not covered in the CPT codes. In VHA, these codes are assigned to an encounter based on the clinical service or procedure performed at the time of the encounter.

Additional information on mental health CPT Codes can be found at American Psychiatric Association and American Psychological Association.

Encounters

As defined in VHA Directive 1082, an encounter is a professional contact between a patient and a practitioner assigned with responsibility for diagnosing, evaluating, and treating the patient's condition. Encounters occur in both the outpatient and inpatient setting. Contact can include face-to-face interactions or those accomplished via telecommunications technology. A telephone contact between a practitioner and a patient is only considered an encounter if the telephone contact is documented. That documentation should include the appropriate elements of a face-to-face encounter, namely history and clinical decision-making.

Per VHA Directive 2011-025, all Encounters must be transmitted within 7 days of seeing a patient.

Historical Visit

In contrast to an encounter, a Historical Visit is one that occurred sometime in the past or at some other location (possibly non-VA), which is entered into CPRS to facilitate administrative communication between providers; or for the documentation of correspondence or other communication that does not occur during a visit (e.g., provider receives a letter from Veteran about their situation, which is documented in the medical record as a historical visit). When the historical visit feature is used the encounter workload is not transmitted to the VHA Central Patient Database in Austin, TX. Although these visits are not submitted for national workload credit, they can be used for recording support services or for other non-workload related reasons.

Event Capture System

The Event Capture System is a nationally-supported VistA application which can be used when programs cannot express their workload in the form of CPT codes, but need to capture the work being performed. A December 20, 2013 Memo – *Productivity for Mental Health Providers Across Settings* – noted that in order to ensure consistency of data capture, all inpatient mental health, residential, and outpatient encounters should be captured using the PCE rather than Event Capture System. **If using the Event Capture System to capture workload, it is essential that the facility ensure that the workload is transmitted to PCE. This can be ensured by collaborating with local facility Managerial Cost Accounting (MCA) site team for guidance.** For workload which can be captured in CPT codes, a patient care encounter must be entered in the medical record. Additionally, a report can be generated in Event Capture that will inform facilities of encounters that have failed to be transmitted to NPCD and should be generated on a regular basis.

For additional information regarding Event Capture see the following web page MCA Learning Community - Event Capture

wRVUs

The Centers for Medicare and Medicaid Service (CMS) relative value unit (RVU) is a measure of the complexity and time required to perform a professional service. In the private sector, the CMS RVU is used to compute reimbursement for services. The number of RVUs associated with each CPT code is determined by CMS as published in the CMS Medicare Fee Schedule. CMS RVUs are also employed to measure workload as well. It is important to note that the RVU used by CMS differ from time-based RVUs, defined locally by MCA which are used to compute VA cost for a rendered service. The total RVU consists of three components: work performed, practice expense, and malpractice expense. For purposes of productivity measurement, only the work component of the RVU value is utilized, and is referred to as wRVU. This is consistent with external benchmark data.

NOTE: RVU tables are available on the VSSC website at the ARC website. A full listing of wRVUs with imputed values is available here.

VHA Directive 1161, **Productivity and Staffing in Outpatient Clinical Encounters for Mental Health**, identifies yearly specialty-specific wRVU targets. Additional materials specific to mental health wRVU generation and productivity guidance can be found in the Mental Health Productivity folder located on the Mental Health Services Sharepoint.

Please refer to VA Directive 1161, Appendix A for additional discussion of the expected variability of wRVU workload with specific program assignments (e.g., PRRC, MHICM, HBPC, CLC, case management, etc) and the importance of taking this into consideration when evaluating individual mental health provider productivity. As noted in Appendix A, productivity can vary based upon the workload associated with the specific program assignment and type of work conducted (e.g., case management vs. psychotherapy). It must be recognized that productivity variability from the median should be expected and may be quite appropriate depending on the program assignment of the particular provider.

