OPTUM360®

CODING & PAYMENT GUIDE

Behavioral Health Services

An essential, coding, billing and reimbursement resource for psychiatrists, psychologists, and clinical social workers

2022

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Contents

Getting Started with Coding and Payment Guide

The *Coding and Payment Guide for Behavioral Health Services* is designed to be a guide to the specialty procedures classified in the CPT® book. It is structured to help coders understand procedures and translate physician narrative into correct CPT codes by combining many clinical resources into one, easy-to-use source book.

The book also allows coders to validate the intended code selection by providing an easy-to-understand explanation of the procedure and associated conditions or indications for performing the various procedures. As a result, data quality and reimbursement will be improved by providing code-specific clinical information and helpful tips regarding the coding of procedures.

CPT Codes

For ease of use, evaluation and mangement codes related to behavioral health are listed first in the *Coding and Payment Guide*. All other CPT and HCPCS Level II codes related to behavioral health are listed in ascending numeric order. Each CPT code is followed by its official code description.

Resequencing of CPT Codes

The American Medical Association (AMA) employs a resequenced numbering methodology. According to the AMA, there are instances where a new code is needed within an existing grouping of codes, but an unused code number is not available to keep the range sequential. In the instance where the existing codes were not changed nor had only minimal changes, the AMA has assigned a code out of numeric sequence with the other related codes being grouped together. The resequenced codes and their descriptions have been placed with their related codes, out of numeric sequence. Codes within the Optum360 *Coding and Payment Guide* series display in their resequenced order. Resequenced codes are enclosed in brackets for easy identification.

ICD-10-CM

Overall, the 10th revision goes into greater clinical detail than did ICD-9-CM and addresses information about previously classified diseases, as well as those diseases discovered since the last revision. Conditions are grouped with general epidemiological purposes and the evaluation of health care in mind. New features have been added, and conditions have been reorganized, although the format and conventions of the classification remain unchanged for the most part.

Detailed Code Information

One or more columns are dedicated to each procedure or service to a series of similar procedures/services. Following the specific HCPCS Level II and CPT code and its narrative, is a combination of features. A sample is shown on page 2. The black boxes with numbers in them correspond to the information on the page following the example.

Appendix Codes and Descriptions

Some procedure codes are presented in a less comprehensive format in the appendix. The CPT and HCPCS Level II codes appropriate to the specialty are included in the appendix with the official code description and associated relative value units, with the exception of the Category II and III CPT Codes. Because no values have been established by CMS for the Category II and Category III codes, no relative value unit and Medicare edits can be identified.

CCI Edit Updates

The *Coding and Payment Guide* series includes the a list of codes from the official Centers for Medicare and Medicaid Services' *National Correct Coding Policy Manual for Part B Medicare Contractors* that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from version XX.X, the most current version available at press time. The CCI edits are now located in a section at the back of the book. Optum360 maintains a website to accompany the *Coding and Payment Guide* series and posts updated CCI edits on this website so that current information is available before the next edition. The website address is https://www.optum360coding.com/ProductUpdates/. The 2022 edition password is: **XXXXXXXX22**. Please note that you should log in each quarter to ensure you receive the most current updates. An email reminder will also be sent to you to let you know when the updates are available.

Index

A comprehensive index is provided for easy access to the codes. The index entries have several axes. A code can be looked up by its procedural name or by the diagnoses commonly associated with it. Codes are also indexed anatomically. For example:

Brain
Cortex
Magnetic Stimulation, 90867-90869
Mapping, 90867, 96020

General Guidelines

Providers

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, the service or procedure itself is not limited to use only by that specialty group. Additionally, the procedures and services listed throughout the book are for use by any qualified physician or other qualified health care professional or entity (e.g., hospitals, laboratories, or home health agencies). Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Supplies

Some payers may allow physicians to separately report drugs and other supplies when reporting the place of service as office or other nonfacility setting. Drugs and supplies are to be reported by the facility only when performed in a facility setting.

Professional and Technical Component

Some pathology codes have a technical and a professional component. When physicians do not own their own equipment and send their patients to outside testing facilities, they should append modifier 26 to the procedural code to indicate they performed only the professional component.

