CPT Coding and Documentation Update –
CPT Coding for Psychiatric Care in 2014

Background Material

- **CPT Primer for Psychiatrists**
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- **Selected Sections from the 2011 *Procedure Coding Handbook for Psychiatrists, Fourth Edition*.**
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CPT Primer for Psychiatrists

What is CPT?

Current Procedural Terminology (CPT) was first published by the American Medical Association (AMA) in 1966. The CPT coding system was created to provide a uniform language for describing medical and surgical procedures and diagnostic services that would facilitate more effective communication between clinicians, third-party payers, and patients. The 2013 CPT Manual is the most recent revision of the 4th edition of the book.

The AMA's CPT Editorial Panel has the sole authority to revise, update, or modify CPT. The panel has seventeen members, eleven nominated by the AMA, and one each from the Blue Cross and Blue Shield Association, the Health Insurance Association of American, the Centers for Medicare and Medicaid Services (formerly HCFA), the American Hospital Association, and the Health Care Professionals Advisory Committee, and one representative from the AMA/Specialty Society RVS Update Committee. In 1990, Tracy Gordy, M.D., became the first psychiatrist to be appointed to the panel. He retired as chair of the panel in November 2007.

The CPT Editorial Panel is supported by the CPT Advisory Committee, which has representatives from over 90 specialty societies. The committee's main role is to advise the editorial panel on procedural coding and nomenclature that is relevant to each committee member's specialty. The committee also serves as a conduit through which revision to CPT can be proposed by specialty societies, or by individual members of those specialty societies.

The AMA's CPT coding system is now used almost universally throughout the United States. The Transaction Rule of the Health Insurance Portability and Accountability Act (HIPAA), which went into effect on October 16, 2002, requires the use of CPT codes by all who are covered by HIPAA. The CPT codes comprise Level I of the HCPCS (Health Care Financing Administration Common Procedure Coding System) codes used by Medicare and Medicaid. Every healthcare provider who is paid by insurance companies, or whose patients are reimbursed by insurance companies, should have a working knowledge of the CPT system.

How Is the CPT Manual Organized?

The CPT manual is organized to be as user friendly as possible. The following is a quick survey of its contents as it pertains to psychiatry.

Introduction

The short introduction contains valuable information for the clinician on how to use the manual, including:

- A description and explanation of the format of the terminology (This section describes how some routine procedural terms are not repeated for subsequent related procedures to conserve entry space.);
- A description of how to request updates of CPT (It is vital that physicians keep the AMA aware of changes in practice that require coding changes.);
- A discussion of the specific guidelines that precede each of the manual's six sections (E/M and the five clinical sections);
- A discussion of —add-on codesǁ for additional or supplemental procedures;
- An explanation of code modifiers and how they are to be used;
- A brief discussion of how place of service relates to CPT;
- A discussion of the inclusion of codes for unlisted procedures or services in each section;
- A note that some CPT codes require interpretation and reporting if they are to be used;
- A note that special reports may be required to determine the medical appro- priateness

of rare or very new services;
- A discussion of how to identify code changes from year to year;
- A reference to the expanded alphabetical index now included in the Manual;
- A note on how to obtain electronic versions of CPT; and finally
- How references to AMA resources on the CPT codes are noted in the Manual.

Evaluation and Management Codes

Although the rest of the CPT manual is organized according to the numerical order of the codes, the evaluation and management (E/M) codes, 99xxx, are provided in the first code section because they are used by physicians in *all* specialties to report a considerable number of their services. The E/M codes are preceded by tables that indicate the required components for the various E/M codes and fairly extensive guidelines that define the terms used in the code descriptors and provide instructions for selecting the correct level of E/M service.

Major Clinical Sections

Next come the major clinical sections: Anesthesia, Surgery, Radiology, Pathology and Laboratory, and Medicine. Each of these sections is preceded by guidelines. The psychiatry codes, 908xx, are found in the Medicine section. The codes in the Psychiatry subsection cover most of the services mental health professionals provide to patients in both inpatient and outpatient settings.

Category II and III Codes

The Medicine section is followed by a listing of the supplemental Category II and Category III codes. These codes are generally optional codes used to facilitate data collection and are never used as substitutes for the standard Category I CPT codes.