MCA Labor Mapping

Labor mapping is a method for assigning labor costs and hours to a cost center, known as the Account Level Budgeter Cost Center (ALBCC). These cost centers indicate where the work occurred and houses the cost and hours for the products/services provided. Labor mapping provides data on how much it costs to run and support a clinical program. Showing correct productivity and workload

for a program is important to managers to reliably benchmark the activity, and as indicated, justify additional expenditures or new positions. If labor mapping is not accurate, it will result in over or under inflated costs in the department, which could have an adverse effect on budgets and staffing. Labor mapping is cost and cost follows workload. Always map providers' labor time to the same locations where they collect workload.

Guidance on mental health labor mapping and wRVUs is reviewed in the following Directives: VHA Directive 1161 Productivity and Staffing in Outpatient Clinical Encounters for Mental Health Providers and/or VHA Directive 2011-009 Physician and Dentist Labor Mapping

Ensuring Accurate Documentation for Workload Capture

CPT Psychotherapy codes (i.e., 90832), some counseling codes (H0004), and case management (T1016) are time-based and the correct capture of these services requires time spent face-to-face with the patient/resident to be documented in the clinical record.

IF IT IS NOT DOCUMENTED, IT WAS NOT DONE!

The correct CPT or HCPCS code assignment impacts insurance as well as Veterans Equitable Resource Allocation (VERA) funding allocations. Keep in mind, the encounter form is not a part of the medical/ legal record. **All services provided to the patient will be coded based on documentation. Document diagnoses completely and concisely in the progress note**.

The elements of an encounter include:

1) Patient identifiers
2) Date and time of service
3) Practitioner- found in **Person Class File**
4) Place of service- clinic location with appropriate stop codes attached.
5) Problems addressed during encounter- patient diagnosis in the current International Classification of Diseases (**ICD) codes**
6) Classification questions if treatment was related to an adjudicated service-connected condition or treatment related to Agent Orange, Ionizing Radiation, Military Sexual Trauma, combat veteran or environmental contaminants
7) Services rendered CPT and HCPCS codes
8) Primary and Secondary Provider
9) Documentation of supervising practitioner involvement in trainee/veteran encounters

Workload Capture for Primary Care Mental Health Integration (PCMHI)

Developing Clinics

In the creation of Clinic Profiles, clinics are designated as either Count Clinics or Non-Count Clinics. **Count Clinics are transmitted to NPCD as encounters**. **Non-Count Clinics are not transmitted to NPCD.**

At the local level, get to know your service Automated Data Processing Application Coordinator (ADPAC) or the Health Administration Services (HAS) ADPAC, Health Information Management

(HIMS) professional and the site MCA Coordinator. These individuals have knowledge about stop codes usage, clinic set up and CPT codes.

Stop Code Number	Primary, Secondary, or Either	Stop Code Name
534	**E**	**PC-MHI, Individual.** Records individual patient visit for mental health integrated care by a mental health provider in Primary Care-Mental Health Integrated programs. Use in the credit position only when combined with a telephone code. Secondary code can be for provider type, clinic (e.g., pain management=420), or modality (e.g., telemental health=690 for provider site).
539	**P**	**PC-MHI, Group.** Records group patient visits for mental health integrated care by a mental health provider in Primary Care-Mental Health Integrated programs.
527	**P**	**Mental Health Telephone.** Records patient consultation or medical care management, advice, and/or referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical and/or professional staff assigned to the Mental Health service. Includes the administrative and clinical services. Provisions of 38 U.S.C. Section 7332 requires that records which reveal the identity, diagnosis, prognosis, or treatment of VA patients which relate to drug abuse, alcoholism or alcohol abuse, infection with HIV, or sickle cell anemia, are strictly confidential and may not be released or discussed unless there is a written consent from the individual. 534 is in the secondary position.
338	**P**	**Telephone Primary Care** Records telephone care in officially designated primary care clinics (322, 323, 348, 350, 531). The code will be used to set-up telephone clinic profiles for members of the Primary Care Team and should be associated with an appropriate discipline specific stop code in the secondary position. Primary Care Telephone Clinic profiles, workload generation, and documentation requirements will remain consistent with VHA policy and guidance. Includes patient consultation or medical care management, advice, and/or referral provided by telephone contact between patient or patient's next-of-kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical/professional staff assigned to a Primary Care Team. Includes the provider and support services. Provisions of 38 U.S.C. Section 7332 requires that records which reveal the identity, diagnosis, prognosis, or treatment of VA patients which relate to drug abuse, alcoholism or alcohol abuse, infection with HIV, or sickle cell anemia, are strictly confidential and may not be released or discussed unless there is written consent from the individual. For disease-specific care management (e.g., TIDES, BHL, etc.): 534 is in the secondary position.