Sample Page and Key

On the following pages are a sample page from the book displaying the format of *Coding and Payment Guide* with each element identified and explained on the opposite page.

the third-party payer. Unlisted codes are found at the end of the section or subsection of codes and most often end in "99." For example:

90899 Unlisted psychiatric service or procedure

Whenever an unlisted code is reported, it is necessary to include a descriptive narrative of the procedure performed in item 19 of the CMS-1500 claim form, as long as it can be adequately explained in the space provided.

Payers generally require additional documentation (e.g., progress notes, operative notes, consultation report, or history and physical) before considering claims with unlisted procedure codes.

Modifiers

The CPT coding system also includes modifiers that can be added to codes to describe extenuating or special circumstances or to provide additional information about a procedure that was performed, or a service or supply that was provided. Addition of the modifier does not alter the basic description for the service; it merely qualifies the circumstances under which the service was provided. Some third-party payers, such as Medicare, require modifier use in some circumstances. Circumstances that modify a service include the following:

- Procedures have both a technical and professional component
- More than one individual or setting was involved in the service
- Only part of a service was performed
- The service was delivered to more than one patient
- Adjunctive, complex, or bilateral procedures were performed

The following CPT modifiers are used most often by behavioral health providers:

22 **Increased Procedural Services.** When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required).

Note: This modifier should not be appended to an E/M service.

25 **Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service.** It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service.

Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

26 **Professional Component.** Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

32 **Mandated Services.** Services related to *mandated* consultation and/or related services (eg, third party payer, governmental, legislative or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

51 **Multiple Procedures.** When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (eg, vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s).

Note: This modifier should not be appended to designated "add-on" codes.

52 **Reduced Services.** Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.

Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

53 **Discontinued Procedure.** Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the individual for the discontinued procedure.

Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

59 **Distinct Procedural Service.** Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the

99202-99205

▲★**99202** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

▲★**99203** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

▲★**99204** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

▲★**99205** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

Explanation

Providers report these codes for new patients being seen in the doctor's office, a multispecialty group clinic, or other outpatient environment. All require a medically appropriate history and/or examination. Code selection is based on the level of medical decision making (MDM) or total time personally spent by the physician and/or other qualified health care professional(s) on the date of the encounter. Factors to be considered in MDM include the number/complexity of problems addressed during the encounter, amount and complexity of data requiring review and analysis, and the risk of complications and/or morbidity or mortality associated with patient management. The most basic service is represented by 99202, which entails straightforward MDM. If time is used for code selection, 15 to 29 minutes of total time is spent on the day of encounter. Report 99203 for a visit requiring a low level of MDM or 30 to 44 minutes of total time; 99204 for a visit requiring a moderate level of MDM or 45 to 59 minutes of total time; and 99205 for a visit requiring a high level of MDM or 60 to 74 minutes of total time.

Coding Tips

These codes are used to report office or other outpatient services for a new patient. A medically appropriate history and physical examination, as determined by the treating provider, should be documented. The level of history and physical examination are no longer used when determining the level of service. Codes should be selected based upon the CPT revised 2021 Medical Decision Making table. Alternately, time alone may be used to select the appropriate level of service. Total time for reporting these services includes face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional on the date of the encounter. For office or other outpatient services for an established patient, see 99211-99215. For observation care services, see 99217-99226. For patients admitted and discharged from observation or inpatient status on the same date, see 99234-99236. Telemedicine services may be reported by the performing provider by adding modifier 95 to these procedure codes. Services at the origination site are reported with HCPCS Level II code Q3014.

Reimbursement Tips

Telemedicine services may be reported by the performing provider by adding modifier 95 to these procedure codes. Services at the origination site are reported with HCPCS Level II code Q3014.