Category II codes are used for performance measurement. According to the CPT Manual, Category II codes are —intended to facilitate data collection about the quality of care rendered by coding certain services and test results that support nationally established performance measures and that have an evidence base as contributing to quality patient care.‖ These codes will be used more and more as Medicare attempts to shift from volume-based payment to quality-based payment.

Category III codes are temporary codes that are used to allow data tracking for emerging services and procedures.

Appendixes and Index (relevant to psychiatry)

The last section of the manual includes appendixes and an extensive alphabetical index. There are 13 appendixes:

1. Appendix A: Modifiers—modifiers are two-digit suffixes that are added to CPT codes to indicate that the service or procedure has been provided under unusual circumstances (e.g., –21, which indicates a prolonged E/M service) (See Appendix B of this book for a list of modifiers.)

2. Appendix B: Summary of Additions, Deletions, and Revisions (of codes in the current manual)

3. Appendix C: Clinical Examples—provides clinical examples to clarify the use of E/M codes in various situations

4. Appendix D: Summary of CPT Add-On Codes—codes used to denote procedures commonly carried out in addition to a primary procedure

5. Appendix E: Summary of CPT Codes Exempt From Modifier –51 (multiple procedures)

6. Appendix H: Alphabetic Index of Performance Measures by Clinical Condition or Topic (a listing of the diseases, clinical conditions, and topics with which the Category II codes are associated.)

7. Appendix M: Crosswalk to Deleted CPT Codes (indicating which current codes are to be used in place of the deleted ones)

The index is preceded by instructions explaining that there are four primary classes of index entries:

1. Procedure or Service
2. Organ or Other Anatomic Site
3. Condition
4. Synonyms, Eponyms, and Abbreviations

The instructions also explain the index's use of modifying terms, code ranges, and space- saving conventions.

Psychiatry Codes

The codes most frequently used by psychiatrists can be found in the Psychiatry subsection of the Medicine section of the CPT Manual (codes 90785-90899). In 2013 there were major changes to the Psychiatry codes. A distinction was made between an initial evaluation with medical services done by a physician (90792) and an initial evaluation done by a non-physician (90791). The psychotherapy codes were simplified: There are now three timed codes to be used in all settings (90832- 30 minutes; 90834- 45 minutes; 90837- 60 minutes) and parallel add-on codes for psychotherapy (indicated by the + symbol in the CPT Manual) that are to be used by psychiatrists when the psychotherapy is provided in the same encounter as medical evaluation and management (90833 -30 minutes, 90836 - 45 minutes, 90838 – 60 minutes). In lieu of the codes for interactive psychotherapy, there is now an add-on code for interactive complexity (90785) that may be used with any code in the Psychiatry section for which it is appropriate. Another change is that a new code was added for psychotherapy for a patient in crisis (90839). When a crisis encounter goes beyond 60 minutes there is an add-on code for each additional 30 minutes (90840). Code 90862 was eliminated, and psychiatrists now use the appropriate evaluation and management (E/M) code when they do pharmacologic management for a patient. (A new code, add-on code 90863, was created for medication management when done with psychotherapy by the psychologists in New Mexico and Louisiana who are permitted to prescribe, but this code is **not** to be used by psychiatrists or other medical mental health providers). All of these changes are discussed in detail below.

Interactive Complexity Add-On

90785 ♦ Interactive Complexity -- This add-on code may be used with any of the codes in the Psychiatry section when the encounter is made more complex by the need to involve others along with the patient. It will most frequently be used in the treatment of children. When this add-on is used, documentation must explain what exactly the interactive complexity was (i.e., the need for play equipment with a younger child; the need to manage parents' anxiety; the involvement of parents with discordant points of view).

What is an add-on code? An add-on code is a code that can only be used in conjunction with another code and is indicated by the plus symbol (+) in the CPT manual. While basic CPT codes are valued to account for pre- and post-time, add-on codes are only valued based on intra-service time since the pre- and post-time is accounted for in the basic code. In the current Psychiatry codes there are three different types of add-on codes: 1.) Timed add-on codes to be used to indicate psychotherapy when it is done with along with medical evaluation and management; 2.) A code to be used when psychotherapy is done that involves interactive complexity (e.g., psychotherapy provided to children or geriatric patients who have difficulty communicating without assistance); and 3.) A code to be used with the crisis therapy code for each 30 minutes beyond the first hour.