		Either PC or MH telephone code can be used

Further guidance and examples for stop code usage in PC-MHI programs is available at PCMHI Stop Code Guidance.

CPT Codes commonly used in the PC-MHI Programs

Note: Mental health encounters provided by PC-MHI staff working within the discipline-specific Patient Aligned Care Team (PACT) are expected to be brief and problem focused. In some situations, longer visits are necessary. **Those codes not commonly used in PC-MHI care are listed in italics.**

CPT/ HCPCS	Description	2016 wRVU	Provider approved**
	Assessment		
90791	*Psychiatric diagnostic evaluation*	**3.00**	MD, DO, CNS, ANP, PA, CP, SW, LPMHC, MFT
90792	*Psychiatric diagnostic evaluation with medical services*	**3.25**	MD, DO, CNS, ANP, PA
H0001	Alcohol and/or Drug Assessment	**0.5***	All within scope of practice
	Individual Psychotherapy		
90832	Psychotherapy face-to-face with patient and/or family member.; 16-37 minutes	**1.50**	MD, DO, CNS, ANP, PA, CP, SW, LPMHC, MFT
90834	**Psychotherapy face-to-face with patient and/or family member. 38-52 minutes*	**2.00**	MD, DO, CNS, ANP, PA, CP, SW, LPMHC, MFT
	Individual Psychotherapy with E&M		
+90833	Psychotherapy face-to-face with patient and/or family member.; 16-37 minutes First code Evaluation & Management (E&M) service.	**1.50**	MD, DO, CNS, ANP, PA
+90836	*Psychotherapy face-to-face with patient and/or family member.; 38-52 minutes First code E&M service.*	**1.90**	MD, DO, CNS, ANP, PA
	Crisis Intervention Codes		
90839	Psychotherapy for crisis first 60 minutes	**3.13**	MD, DO, CNS, ANP, PA CP, SW, LPMHC, MFT
+90840	Psychotherapy for crisis; use in conjunction with 90839 for each additional 30 minutes after 60 minutes	**1.5**	MD, DO, CNS, ANP, PA CP, SW, LPMHC, MFT
H2011	Crisis intervention service, per 15 minutes	**0.5**	MD, DO, CNS, ANP, PA CP, SW, LPMHC, MFT
S9484	Crisis Intervention, per hour	**0.5**	MD, DO, CNS, ANP, PA CP, SW, LPMHC, MFT
	Outpatient Prolonged Service Codes		