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

AMA: **99202** 2020,Sep,3; 2020,Sep,14; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,16; 2015,Jan,12; 2015,Dec,3; 2014,Oct,8; 2014,Oct,3; 2014,Nov,14; 2014,Jan,11; 2014,Aug,3 **99203** 2020,Sep,3; 2020,Sep,14; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,10; 2018,Apr,9; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3; 2014,Oct,3; 2014,Oct,8; 2014,Nov,14; 2014,Jan,11; 2014,Aug,3 **99204** 2020,Sep,14; 2020,Sep,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,13; 2016,Jan,7; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3; 2014,Oct,3; 2014,Oct,8; 2014,Nov,14; 2014,Jan,11; 2014,Aug,3 **99205** 2020,Sep,3; 2020,Sep,14; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,10; 2018,Apr,9; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3; 2014,Oct,8; 2014,Oct,3; 2014,Nov,14; 2014,Jan,11; 2014,Aug,3

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99202	0.93	1.12	0.09	2.14
99203	1.42	1.48	0.13	3.03
99204	2.43	1.98	0.22	4.63
99205	3.17	2.4	0.28	5.85
Facility RVU	**Work**	**PE**	**MP**	**Total**
99202	0.93	0.41	0.09	1.43
99203	1.42	0.59	0.13	2.14
99204	2.43	1.01	0.22	3.66
99205	3.17	1.33	0.28	4.78

	FUD	Status	MUE	Modifiers				IOM Reference
99202	N/A	A	1(2)	N/A	N/A	N/A	80*	None
99203	N/A	A	1(2)	N/A	N/A	N/A	80*	
99204	N/A	A	1(2)	N/A	N/A	N/A	80*	
99205	N/A	A	1(2)	N/A	N/A	N/A	80*	

* with documentation

F51.11 Primary hypersomnia
F51.12 Insufficient sleep syndrome
F51.3 Sleepwalking [somnambulism]
F51.4 Sleep terrors [night terrors]
F51.5 Nightmare disorder
F52.0 Hypoactive sexual desire disorder
F52.1 Sexual aversion disorder
F52.21 Male erectile disorder ♂
F52.22 Female sexual arousal disorder ♀
F52.31 Female orgasmic disorder ♀
F52.32 Male orgasmic disorder ♂
F52.4 Premature ejaculation ♂
F52.5 Vaginismus not due to a substance or known physiological condition ♀
F52.6 Dyspareunia not due to a substance or known physiological condition ♀
F53.0 Postpartum depression M ♀
F53.1 Puerperal psychosis M ♀
F54 Psychological and behavioral factors associated with disorders or diseases classified elsewhere
F55.0 Abuse of antacids
F55.1 Abuse of herbal or folk remedies
F55.2 Abuse of laxatives
F55.3 Abuse of steroids or hormones
F55.4 Abuse of vitamins
F55.8 Abuse of other non-psychoactive substances
F60.0 Paranoid personality disorder
F60.1 Schizoid personality disorder
F60.2 Antisocial personality disorder
F60.3 Borderline personality disorder
F60.4 Histrionic personality disorder
F60.5 Obsessive-compulsive personality disorder
F60.6 Avoidant personality disorder
F60.7 Dependent personality disorder
F60.81 Narcissistic personality disorder
F63.0 Pathological gambling
F63.1 Pyromania
F63.2 Kleptomania
F63.3 Trichotillomania
F63.81 Intermittent explosive disorder
F64.0 Transsexualism
F64.1 Dual role transvestism
F64.2 Gender identity disorder of childhood P
F65.0 Fetishism
F65.1 Transvestic fetishism
F65.2 Exhibitionism
F65.3 Voyeurism
F65.4 Pedophilia
F65.51 Sexual masochism
F65.52 Sexual sadism
F65.81 Frotteurism
F68.11 Factitious disorder imposed on self, with predominantly psychological signs and symptoms
F68.12 Factitious disorder imposed on self, with predominantly physical signs and symptoms
F68.13 Factitious disorder imposed on self, with combined psychological and physical signs and symptoms
F68.A Factitious disorder imposed on another
F70 Mild intellectual disabilities
F71 Moderate intellectual disabilities
F72 Severe intellectual disabilities
F73 Profound intellectual disabilities
F80.0 Phonological disorder
F80.1 Expressive language disorder
F80.2 Mixed receptive-expressive language disorder
F80.4 Speech and language development delay due to hearing loss
F80.81 Childhood onset fluency disorder
F80.82 Social pragmatic communication disorder
F81.0 Specific reading disorder
F81.2 Mathematics disorder
F81.81 Disorder of written expression
F82 Specific developmental disorder of motor function
F84.0 Autistic disorder
F84.5 Asperger's syndrome
F90.0 Attention-deficit hyperactivity disorder, predominantly inattentive type
F90.1 Attention-deficit hyperactivity disorder, predominantly hyperactive type
F90.2 Attention-deficit hyperactivity disorder, combined type
F90.8 Attention-deficit hyperactivity disorder, other type
F91.1 Conduct disorder, childhood-onset type
F91.2 Conduct disorder, adolescent-onset type
F91.3 Oppositional defiant disorder
F93.0 Separation anxiety disorder of childhood P
F94.0 Selective mutism
F94.1 Reactive attachment disorder of childhood P
F94.2 Disinhibited attachment disorder of childhood P
F95.1 Chronic motor or vocal tic disorder
F95.2 Tourette's disorder
F98.0 Enuresis not due to a substance or known physiological condition
F98.1 Encopresis not due to a substance or known physiological condition
F98.21 Rumination disorder of infancy P
F98.3 Pica of infancy and childhood P
F98.4 Stereotyped movement disorders
F98.5 Adult onset fluency disorder
H93.25 Central auditory processing disorder
I69.020 Aphasia following nontraumatic subarachnoid hemorrhage
I69.120 Aphasia following nontraumatic intracerebral hemorrhage
I69.220 Aphasia following other nontraumatic intracranial hemorrhage
I69.320 Aphasia following cerebral infarction
I69.820 Aphasia following other cerebrovascular disease

