Unraveling the Mysteries of Mental Health Coding

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Agenda

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- Mental Health Providers
- LCDS
- CPT Codes
- DSM

Disclaimer

All example used in this presentation were created using AI technology.

Mental Health Providers

Mental Health Providers

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- Physicians (MD/DO)
- Mid-Levels
  - Nurse practitioners
  - Clinical Nurse Specialists
  - Physician Assistants
- Residents and Fellowes

Mental Health Providers

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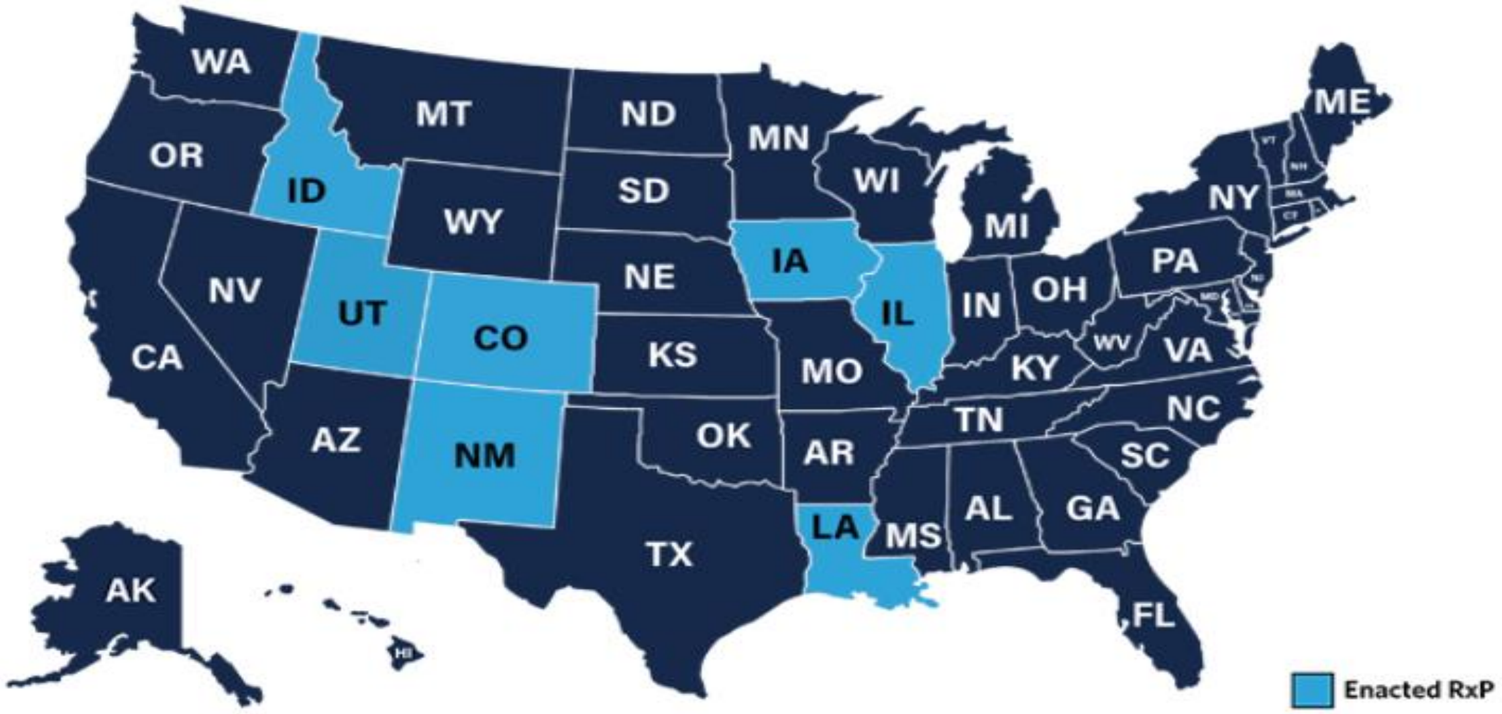
- Psychologists (PH.D/PsyD)
  - Clinical or Medical depending on the state
- Licensed Clinical Social Workers
- Counselors (LPC/LMFT)
- Psychometrists

Psychologist Map



Local Coverage Determinations

Local Coverage Determination

- Almost all Medicare Macs have at least one LCD for mental health services
- This includes CGS, First Coast, NGS, Novitas, Palmetto, and WPS
- It is recommended that coders and auditors become very familiar with the LCDs for their area.

