

PRIMARY CARE DEPRESSION REIMBURSEMENT

Tips for Physicians and Practice Managers

The Mid-America Coalition on Health Care developed a work group of key stakeholders (health plans, physicians and medical office managers) to collaboratively address the complexities surrounding the diagnosis, coding and reimbursement of the management of depression in the primary care setting. As a result, reimbursement tips were developed for primary care physician and practice managers to improve the consistent reimbursement of depression treatment in primary care.

TIP # 1: Diagnosis Codes

Use one of the following ICD-9 diagnosis codes, if appropriate:

311.00	Depressive Disorder, NOS (This is the most commonly used code for depression screening in primary care. 99.9% of claims have been paid without challenge.)
296.90	Mood Disorder, NOS
300.00	Anxiety Disorder, NOS
296.21	Major Depressive Disorder, Single Episode, Mild
296.22	Major Depressive Disorder, Single Episode, Moderate
296.30	Major Depressive Disorder, Recurrent
309.00	Adjustment Disorder with Depressed Mood
309.02	Generalized Anxiety Disorder
293.83	Mood Disorder due to Medical Condition (i.e. Postpartum Depression)

Note: While other codes might be appropriate and reimbursable, these codes were used during the health plan test claim process for fully insured benefit plans.

TIP # 2: Evaluation and Management Codes

Use E & M codes 99201-99205 or 99211-99215 with a depression claim with any of the diagnosis codes in Tip #1.

Counseling - Office/Outpatient:

Typical Face-to-face times:			
<i>New Patients</i>		<i>Established Patients</i>	
99201	10 min	99212	10 min
99202	20 min	99213	15 min
99203	30 min	99214	25 min
99204	45 min	99215	40 min
99205	60 min		

Do not use psychiatric or psychotherapy codes (90801-90899) with a depression claim for a primary care setting. These codes tend to be reserved for psychiatric providers only.

Note: According to AMA CPT 2005 Evaluation and Management Services Guidelines when counseling and/or coordination of care dominates (more than 50%) the physician/patient and/or family encounter, then time may be considered the controlling factor to qualify for a particular level of E/M service (**this may allow the physician to code a higher level of service**).