AMA: **96116** 2018,Oct,5; 2018,Nov,3; 2018,Jan,8; 2018,Feb,11; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16; 2015,Aug,5; 2014,Jun,3; 2014,Jan,11 **96121** 2018,Nov,3

 N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 ♂ Male Only ♀ Female Only

96136-96146

96136 Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes

\+ **96137** each additional 30 minutes (List separately in addition to code for primary procedure)

96138 Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes

\+ **96139** each additional 30 minutes (List separately in addition to code for primary procedure)

96146 Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only

Explanation

The physician or other qualified health care provider performs a neuropsychological testing evaluation and administers a series of tests in thinking, reasoning, judgment, and memory to evaluate the patient's neurocognitive abilities. Code 96132 describes the examination component, including combining data from different sources, interpreting test results and clinical data, decision-making, providing a plan of treatment report, as well as providing interactive feedback with the patient and family members or caregivers for the first hour; report 96133 for each additional hour thereafter. Report 96136 for the initial 30 minutes of time by a physician or other qualified health care professional administering two or more tests to the patient by any method, as well as scoring of the tests; report 96137 for each additional 30 minutes. When a technician performs the test administration and scoring, report 96138 for the initial 30 minutes and 96139 for each subsequent 30-minute time period. In 96146, the test is administered via a computer providing an automated result, which is interpreted and reported by a qualified health care professional.

Coding Tips

These codes are used to report the physician or other qualified healthcare professional's time spent in administrating and scoring psychological or neuropsychological tests. A minimum of 31 minutes must be provided before assigning these codes. For codes 96136–96139, time should not be included when determining evaluation services such as integration of patient data or the interpretation of test results as this time is already included in services reported by 96130–96133.

Report 96136–96139 with 96130–96133 on the same or different days.

Report automated psychological or neuropsychological tests that include automated test results with 96146.

Report a mini-mental health status with the appropriate level of evaluation and management service.

Report psychological testing evaluation services with 96130–96131; neuropsychological testing evaluation services with 96132–96133; developmental/behavioral screening and testing, see 96110, 96112–96113, and 96127.

Documentation Tips

Because 96136–96139 are time-based codes, the medical record documentation should contain the total time spent rendering and interpreting the service, including the stop and start times of testing.

Reimbursement Tips

Medicare has provisionally identified codes 96136, 96137, 96138, and 96139 as telehealth/telemedicine services. Current Medicare coverage guidelines should be reviewed. Commercial payers should be contacted regarding their coverage guidelines. Telemedicine services may be reported by the performing provider by adding modifier 95 to these procedure codes. Services at the origination site are reported with HCPCS Level II code Q3014.