Psychiatric Diagnostic Evaluation Codes

90791 ♦ Psychiatric Diagnostic Evaluation ✱

This code is used for an initial diagnostic interview exam that does not include any medical services. In all likelihood this code will not be used by psychiatrists . It includes a chief complaint, history of present illness, review of systems, family and psychosocial history, and complete mental status examination, as well as the order and medical interpretation of laboratory or other diagnostic studies. In the past most insurers would reimburse for one 90791 (then a 90801) per episode of illness. The guidelines now allow for billing this on subsequent days when there is medical necessity for an extended evaluation (i.e., when an evaluation of a child that requires that both the child and the parents be seen together and independently). Medicare will pay for only one 90791 per year for institutionalized patients unless medical necessity can be established for others.

90792 ♦ Psychiatric Diagnostic Evaluation with Medical Services ✱

This code is used for an initial diagnostic interview exam for an adult or adolescent patient that includes medical services. It includes a chief complaint, history of present illness, review of systems, family and psychosocial history, and complete mental status examination, as well as the ordering and medical interpretation of laboratory or other diagnostic studies. In the past most insurers would reimburse for one 90792 (then a 90801) per episode of illness. The guidelines now allow for billing this on subsequent days when there is medical necessity for an extended evaluation (i.e., when an evaluation of a child that requires that both the child and the parents be seen together and independently). Medicare will pay for only one 90792 per year for institutionalized patients unless medical necessity can be established for others. Medicare permits the use of this code or the appropriate level of the E/M codes (see below) to denote the initial evaluation or first-day services for hospitalized patients. Medicare also allows for the use of 90792 if there has been an absence of service for a three-year period.

Psychiatric Therapeutic Procedure Codes

There are three basic timed individual psychotherapy codes, which are to be used in all settings and add-on codes to be used when psychotherapy is done along with medical evaluation and management and/or when psychotherapy is provided for a patient when there is interactive complexity. Note that the descriptors for the psychotherapy codes now list the time as the time spent with patient and/or family member, rather than face- to-face with the patient as was the case for the previous psychotherapy codes.

Another difference is the way time is now defined by CPT. The CPT manual has standards in place that are to be used when selecting codes that have a time attached to them, except when rules are stipulated within the codes themselves. The bullets below will provide you with the basics for coding timed psychiatric services.

- Time is only the time spent face-to-face with the patient and/or family member.
- When codes have sequential typical times attached to them, as with the basic psychotherapy codes, the code that is closest to the typical time should be selected.
- A unit of time is attained when the mid-point is passed. (For example, if you see a patient for *more than* 15 minutes you may code using 90832, the 30-minute code; and if you see a patient for 35 minutes, you would also use 90832. However, if you see the patient for 38 to 52 minutes, you would use 90834, the 45-minute code; and for 53 minutes or more you would use 90837, the 60-minute code).
- The time spent providing evaluation and management services should not be included when determining the amount of time spent providing psychotherapy (when psychotherapy is done in addition to an E/M service).
- When psychotherapy is performed in addition to an E/M service, the level of the E/M service must be selected on the basis of the work performed and NOT on the amount of time spent with the patient.

90832 ♦ Individual Psychotherapy, 30 minutes with patient and/or family member ✱

90833 ♦ Individual Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the

code for the primary procedure.)✱

90834 ♦ Individual Psychotherapy, 45 minutes with patient and/or family member✱
90836 ♦ Individual Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the code for the primary procedure.) ✱

90837 ♦ Individual Psychotherapy, 60 minutes with patient and/or family member✱
90838 ♦ Individual Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the code for the primary procedure.) ✱

Other Psychotherapy Codes

90845♦Psychoanalysis

Psychoanalysis is performed by therapists who are trained and credentialed to practice it. Psychoanalysis is reported on a per-session basis and is reimbursed by most insurance programs. The issue of medical necessity has resulted in challenges to reimbursement for psychoanalysis by managed care companies. Note that 90845 is not a time-based code.