CPT Codes

Diagnostic Evaluations

90791- Psychiatric diagnostic evaluation

90792- Psychiatric diagnostic evaluation with medical services

- A psychiatric diagnostic evaluation is an assessment of a patient's history and current mental status, the ordering of appropriate studies, and treatment recommendations.

- These visits can never be billed with an E/M

Diagnostic Evaluations- 90791

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Code 90791 is used for an initial diagnostic interview exam that does not include any medical services. It should include the following documentation:

- A complete medical & psychiatric history (including past, family, and social)
- Mental status examination
- Establishment of a tentative diagnosis
- Evaluation of the patient's ability & capacity to respond to treatment if needed
- Initial plan of treatment

Diagnostic Evaluations- 90792

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Code 90792 is used for an initial diagnostic interview exam that includes medical services. In addition to the documentation required for code 90791, this code should also include the following documentation:

Medical services

- Medical Exam
- Ordering and reviewing labs or diagnostic studies
- Prescribing medication

Diagnostic Evaluation Example

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Presenting Problem:
Patient presents for evaluation due to ongoing mood instability, impulsivity, difficulty maintaining relationships, and fluctuating energy levels.

Identifying Information

Age: 35
Gender: Female
Race/Ethnicity: Caucasian
Marital Status: Single
Occupation: Freelance writer
Living Situation: Lives alone in an apartment

Chief Complaint (in patient's words):
"I feel like I'm either on top of the world or I can't get out of bed. It's like I have no middle ground."

History
Patient reports experiencing mood swings for over 10 years. She describes periods lasting several days to weeks of increased energy, decreased need for sleep, excessive talking, racing thoughts, risky behaviors (spending sprees, sexual promiscuity), and grandiose ideas about her abilities. These episodes are followed by periods of intense depression, marked by low mood, anhedonia, hypersomnia, feelings of worthlessness, and suicidal ideation. Recent manic episode occurred approximately 3 weeks ago and lasted 6 days. During this time, the patient reported sleeping only 2–3 hours per night, starting multiple creative projects, and impulsively quitting a freelance job. The most recent depressive episode began one week after the manic period and has persisted for 2 weeks. There is no history of psychotic symptoms reported during either mood state. Patient denies current suicidal ideation but has had passive thoughts in the past.

Psychiatric History

- First mood episode reported at age 22 (depressive episode following breakup).
- First manic episode at age 25 (unmedicated).
- Past diagnoses: Bipolar I Disorder (by previous psychiatrist).
- Previous medications: lithium (discontinued due to side effects), lamotrigine, sertraline (not effective).
- Previous therapy: intermittent CBT.
- Psychiatric hospitalization: 1 (in 2021 during severe manic episode).

Diagnostic Evaluation Example

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Medical History
- Migraines
- Hypothyroidism
- Allergies-None known
- Medications: Synthroid 50 mcg daily

Family Psychiatric History
Mother: Depression
Father: Alcohol use disorder
Maternal uncle: Bipolar disorder

Substance Use History
- Occasional alcohol (1-2 drinks/week)
- No history of illicit drug use
- Denies tobacco or vaping

Mental Status Examination (MSE)
- **Appearance:** Well-groomed, casual attire
- **Behavior:** Cooperative, restless
- **Speech:** Pressured at times, increased rate
- **Mood:** "Tired and irritable"
- **Affect:** Labile, congruent with mood
- **Thought Process:** Tangential, but redirectable
- **Thought Content:** No delusions or hallucinations
- **Cognition:** Alert and oriented x3
- **Insight:** Limited
- **Judgment:** Impaired during mood episodes
- **Suicidality:** Denies current SI/HI

Diagnostic Evaluation Example

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Assessment

Based on the clinical interview, collateral history, and patient self-report, this patient meets the DSM-5 criteria for **Bipolar I Disorder**, characterized by at least one full manic episode lasting at least 7 days, followed by periods of depression. There is functional impairment during manic episodes, and her symptoms are not better explained by another psychiatric or medical condition.

DSM-5 Diagnosis

Primary Diagnosis:

F31.12 – Bipolar Disorder, current episode manic without psychotic features, moderate

Secondary Diagnoses

F33.1 – Major Depressive Disorder, recurrent, moderate

Treatment plan

Psychotherapy

- Recommended ongoing psychotherapy (CBT or DBT for emotional regulation) will send a referral
- Psychoeducation on mood tracking and relapse prevention recommended

Safety Plan

- Created a crisis plan including emergency contacts
- Provided the 24-hour crisis line

Psychotherapy

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Psychotherapy is a collaborative treatment based on the relationship between an individual and a mental health provider.