+99354	Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service, first hour	**1.77**	MD, DO, CNS, ANP, PA CP, SW, LPMHC, MFT
+99355	Outpatient prolonged service; use in conjunction with +99354 for each additional 30 minutes	**1.77**	MD, DO, CNS, ANP, PA CP, SW, LPMHC, MFT
	Inpatient Prolonged Service Codes		
+99356	Prolonged service in the inpatient or observation setting requiring unit/floor time with direct face-to-face patient contact beyond the usual service, first hour	**1.71**	MD, DO, CNS, ANP, PA CP, SW, LPMHC, MFT
+99357	Inpatient prolonged service; use in conjunction with +99356 for each additional 30 minutes	**1.71**	MD, DO, CNS, ANP, PA CP, SW, LPMHC, MFT
	Group Psychotherapy and Interventions		
90853	Group psychotherapy other than of a multifamily group.	**0.59**	MD, DO, CNS, ANP, PA CP, SW, LPMHC, MFT
	Family Services		
90846	Family psychotherapy (without the patient present)	**2.4**	MD, DO, CNS, ANP, PA CP, SW, LPMHC, MFT
90847	Family psychotherapy (conjoint psychotherapy with patient present)	**2.5**	MD, DO, CNS, ANP, PA CP, SW, LPMHC, MFT
90849	Multiple Family psychotherapy	**.59**	MD, DO, CNS, ANP, PA CP, SW, LPMHC, MFT
90887	Consultation with Family. Family Feedback/Education. Explanation of results of examination, procedures, data, to family or other responsible person.	**1.48**	All within scope of practice
	Health and Behavior (Family) Education		
96154	H/B Family (with the patient present) intervention (e.g. stress management/coping strategies), each 15 min	**.45**	All within scope of practice
96155	H/B Family (without the patient present) intervention (e.g. stress management/coping strategies), each 15 min	**.44**	All within scope of practice
H2027	Family with Veteran, psychoeducational service. Activities to provide information and education to clients, families, and significant others regarding mental disorders and their treatment. Each 15 minutes.	**.5***	All within scope of practice
	Health and Behavior (Individual) Education		
96150	Initial H/B assessment (e.g. Health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment	**.5**	MD, DO, CNS, ANP, PA, CP, SW, LPMHC, MFT
96151	Assessment, health and behavior subsequent (per 15 minutes)	**.48**	MD, DO, CNS, ANP, PA, CP, SW, LPMHC, MFT
96152	Intervention, health and behavior, individual (per 15 minutes)	**.46**	MD, DO, CNS, ANP, PA, CP, SW, LPMHC, MFT
	Health and Behavior (Group) Education		
96153	H/B Group (2 + patients) intervention (e.g. stress management/coping strategies), each 15 min	**0.1**	All within scope of practice
98961	Self-Management education and training (2-4 patients) with standardized curriculum. May include caregiver/family. Each 30 minutes	**0**	All non-prescriptive within scope of practice
98962	Self-Management education and training (5-8 patients)	**0**	All non-prescriptive

	with standardized curriculum. May include caregiver/family. Each 30 minutes		within scope of practice
99078	Group health educational/counseling services	**0.4***	All within scope of practice
S9446	Group educational services not otherwise classified	**0.4***	All non-prescriptive within scope of practice
S9449	Weight Management Class Non-MD Per Session	**0.2***	All within scope of practice
S9452	Nutrition Classes Non-MD Per Session	**0.2***	All within scope of practice
S9453	Smoking Cessation Class Non-MD Per Session	**0.5***	All within scope of practice
S9454	Class for stress management	**0.2***	All non-prescriptive within scope of practice
	Team Conference with Veteran/Family		
99366	Team conference (minimum 3 different disciplines) with participation by qualified non-prescriptive provider, face-to-face with patient and/or family, 30 minutes or more	**0.82**	All non-prescriptive within scope of practice
	Team Conference without Veteran/Family		
99367	Team conference (minimum 3 different disciplines) with participation by prescriptive provider. Patient and/or family not present, 30 minutes or more devoted to the same patient	**1.1**	MD, DO, CNS, ANP, PA and all others within scope of practice
99368	Team conference (minimum 3 different disciplines) with participation by qualified non-prescriptive provider. Patient and/or family not present, 30 minutes or more devoted to the same patient	**0.72**	All non-prescriptive within scope of practice
	Telephone		
98966	5-10 minutes of medical discussion.	**0.25**	All non-prescriptive within scope of practice
98967	11-20 minutes of medical discussion.	**0.5**	All non-prescriptive within scope of practice
98968	21-30 minutes of medical discussion.	**0.75**	All non-prescriptive within scope of practice
99441	5-10 minutes of medical discussion.	**0.25**	MD, DO, CNS, ANP, PA
99442	11-20 minutes of medical discussion.	**0.5**	MD, DO, CNS, ANP, PA
99443	21-30 minutes of medical discussion.	**0.75**	MD, DO, CNS, ANP, PA
	Other		
90885	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes.	**0.97**	All within scope of practice
90889	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other individuals, agencies, or insurance carriers.	**0.57**	All within scope of practice
H0038	Self-Help/Peer Services, each 15 minutes	**0.0**	Peer Support Specialist
H0004	Behavioral health counseling and therapy, per 15 minutes	**0.5***	All within scope of practice