90846♦Family Psychotherapy (Without the Patient Present)

This code is used when the psychiatrist provides therapy for the family of a patient without the patient being present. Under Medicare rules, 90846 is only covered if the therapy is clearly directed toward the treatment of the patient, rather than to treating family members who may have issues because of the patient's illness. While most insurance companies will reimburse for this code, problems may occur because the service is not face-to-face with the patient.

90847♦Family Psychotherapy (Conjoint Psychotherapy) (With Patient Present)

This code is used when the therapy includes the patient and family members. It is covered by most insurance plans, and is challenged less often than 90846 because the patient is present. It should also be used for couples therapy.

90849♦ Multiple-Family Group Psychotherapy

This code is used when the psychiatrist provides psychotherapy to a group of adult or adolescent patients and their family members. The usual treatment strategy is to modify family behavior and attitudes. The service is covered by most insurance plans.

90853♦Group Psychotherapy (Other Than of a Multiple-Family Group)✱

This code relies on the use of interactions of group members to examine the pathology of each individual within the group. In addition, the dynamics of the entire group are noted and used to modify behaviors and attitudes of the patient members. The size of the group may vary depending on the therapeutic goals of the group and/or the type of therapeutic interactions used by the therapist. The code is used to report per-session services for each group member. Most insurance plans cover this procedure.

<u>Codes for Other Psychiatric Services or Procedures</u>

90865♦Narcosynthesis for Psychiatric Diagnostic and Therapeutic Purposes (e.g. sodium amobarbital (Amytal) interview)

This procedure involves the administration, usually through slow intravenous infusion, of a barbiturate or a benzodiazepine in order to suppress inhibitions, allowing the patient to reveal and discuss material that cannot be verbalized without the disinhibiting effect of the medication. This code is reimbursed by most insurers.

90867♦ Therapeutic Repetitive Transcranial Magnetic Stimulation

(TMS) initial treatment, including cortical mapping, motor threshold determination, delivery and management

90868♦Subsequent TMS Delivery and Management, per session

90869♦ Subsequent TMS Motor Threshold Re-Determination with Delivery and Management

90870♦Electroconvulsive Therapy (Includes Necessary Monitoring); Single seizure
This code is for electroconvulsive therapy (ECT), which involves the application of electric current to the patient's brain for the purposes of producing a seizure or series of seizures to alleviate mental symptoms. ECT is used primarily for the treatment of depression that does not respond to medication. The code includes the time the physician takes to monitor the patient during the convulsive phase and during the recovery phase. When the psychiatrist also administers the anesthesia for ECT, the anesthesia service should be reported separately, using an anesthesia code. ECT is covered by most insurance plans.

90875♦Individual Psychophysiological Therapy Incorporating Biofeedback Training by any Modality (face-to-face with the patient), With Psychotherapy (e.g., insight-oriented, behavior modifying, or supportive psychotherapy); approximately 20-30 minutes **and**,
90876♦approximately 45-50 minutes
These two procedures incorporate biofeedback and psychotherapy (insight oriented, behavior modifying, or supportive) as combined modalities conducted face-to-face with the patient. They are distinct from biofeedback codes 90901 and 90911, which do not incorporate psychotherapy and do not require face-to-face time. Medicare will not reimburse for either of these codes.

90880♦Hypnotherapy
Hypnosis is the procedure of inducing a passive state in which the patient demonstrates increased amenability and responsiveness to suggestions and commands, provided they do not conflict seriously with the patient's conscious or unconscious wishes. Hypnotherapy may be used for either diagnostic or treatment purposes. This procedure is covered by most insurance plans.

90882♦Environmental Intervention for Medical Management Purposes on a Psychiatric Patient's Behalf With Agencies, Employers, or Institutions
The activities covered by this code include physician visits to a work site to improve work conditions for a particular patient, visits to community-based organizations on behalf of a chronically mentally ill patient to discuss a change in living conditions, or accompaniment of a patient with a phobia in order to help desensitize the patient to a stimulus. Other activities include coordination of services with agencies, employers, or institutions. This service is covered by some insurance plans, but because some of the activities are not face-to-face, the clinician should check with carriers about their willingness to reimburse for this code.