The treatment helps the individual work through their problems. The psychotherapy must be individualized for each patient and be medically necessary.

Individual Psychotherapy Codes

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90832

Psychotherapy, 30 minutes with patient (16-37)

90834

Psychotherapy, 45 minutes with patient (38-52)

90837

Psychotherapy, 60 minutes with patient (53+)

Individual Psychotherapy Codes with an E/M

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+90833

Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (16-37)

+90836

Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (38-52)

+90838

Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (53+)

Psychotherapy Documentation

All psychotherapy codes in addition to time must include the following documentation:

- Total time spent
- Assessment of the patient
- Content of the session (maneuvers, behavior modification, supportive interactions)
- Any adjustments or progression made towards goals during the current session
- Involvement of others during the session

Psychotherapy Guidelines

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- A unit of time is attained when the mid-point is passed. Anything less than 16 minutes is not billable. **The exact time** should be documented, not an estimate. Start/Stop time can be used.

- When billing the codes with an E/M service, the two services must be separately identifiable, and time associated with therapy cannot be used for the E/M code. The E/M cannot be billed based on time.

- Example: “In addition to the E/M, 30 minutes was spent with the patient in psychotherapy.”

Psychotherapy Example

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Patient Name: John Smith
Date of Service: 5/1/25
Start Time: 1:30 pm
Stop Time: 2:00 pm

Patient presented today for individual therapy. He is reporting continued symptoms of severe depression. Patient stated, “I wake up exhausted, and I can’t get anything done. I feel like a failure.” The patient described passive thoughts of death but denied any active suicidal ideation, plan, or intent. No recent changes in medications. Sleep is averaging 4–5 hours per night with early morning awakening. Appetite remains poor. Patient reports isolation from friends and family and describes frequent crying spells and difficulty concentrating at work.

Objective:

Patient arrived on time, appeared unkempt with poor eye contact and flat affect. Speech was slowed but coherent. No psychomotor agitation or retardation was observed. Thought process was logical and goal-directed. Judgment and insight appeared intact. Mood was “very low,” affect congruent. No perceptual disturbances noted.

Assessment:

The patient continues to experience **Major Depressive Disorder, Severe, without psychotic features**. Symptoms remain persistent despite current treatment, though patient is engaged and motivated to continue therapy. Passive death wishes remain present but are non-specific and without intent or plan.

Psychotherapy Example

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Interventions (Maneuvers Performed):

- **Cognitive Restructuring:** Provider guided the patient through identifying and challenging automatic negative thoughts. Patient was asked to write down one distressing thought ("I'm a failure") and worked with the provider to dispute this by identifying evidence to the contrary (e.g., "I got out of bed and went to work even though I felt awful").
- **Behavioral Activation:** Discussed scheduling one pleasurable or meaningful activity in the next 24 hours. Patient agreed to take a short walk outdoors and journal afterward.
- **Mindfulness Grounding Exercise:** Provider led the patient in a brief, 3-minute grounding exercise using the 5-4-3-2-1 technique (five senses awareness) to manage present-moment distress and reduce ruminative thought patterns.
- **Suicide Risk Assessment:** Patient was screened for safety using a structured approach (direct questioning about intent, plan, means). No current SI/plan/intent. Safety plan reviewed.
- **Psychoeducation:** Brief discussion about how depression impacts executive function and motivation, and how small behavioral shifts can influence neurochemical balance.

Patient will continue weekly psychotherapy session. Behavioral activation goals were reinforced and the provider will coordinate with the patient's psychiatrist to consider medication if no improvements are shown by the next visit. Patient agrees to call the crisis line or got to the ER if safety becomes a concern.

Diagnosis: F33.2- Major depressive disorder, recurrent, severe, without psychotic features

Prognosis- Guarded but patient is treatment compliant and engaged.

Family and Group Therapy

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90846- Family psychotherapy (without the patient present), 50 minutes

90847- Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes

90853- Group psychotherapy

Do not report family therapy unless a minimum of 26 minutes of therapy is performed. Total time must be documented for the family therapy.

Family Therapy Information

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- These codes describe the treatment of a family unit when maladaptive behaviors of family members are exacerbating the beneficiary's mental illness or interfering with the treatment.