H0007	Alcohol and/or drug services; crisis intervention (outpatient)	**1.2***	All within scope of practice
H0014	Alcohol and/or drug services; ambulatory detoxification	**0.95***	All within scope of practice
H2027	Psychoeducational Service, per 15 minutes	**0.5**	All Scope of Practice

* These are imputed wRVU values; codes with imputed wRVU values are not billed

+ These are add-on codes; report in addition to the primary service

**MD and DO= Physician, CNS=Clinical Nurse Specialist, ANP=Advanced Nurse Practitioner, PA=Physician Assistant, CP=Clinical/Counseling Psychologist, SW=Social Worker, LPMHC=Licensed Professional Mental Health Counselor, MFT=Marital and Family Therapist;

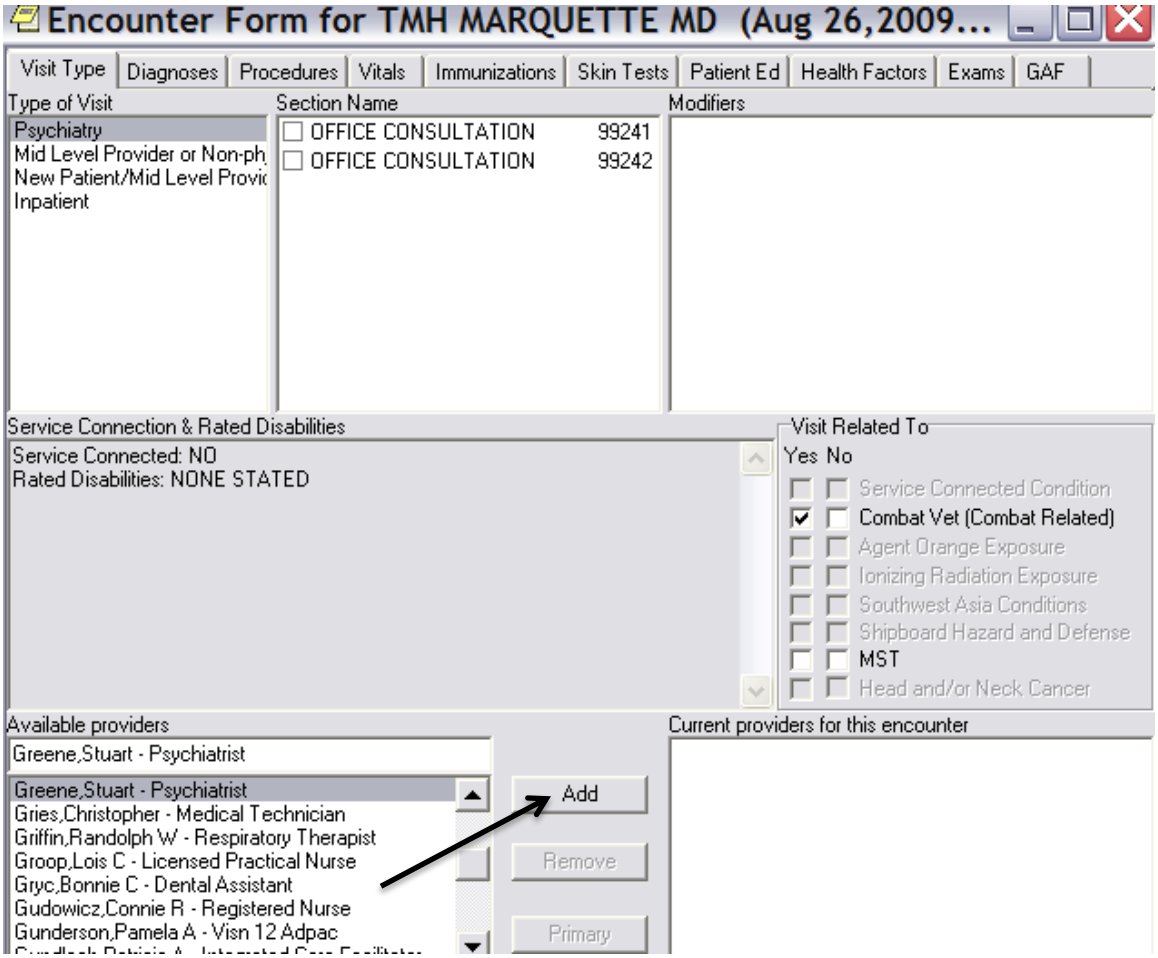
"All within scope of practice" includes Addiction Therapists, Registered Nurses; other Therapists