ICD-10-CM Diagnostic Codes

F01.50 Vascular dementia without behavioral disturbance A

F01.51 Vascular dementia with behavioral disturbance A

F02.80 Dementia in other diseases classified elsewhere without behavioral disturbance

F02.81 Dementia in other diseases classified elsewhere with behavioral disturbance

F04 Amnestic disorder due to known physiological condition

F05 Delirium due to known physiological condition

F06.0 Psychotic disorder with hallucinations due to known physiological condition

F06.1 Catatonic disorder due to known physiological condition

F06.2 Psychotic disorder with delusions due to known physiological condition

F06.31 Mood disorder due to known physiological condition with depressive features

F06.32 Mood disorder due to known physiological condition with major depressive-like episode

F06.33 Mood disorder due to known physiological condition with manic features

F06.34 Mood disorder due to known physiological condition with mixed features

F06.4 Anxiety disorder due to known physiological condition

F06.8 Other specified mental disorders due to known physiological condition

F07.0 Personality change due to known physiological condition

F07.81 Postconcussional syndrome

F07.89 Other personality and behavioral disorders due to known physiological condition

F10.10 Alcohol abuse, uncomplicated

F10.11 Alcohol abuse, in remission

F10.120 Alcohol abuse with intoxication, uncomplicated

F10.121 Alcohol abuse with intoxication delirium

F10.131 Alcohol abuse with withdrawal delirium

F10.132 Alcohol abuse with withdrawal with perceptual disturbance

F10.14 Alcohol abuse with alcohol-induced mood disorder

F10.150 Alcohol abuse with alcohol-induced psychotic disorder with delusions

F10.151 Alcohol abuse with alcohol-induced psychotic disorder with hallucinations

F10.180 Alcohol abuse with alcohol-induced anxiety disorder

F10.181 Alcohol abuse with alcohol-induced sexual dysfunction

F10.188 Alcohol abuse with other alcohol-induced disorder

F10.20 Alcohol dependence, uncomplicated

F10.21 Alcohol dependence, in remission

F10.220 Alcohol dependence with intoxication, uncomplicated

F10.221 Alcohol dependence with intoxication delirium

 ● New ▲ Revised + Add On ★ Telemedicine AMA: CPT Assist [Resequenced] ☑ Laterality

99026-99027

99026 Hospital mandated on call service; in-hospital, each hour

99027 out-of-hospital, each hour

Explanation

These codes report the time for hospital mandated on call service provided by the physician and do not include prolonged physician attendance time for standby services or the time spent performing other reportable procedures or services. Report 99026 for each hour of hospital mandated on call service spent in the hospital and 99027 for each hour of hospital mandated on call service spent outside the hospital.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99026	0.0	0.0	0.0	0.0
99027	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
99026	0.0	0.0	0.0	0.0
99027	0.0	0.0	0.0	0.0

99050

99050 Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service

Explanation

This code is adjunct to basic services rendered. The physician reports this code to indicate services after posted office hours in addition to basic services.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99050	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
99050	0.0	0.0	0.0	0.0

99051

99051 Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service

Explanation

This code is adjunct to basic services rendered. The physician reports this code to indicate services provided during posted evening, weekend, or holiday office hours in addition to basic services.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99051	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
99051	0.0	0.0	0.0	0.0

99053

99053 Service(s) provided between 10:00 PM and 8:00 AM at 24-hour facility, in addition to basic service

Explanation

This code is adjunct to basic services rendered. The physician reports this code to indicate services provided between 10 p.m. and 8 a.m. at a 24-hour facility in addition to basic services.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99053	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
99053	0.0	0.0	0.0	0.0

99056

99056 Service(s) typically provided in the office, provided out of the office at request of patient, in addition to basic service

Explanation

This code is adjunct to basic services rendered. The physician reports this code to indicate services typically provided in the office that are provided in a different location at the request of a patient.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99056	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
99056	0.0	0.0	0.0	0.0

99058

99058 Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service

Explanation

This code is adjunct to basic services rendered. The physician reports this code to indicate services provided in the office on an emergency basis that disrupt other scheduled office services.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99058	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
99058	0.0	0.0	0.0	0.0

99060

99060 Service(s) provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service

Explanation

This code is adjunct to basic services rendered. The physician reports this code to indicate services provided on an emergency basis in a location other than the physician's office that disrupt other scheduled office services.

CPT Index