- Many insurance companies will cover family psychotherapy services only where the primary purpose of such psychotherapy is the treatment of the patient's condition.

Examples include

- When there is a need to observe and correct, through psychotherapeutic techniques, the patient's interaction with family members.

- Where there is a need to assess the conflicts or impediments within the family, and assist, through psychotherapy, the family members in the management of the patient.

Family Therapy Documentation

Documentation for family therapy should include:

- Specific participation
- Contributions
- Interventions
- Progress toward treatment goals
- Diagnoses
- Reactions of the patient and/or family members

Family Therapy Example

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Patient Name: Jane Smith
Date of Service: 6/27/25
Duration: 45 minutes
Family Members present: Dad- Joe; Mom- Sarah; Sister-Mary; Brother-John

The family reported ongoing challenges with managing the patient's borderline personality disorder symptoms, specifically episodes of mood instability. The patient's mother expressed frustration with the unpredictability of mood swings, while the father expressed concern over the patient's adherence to medication. The patient reported feeling overwhelmed by family expectations and shared that they experience pressure from both their family and themselves to "be stable." The siblings present expressed feeling neglected due to the amount of attention focused on the patient's condition.

The family is worried about how borderline personality disorder is affecting family dynamics, and they seek ways to better support the patient while also addressing their own needs.

- Patient appeared somewhat restless during the session, with periods of emotional expression alternating between subdued and irritable.
- Family members were attentive but also showed signs of frustration, evidenced by sighing, crossed arms, and raising voices at different points during the discussion.
- The mother was tearful at moments when expressing feelings of helplessness in managing the patient's condition.
- The siblings remained quiet for most of the session but engaged when asked directly about their experiences.
- The father was proactive in suggesting practical solutions but also appeared disconnected from emotional discussions.

Family Therapy Example

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Assessment:

- The family is under significant emotional strain due to the impact of borderline personality disorder on the patient's behavior and family dynamics.
- There are unresolved issues surrounding communication, boundaries, and roles in caregiving.
- The patient is exhibiting some frustration around perceived external pressures but also desires a better relationship with their family.
- The siblings may be experiencing feelings of neglect, but the focus on the patient's mental health seems to overshadow the sibling's emotional needs.
- Family dynamics are strained, with each member exhibiting different coping strategies that may not always align with the patient's needs.

Plan:

1. **Increase Communication:** Encourage open communication in a structured way. The family will begin using a "check-in" system where everyone shares their feelings once a week to avoid bottling emotions.

2. **Psychoeducation:** Continue educating the family on borderline personality disorder, emphasizing the importance of understanding mood cycles and how it impacts behavior, relationships, and self-management strategies.

3. **Support and Boundaries:** Develop clearer boundaries for family members, particularly for the sibling, to ensure they feel included and not neglected. Explore ways for family members to support the patient without overstepping, maintaining a balance between care and independence for the patient.

4. **Medication Adherence:** Explore ways to address medication adherence collaboratively with the patient, potentially involving the family in reminders or supporting the patient's routine without making it a point of conflict.

Next Session: Schedule a follow-up family session in two weeks to assess progress and explore deeper issues related to family dynamics, including the sibling's role in the family system and further work on communication

Notes: All family members were cooperative and expressed willingness to work on strategies introduced during the session.

Group Therapy

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- Group therapy should involve no more than the number of participants allowed by the LCD or insurance.
- Group therapy sessions should typically last 45 to 60 minutes.
- Group therapy sessions notes should include specific participation, contributions, interventions, progress toward treatment goals, diagnoses, and reactions of group members. Clinicians can document individual notes or they can use a group note format such as this.
    - One group note that is common to all patients, documenting date, length of time for each session, along with key issues presented. Other group members' names should not appear in this note.

Group Therapy- Example

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Group Therapy Note
Facilitator: Dr. Davis
Date of Service: 6/2/2025
Participants: 10 patients diagnosed with Opioid Use Disorder

Session Theme: Emotional Regulation and Interpersonal Effectiveness

Objectives:

- Enhance emotional awareness and regulation skills.
- Improve distress tolerance and coping strategies.
- Strengthen interpersonal relationships and communication.

Summary of Session:
The session began with a mindfulness grounding exercise to help patients center themselves. Patients were encouraged to focus on their breath and bodily sensations to increase present-moment awareness.

Following the mindfulness exercise, a psychoeducational component was provided on Dialectical Behavior Therapy (DBT) skills, specifically emotional regulation techniques such as opposite action, checking the facts, and self-soothing strategies. Patients were invited to discuss personal experiences where these skills might be beneficial.