Note:

Group Psychotherapy (90853) and Group Interventions

Consistent with CMS standards, the group psychotherapy CPT code, 90853 with a 2016 wRVU of .59 per participant, may be utilized for group psychotherapy with an upper limit of 12 participants. (http://vaww.arc.med.va.gov/vapublic/cpt_input.html. This is an internal VA link not available to the public). For groups where 90853 and 90785 (Interactive Complexity) are coded, CMS standards limit group size to 10. Group counseling for alcohol and drug use may be coded with the CPT code H0005, which has an existing Allocation Resource Center (ARC) imputed wRVU of 0.3 per participant. Other group interventions that accommodate larger numbers of patients or do not meet the standards of group psychotherapy can use "Group health educational/counseling services" (99078) that has an imputed wRVU of .4 per participant regardless of the length of the encounter. It is important for group co-leaders to be sure that both provider names are entered on the encounter form so that each receive workload credit.

For Co-Led groups, only one group note for each Veteran is appropriate. Both providers are to be listed on the Encounter as a provider for the encounter. All providers listed on the encounter will receive the workload credit.



Team Conference

The 2013 American Medical Association (AMA) CPT Manual included three (3) new Team Conference codes for documenting team meetings with a minimum of three qualified health care professionals from different disciplines meeting for a minimum of 30 minutes. Two team meeting codes (99367, 99368) are available without the Veteran or collateral present, and one code (99366) is available for non-prescriber led team meetings with the Veteran. For Outpatient/Inpatient Team Conferences **with** Prescriber present and patient/ family present, the prescriber can create an encounter using the appropriate E&M code for the setting (99201-99215, 99241-99245, 99324-99337, 99341-99350) in conjunction with the appropriate Prolonged Service code (99354 or 99356) reflecting face-to-face patient contact beyond 30 minutes. Following the first hour of prolonged services, each additional 30 minutes of direct face-to-face patient contact may be reported by the respective CPT code (99355, 99357).

Clinical team conferences/case management can be captured as separate workload when the AMA criteria is met utilizing a Team Conference Clinic and Stop Code 673. The team conference codes include a time component and allow reporting only for conferences lasting 30 minutes or more. Team conference services of less than 30 minutes are not reported. Team conferences by physicians that involve both face-to-face and non-face-to-face time are reported using the appropriate E/M code. Team conference codes are not reported separately if reported using E/M codes.

Name	Stop Code	Primary, Secondary or Either	Definition
Clinical Team Conference	673	S	Records a formal medical/clinical team conference for the formulation of an integrated plan of care without the presence of the patient or collateral. There must be face-to-face participation by a minimum of three qualified health care professionals from different specialties or disciplines each of whom is providing direct care to the Veteran. The participants must be actively involved in the development, revision, coordination, and provision of health care services needed by the Veteran. Participants shall have performed face-to-face evaluations or treatments for the Veteran independently of any team conference within the previous 60 days. The result of the conference is the integration of new information into the medical treatment plan and/or modification of medical therapy provided to the Veteran. Team conference services of less than 30 minutes are not reported.