90885♦Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes
Although this would seem to be a very useful code, because reviewing data is not a face-to-face service with the patient, Medicare will not reimburse for this code and some commercial carriers have followed suit. Medicare considers the review of data to be part of the pre-/postwork associated with any face-to-face service.

90887♦Interpretation or Explanation of Results of Psychiatric, Other Medical Examinations and Procedures, or Other Accumulated Data to Family or Other Responsible Persons, or Advising Them How to Assist Patient
Medicare will not reimburse for this service because it is not done face-to-face with the patient, and clinicians should verify coverage by other insurers to ensure reimbursement. It is appropriate to use an E/M code in the hospital where floor time is expressed in coordination of care with the time documented.

90889♦Preparation of Report of Patient's Psychiatric Status, History, Treatment, or Progress (Other Than for Legal or Consultative Purposes) for Other Physicians, Agencies, or Insurance Carriers – Psychiatrists are often called upon to prepare reports about the patient for many participants in the healthcare system. This code would be best used to denote this service. However, because this is not a service provided face-to-face with a patient, Medicare will not reimburse for this code either, and clinicians should verify coverage by other insurers.

90899♦Unlisted Psychiatric Service or Procedure – This code is used for services not specifically defined under another code. It might also be used for procedures that require some degree of explanation or justification. If the code is used under these circumstances, a brief, jargon-free note explaining the use of the code to the insurance carrier might be helpful in obtaining reimbursement. If it is used for a service that is not provided face-to-face with a patient, the psychiatrist should check with the patient's insurer regarding reimbursement.

95970, 95974, 95975♦Neurostimulators, Analysis–Programming – These codes have been approved for vagus nerve stimulation (VNS) therapy for treatment-resistant depression. Clinicians performing VNS therapy should use the appropriate code from the 95970, 95974, and 95975 series of codes found in the neurology subsection of the CPT manual. Medicare will not reimburse for these codes.

M0064♦Brief Office Visit for the Sole Purpose of Monitoring or Changing Drug Prescriptions Used in the Treatment of Mental Psychoneurotic and Personality Disorders
M0064 is not, in fact, a CPT code. It is a HCPCS Level II code (CPT codes are HCPCS Level I), part of the HCPCS system used by Medicare and Medicaid. M0064 should only be used for the briefest medication check with stable patients.

Evaluation and Management Codes

With the elimination of code 90862 and the addition of the add-on codes for psychotherapy when done with evaluation and management (E/M), psychiatrists are now using far more E/M codes than they did in the past. Previously, many psychiatrists just used the E/M codes for their inpatient and nursing facility encounters, but now they must be used for outpatient care as well.

The evaluation and management codes were introduced in 1992 to cover a broad range of services for patients, in both inpatient and outpatient settings. E/M code descriptors provide explicit criteria for selecting codes, and the clinical vignettes given in Appendix C of the CPT Manual provide examples of situations that fulfill these criteria.

Evaluation and management codes cover a family of *general medical services* provided in various settings, i.e., office, hospital, nursing home, emergency department, etc. It is extremely important to read the guidelines to the Evaluation and Management section of the CPT Manual because they explain how to choose the appropriate level of service when using E/M codes.

<u>Level of Service</u>
The level of service for an E/M code encompasses the skill, effort, time, responsibility, and medical knowledge necessary to evaluate, diagnose, and treat medical conditions.

The three key components used in selecting the level of service within each category or subcategory of E/M service are:

- the extent of the history
- the extent of the examination
- the complexity of medical decision making involved

The clinician's ability to determine the appropriate level of service being provided to the patient within each category or subcategory of evaluation and management services is dependent on a thorough understanding of the Definition of Terms (found in the Evaluation and Management Services Guidelines that precede the listing of the E/M codes in the CPT Manual) and the Instructions for Selecting a Level of E/M Service (also in the Guidelines). The brief synopsis that follows is not an adequate substitute for a careful review of these sections of the CPT Manual.

There are three to five levels of service for each category or subcategory of E/M services. Each level of service represents the total work (skill, time, effort, medical knowledge, risk) required of the clinician during an incident of service. For example, outpatient E/M codes are divided by *new patient* and *established patient,* with five levels of service for new patient care (99201-99205) and five for

established patient care (99211-99215). Each of the levels is based on the depth of history and examination and complexity of the decision making involved, and the descriptors for the codes provide a typical time for the code as well.