A structured group discussion followed, where patients shared challenges related to emotional dysregulation and interpersonal conflicts. The group explored adaptive coping mechanisms and role-played assertive communication strategies. The counselor facilitated reflective feedback and reinforced effective communication techniques.

The session concluded with a guided relaxation exercise and a homework assignment focusing on tracking emotional triggers and practicing one DBT skill before the next session.

Group Therapy- Example

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Patient Engagement:

- 7 out of 10 patients actively participated in discussions.
- 2 patients were initially withdrawn but engaged after prompting.
- 1 patient was minimally engaged and required additional support.

Clinical Observations:

- Several patients demonstrated improved insight into their emotional responses.
- Some patients reported difficulty applying DBT skills outside of therapy.
- A few patients expressed frustration with interpersonal conflicts and needed further guidance.

Interventions Used:

- Mindfulness-based grounding techniques.
- Psychoeducation on DBT skills.
- Group discussion and role-playing exercises.
- Encouragement of peer support and feedback.
- Relaxation exercise to conclude the session.

Plan for Next Session:

- Review progress on homework assignments.
- Introduce distress tolerance skills.
- Continue practicing interpersonal effectiveness through role-playing.
- Provide additional support for patients struggling with engagement.

Interactive Complexity

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Add-on code **+90785** is for interactive complexity and must be used in conjunction with the following:

- Diagnostic evaluation
- Psychotherapy
- Psychotherapy performed with an E/M
- Group psychotherapy

Code **+90785** cannot be billed with the following:

- Psychotherapy in crisis
- Family psychotherapy
- An E/M when no psychotherapy service is performed

Interactive Complexity

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In addition to needing a third party involved, the visit must also meet one of the four Communication factors as noted in the CPT guidelines. The factor along with the third party must be documented in the note:

- The need to manage maladaptive communication (related to high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicate the delivery of care.
- Caregiver emotions/behavior that interfere with the implementation of the treatment plan.
- Evidence/disclosure of a sentinel event and mandated report to a third party(abuse or neglect with a report to the state agency) with the initiation of discussion of the sentinel event and/or report with the patient and other visit participants.
- Use of play equipment or other physical devices to communicate with the patient to overcome barriers to therapeutic or diagnostic interaction between the physician or other qualified health care professional and a patient who has not developed, or has lost, either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the physician or other qualified health care professional if he/she were to use typical language for communication.

Interactive Complexity- Example

Interactive Complexity Consideration: The increased **interactive complexity** from the patient's relational difficulties was addressed, as the **family dynamics** are compounding the patient’s depression. The session focused on reframing negative thoughts around his wife’s behavior and encouraging the patient to take agency over their own emotional responses rather than depending on the partner's actions for validation. The patient struggled with this but expressed a desire to work on improving communication with the partner in future sessions.

Diagnostic and Statistical Manual of Mental Disorders

DSM- Information

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The *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) is the handbook used by healthcare professionals in the United States and much of the world as the authoritative guide to the diagnosis of mental disorders.

DSM contains descriptions, symptoms, and other criteria for diagnosing mental disorders. It provides a common language for clinicians to communicate about their patients and establishes consistent and reliable diagnoses that can be used in the research of mental disorders.

It also provides a common language for researchers to study the criteria for potential future revisions and to aid in the development of medications and other interventions.

According to the DSM, the primary purpose of DSM is to assist trained clinicians in the diagnosis of mental disorders as part of a case formulation assessment that leads to an informed treatment plan for each individual.

DSM- History

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- The first edition of the DSM was published in 1952 with 60 disorders. It became necessary due to an increased need to classify and define mental health conditions, especially in the Veterans who came home after serving in World War II.
- DSM-II was released in 1968 which was the same year as ICD-8.
- In 1973, the APA voted to remove homosexuality as a mental condition category. It was removed when the DSM-II was revised in 1974.
- The DSM-III came out in 1980 and introduced many innovations including the introduction of PTSD.
- DSM-IV was created and published in 1994 and saw the APA work more closely with the WHO.
- DSM-5 was released in 2013. It had 312 disorders.
- The DSM-5-TR was published in March 2022.

DSM Basics

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- The History
- The Revision Process and changes that were made
- Framework
- Other resources and tools
- How to use the manual
- Coding and documentation
- Cautionary statement for forensic use

Definition of a Mental Disorder

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A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above.