When documenting a team conference with the Veteran present and face-to-face participation by three or more qualified health care professionals from different specialties or disciplines, the provider with the highest level of credentials should be listed as the Primary Provider. All other participants should be listed as Secondary Providers. If there are multiple providers with the same level of credential, the team can decide on whom to list as Primary Provider. Time spent discussing the patient must be documented as the patient must be discussed for at least 30 minutes to be a codeable event. All providers listed on the encounter will receive the workload credit. Each provider must enter documentation of their involvement in the team conference, either by addendum to the "parent" note or as a separate note linked to the one appointment.

Utilization of the Team Conference Codes requires that all reporting participants have performed face-to-face evaluations or treatment with the patient, independent of any team conference, within the previous 60 days.

Prolonged Services

For individual psychotherapy lasting beyond 89 minutes of face-to-face service, consideration of using the add-on code is appropriate. The CPT time standard applies to the psychotherapy codes. Generally speaking, the CPT time standards apply unless there are different instructions within the CPT guidelines for specific codes or code sets.

Please see the chart below for how to report psychotherapy sessions based on actual duration. The services must be the time spent face-to-face with the patient and does not include time spent on reporting or documentation without the patient. When using Prolonged Services codes, all codes (e.g., 90837, 99354, and 99355) must be added to the encounter.

Additionally, in December, the American Medical Association published an errata to the 2013 CPT Code Book regarding coding for prolonged services, including prolonged psychotherapy sessions. As a result of this correction, psychologists, licensed clinical social workers and other qualified health professionals have an avenue for coding extra-long psychotherapy sessions.

Actual Length of Session	Code As	Code Description
0-15 minutes	Not Reported	-
16-37 minutes	90832	30 minutes
38-52 minutes	90834	45 minutes
53-89 minutes	90837	60 minutes
90-134 minutes	90837 99354	60 minutes Prolonged Services
135-165	90837 99354 99355	60 minutes Prolonged Services Prolonged Services, each additional 30 minutes

Administrative Documentation

Not all important patient-specific work meets the VHA definition of a clinical Encounter or meets the established criteria for CPT coding. For example, some work, such as a Team Conferences without 3 different professions present, does **not** meet the definition necessary for CPT coding, but is still vital patient-specific work. To account for this critical clinical work, facilities can develop individualized wRVU targets, complete position-specific time-studies, and establish local workload expectations based upon the unique features of that position. Utilization of Historical Visit to document administrative information related to patient care is appropriate. To account for time and productivity outside of clinical encounters, non-count clinics can be established for providers to document non-direct face-to-face patient care, such as work with CLC staff members for implementing behavioral interventions. Non-Count clinic information (encounters and CPT coding) is not transferred from PCE to the NPCD. Locally, as outlined in Directive 1161, the Ambulatory Care Reporting Program (ACRP), which takes into account all Count and Non-Count workload, can be utilized to generate productivity workload for individual providers.

Bundled CPT Codes

There are many clinical activities and productivity measures (wRVUs) developed by CMS that are 'bundled" into standard CPT codes. CMS rules specify that these codes cannot be utilized on the same day in which other face-to-face service codes are billed. For example, the time spent reviewing CPRS records before a psychotherapy session and the time spent writing the CPRS Progress Note are included in the face-to-face psychotherapy code (e.g., 90834). A provider cannot bill 90885 (Record Review), 90889 (Report Writing) on the same day in which one has completed a face-to-face encounter. Diagnostic assessment codes (96101, 96116 and 96118) also include time necessary for chart review and report writing, and the additional CPT codes for chart review and report writing would not be added onto the encounter. For prescribers, codes such as 1160F (medication review), 99090 (computer data analysis), etc are bundled into standard face-to-Face E&M codes, and these would not be included as additional CPT codes for a face-to-face encounter.