Consultations are divided into *office or other outpatient consultations, initial inpatient consultations.* There are five levels of service for office consultations (99241-99245), and initial inpatient consultations (99251-99255). Consultations are provided at the request of another healthcare provider to whom a written report must be given. The CPT Editorial Panel voted to delete the follow-up inpatient consultations and the confirmatory consultations. The appropriate E/M service code (i.e., established patient, office or other outpatient service) should be used based on the setting and type of service. Clinicians should become thoroughly familiar with the descriptors and codes within each family of services as well as with the guidelines that spell out the methodology for selecting the level of service provided. Medicare no longer pays for the consultation codes and some commercial insurers have eliminated them as well.

History

There are four levels of history in the E/M codes: problem focused, expanded problem focused, detailed, and comprehensive. The more detailed the history required, the greater the work effort.

Examination

The same four categories define the examination: problem focused, expanded problem focused, detailed, and comprehensive. The more extensive the examination required, the greater the work effort. For psychiatry, a complete mental state examination (single system examination) qualifies as a comprehensive examination.

Decision Making

There are four levels of medical decision making presented in the E/M codes: 1. Straightforward; 2. Low complexity; 3. Moderate complexity; and 4. High complexity. The more complex the medical decision making, the greater the work effort.

The complexity of the medical decision making depends on: the number of diagnoses or management options; the amount and/or complexity of data to be reviewed; and the risk of complications and/or morbidity or mortality.

For example, the lowest level of service a physician would provide for an established patient in an Office or Other Outpatient setting (99212) requires:

- a problem focused history;
- a problem focused examination; and
- straightforward medical decision making

Average time: 10 minutes

While the highest level of service for an established patient in an Office or Other Outpatient setting (99215) requires:

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of high complexity

Average time: 40 minutes

The clinician selects 99212 or 99215 (or any of the other levels: 99211, which is used by nonphysician ancillary staff; 99213, or; 99214) on the basis of the work required (i.e., extent of history and examination, complexity of medical decision making). The average/typical times given for each code are guidelines for the clinician and are not a requirement when using the key components (history, examination, and medical decision making) in selecting the level of service.

Time and Level of Service

Time (as a component in selecting the level of service) has two definitions in the E/M guidelines. The clinician must review these definitions (see CPT 2014, E/M Services Guidelines) in order to fully understand the rationale for the two definitions.

For office and other outpatient visits and office consultations, intraservice time is defined as the *face-to-face* time spent providing services to the patient and/or family members. Time spent pre- and post-service (time that is not face-to-face) is not included in the average times listed for office and outpatient consultation services. The work associated with the pre- and post-encounter time has been calculated into the total work that forms the basis for how each code is reimbursed, and, therefore, the average face-to-face times listed with each E/M code are considered fair proxy for the total work effort.

For inpatient hospital care, hospital consultations, and nursing facility care intraservice time is defined as *unit floor time.* Unit floor time includes all work the clinician performs on behalf of the patient while present on the unit or at the bedside. This work includes direct patient contact, review of chart, writing orders, reviewing test results, writing progress notes, meeting with the treatment team, telephone calls, and meeting with the family. Pre- and post-time work such as reviewing patient records in another part of the hospital has been included in the calculation of total work as described above in the definition of face-to-face time.

There is one final and important twist in using time in the selection of the level of service. When counseling and/or coordination of care (see *Physicians Current Procedural Terminology 2014* , page 10) accounts for more than 50 percent of the patient and/or family encounter unit/floor time, then time becomes the *key factor* in selecting level of service. The clinician makes the selection by matching the time of the encounter (face-to-face or unit/floor) to the typical time listed for the appropriate E/M service. In this instance there is no consideration of the extent of the history, the exam, the medical decision making required, or the nature of the presenting problem; time is the sole determinant. Remember, that when performing psychotherapy in addition to an E/M service, time may NOT be used to determine the level of E/M service.

Counseling is defined as a discussion with the patient and/or family concerning one or more of the following: diagnostic results, prognosis, risks and benefits of treatment, instructions for management, compliance issues, risk factor reduction, patient and family education. Coordination of care entails discussions about the patient's care with other providers or agencies. These two services are considered contributory factors and although important to E/M service, are not required to be provided at every encounter.