American Psychiatric Association (2022)

DSM- Disorders

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Section II: Diagnostic Criteria and Codes

Neurodevelopmental Disorders

Schizophrenia Spectrum and Other Psychotic Disorders

Bipolar and Related Disorders

Depressive Disorders

Anxiety Disorders

Obsessive-Compulsive and Related Disorders

Trauma and Stressor Related Disorders

Dissociative Disorders

Somatic Symptom and Related Disorders

Feeding and Eating Disorders

Elimination Disorders

Sleep-Wake Disorders

Sexual Dysfunctions

Gender Dysphoria

Disruptive, Impulse-Control, and Conduct Disorders

Substance-Related and Addictive Disorders

Neurocognitive Disorders

Personality Disorders

Paraphilic Disorders

Other Mental Disorders and Additional Codes

Medication Induced Movement Disorders and Other Adverse Effects of Medication

Dissociative Disorders

F44.81- Dissociative Identity Disorder

F44.0- Dissociative Amnesia

Specify if:

F44.1- With dissociative fugue

F48.1- Depersonalization/Derealization Disorder

F44.89- Other Specified Dissociative Disorder (Ganser's syndrome or trance/possession disorder)

F44.9- Unspecified Dissociative Disorder

Disorder Criteria

Feeding and Eating Disorders Criteria

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Feeding and eating disorders are characterized by a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning. Diagnostic criteria are provided for pica, rumination disorder, avoidant/restrictive food intake disorder, anorexia nervosa, bulimia nervosa, and binge-eating disorder.

Diagnostic criteria are offered as guidelines for making diagnoses, and their use should be informed by clinical judgment.

American Psychiatric Association (2022)

Pica Criteria

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A. Persistent eating of nonnutritive, nonfood substances over a period of at least 1 month.

B. The eating of nonnutritive, nonfood substances is inappropriate to the developmental level of the individual.

C. The eating behavior is not part of a culturally supported or socially normative practice.

D. If the eating behavior occurs in the context of another mental disorder (e.g., intellectual developmental disorder [intellectual disability], autism spectrum disorder, schizophrenia) or medical condition (including pregnancy), it is sufficiently severe to warrant additional clinical attention.

Coding note: The ICD-10-CM codes for pica are F98.3 in children and F50.89 in adults.

Specify if: In remission: After full criteria for pica were previously met, the criteria have not been met for a sustained period of time.

American Psychiatric Association (2022)

Pica Criteria Explained

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The essential feature of pica is the eating of one or more nonnutritive, nonfood substances on a persistent basis over a period of at least 1 month (Criterion A) that is severe enough to warrant clinical attention.

Typical substances ingested tend to vary with age and availability and might include paper, soap, cloth, hair, string, wool, soil, chalk, talcum powder, paint, gum, metal, pebbles, charcoal or coal, ash, clay, starch, or ice. The term nonfood is included because the diagnosis of pica does not apply to ingestion of diet products that have minimal nutritional content. There is typically no aversion to food in general.

The eating of nonnutritive, nonfood substances must be developmentally inappropriate (Criterion B) and not part of a culturally supported or socially normative practice (Criterion C).

A minimum age of 2 years is suggested for a pica diagnosis to exclude developmentally normal mouthing of objects by infants that results in ingestion.

The eating of nonnutritive, nonfood substances can be an associated feature of other mental disorders (e.g., intellectual developmental disorder [intellectual disability], autism spectrum disorder, schizophrenia). If the eating behavior occurs exclusively in the context of another mental disorder, a separate diagnosis of pica should be made only if the eating behavior is sufficiently severe to warrant additional clinical attention (Criterion D).

American Psychiatric Association (2022)

How DSM Differs from ICD-10

DSM Criteria for Opioid Use Disorder

Per the DSM, codes are based on current severity and are listed as follow

F11.10 Mild: Presence of 2-3 symptoms

F11.20 Moderate: Presence of 4-5 symptoms

F11.20 Severe: Presence of 6 or more symptoms

DSM Coding for Opioid Use Disorder

Opioid Use Disorder Mild= F11.10

Opioid Use Disorder Moderate= F11.20

Opioid Use Disorder Severe= F11.20

ICD-10 Coding for Opioid Use Disorder

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F11.10- Opioid abuse, uncomplicated

Opioid use disorder, mild

F11.20- Opioid Dependence, uncomplicated

Opioid use disorder, moderate

Opioid use disorder, severe

Questions?

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