Modifiers

Services or procedures described by CPT codes may be modified under certain circumstances to more accurately represent a service or item rendered by using 2-digit modifiers. Providers in the VHA do not add modifiers to the encounter form. HIMS coding staff will add modifiers, as appropriate.

CPT E&M Codes commonly used for Primary Care Mental Health Integration (PCMHI)

Use of E&M codes is restricted by medical privileges and scope of practice. Accurate E&M Code selection requires additional education. Facility HIMS managers should be consulted.

EVALUATION & MANAGEMENT CODES: OFFICE and OTHER OUTPATIENT

NEW PATIENT (has not received services from the provider or same specialty in previous 3 years)

E&M CODE	2016 wRVU	HISTORY	EXAM	MDM	TIME: counseling and/or coordination of care	Provider Approved**
		MUST MEET 3/3				
99201	0.48	Problem Focused	Problem Focused	Straight forward	10 minutes face-to-face with patient and/or family	MD, DO, CNS, ANP, PA
99202	0.93	Expanded Problem Focused	Expanded Problem Focused	Straight forward	20 minutes face-to-face with patient and/or family	MD, DO, CNS, ANP, PA
99203	1.42	Detailed	Detailed	Low	30 minutes face-to-face with patient and/or family	MD, DO, CNS, ANP, PA
99204	2.43	Compre-hensive	Compre-hensive	Moderate	45 minutes face-to-face with patient and/or family	MD, DO, CNS, ANP, PA
99205	3.17	Compre-hensive	Compre-hensive	High	60 minutes face-to-face with patient and/or family	MD, DO, CNS, ANP, PA

ESTABLISHED PATIENT (received prior services from the provider or same specialty in previous 3 years)

E&M CODE	2016 wRVU	HISTORY	EXAM	MDM	TIME: counseling	Provider Approved**

		MUST MEET 2/3			and/or coordination of care	
99211	0.18	Problem Focused	Problem Focused	Minimal	5 minutes may not require presence of "attending"	MD, DO, CNS, ANP, PA and all others within scope of practice
99212	0.48	Problem Focused	Problem Focused	Straight forward	10 minutes face-to-face with patient and/or family	MD, DO, CNS, ANP, PA
99213	0.97	Expanded Problem Focused	Expanded Problem Focused	Low	15 minutes face-to-face with patient and/or family	MD, DO, CNS, ANP, PA
99214	1.5	Detailed	Detailed	Moderate	25 minutes face-to-face with patient and/or family	MD, DO, CNS, ANP, PA
99215	2.11	Compre-hensive	Compre-hensive	High	40 minutes face-to-face with patient and/or family	MD, DO, CNS, ANP, PA

EVALUATION & MANAGEMENT CODES: CONSULTATIONS

OFFICE and OUTPATIENT CONSULTATION: NEW or ESTABLISHED PATIENT

E&M CODE	2016 wRVU	HISTORY	EXAM	MDM	TIME: counseling and/or coordination of care	Provider Approved**
		MUST MEET 3/3				
99241	0.64	Problem Focused	Problem Focused	Straight forward	15 minutes face-to-face with patient and/or family	MD, DO, CNS, ANP, PA
99242	1.34	Expanded Problem Focused	Expanded Problem Focused	Straight forward	30 minutes face-to-face with patient and/or family	MD, DO, CNS, ANP, PA
99243	1.88	Detailed	Detailed	Low	40 minutes face-to-face with patient and/or family	MD, DO, CNS, ANP, PA
99244	3.02	Compre-hensive	Compre-hensive	Moderate	60 minutes face-to-face with patient and/or family	MD, DO, CNS, ANP, PA
99245	3.77	Compre-hensive	Compre-hensive	High	80 minutes face-to-face with patient and/or family	MD, DO, CNS, ANP, PA