The following are examples of counseling and coordination of care:
A clinician spends 35 minutes on the hospital floor (third hospital day for patient) and over 50 percent of that time was spent in counseling and/or coordination of care. The correct code is 99233 (subsequent hospital care), average time 35 minutes. In this case, history, examination, and medical decision making are no longer the factors that determine the selection of the level of service. Instead, the clinician documents the extent of the counseling/coordination of care in the daily progress note as well as any standard E/M work that was done.

A patient returns to a psychiatrist's office for a medication check. The encounter takes a total of 25 minutes, during which time more than 12.5 minutes is spent explaining to the patient about how a newly prescribed medication works, how to establish a routine so that no doses will be missed, and the possible side-effects of the medication and what to do if they occur. The appropriate E/M code would be 99214 (office or outpatient service for an established patient), based on the 25-minute time rather than on a detailed history and examination and moderately complex medical decision making that would be required to use this code if counseling and coordination had not taken up more than 50 percent of the time.

Use of Modifiers
Modifiers are two-digit suffixes (e.g., –22, Unusual Procedure Services) that are added to procedural codes to indicate the service or procedure has been provided under unusual circumstances. The modifiers most likely to be used by psychiatrists are:

–22 Unusual Procedure Services
This modifier is used when the work associated with the service provided is greater than that

usually required for the listed code.

–25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service
This modifier is used 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 pre- and postoperative care associated with the procedure performed.

–26 Professional Component
This modifier is used for procedures that are a combination of a physician component and a technical component. When the physician component is reported separately, this modifier is added to the usual procedure.

–52 Reduced Services
This modifier is used to report a service that is reduced in time.

Documentation
Documentation is an extremely complex issue, an issue we can only touch on here. For example, there may be special documentation requirements for Medicare found in the local Medicare contractor's Local Coverage Determination (LCD) policies; and when psychiatrists use E/M codes for treating Medicare patients, the HCFA (CMS) documentation guidelines should be used (but the clinician must decide whether to use the 1995 or 1997 guidelines—see below); and commercial insurers generally use these guidelines as well, but may have other requirements.

Although accurate documentation of services and procedures is vital for good medicine, documentation has become an increasingly troublesome practical issue for clinicians. It is especially problematic for psychiatrists because of confidentiality issues and the amount of clinical information produced during psychotherapy sessions. Also, documentation for psychotherapy codes is one issue, while documentation for E/M codes is another.

In 1995 the Health Care Financing Administration published documentation guidelines for evaluation and management services. In 1997 revised E/M documentation guidelines were issued. Currently, physicians can choose to base their documentation on either the 1995 or 1997 Documentation Guidelines for Evaluation and Management Services. Following either set will fulfill documentation requirements to the satisfaction of the Medicare program, and should be acceptable to private insurers as well. **Generally, psychiatrists will want to use the 1997 guidelines, which allow for a single-system psychiatric exam.**

The Health Insurance Portability and Accountability Act (HIPAA), which went into effect in April 2001, has very specific requirements for the privacy of patient records, and has very clear ramifications for the documentation of psychotherapy. HIPAA distinguishes between psychotherapy notes (notes a therapist may keep about the patient's personal life as distinguished from the patient's medical history and treatment) and the medical record, and holds these personal notes to a higher level of confidentiality. Since 2003, when all physicians were expected to be incompliance with HIPAA, the standard of practice has been that psychotherapy notes be kept so that they can be easily separated from the rest of a patient record.

Reimbursement Issues
It is very important for the clinician to understand that just because a code exists for a service in the CPT Manual, this does not guarantee that an insurance carrier or third-party payer will reimburse for that code. For example, Medicare will not pay for code 90882, Environmental Intervention, nor will it pay for certain codes done on the same day as others. You need to be aware of these exceptions. Clinicians may also find their contracts with managed care organizations specify certain codes that are not reimbursable, or that patients' insurance policies specify certain services that are not covered. It is essential to find out about any of these issues before treatment begins.

The outpatient mental health services limitation under Medicare was eliminated in 2014. Medicare now reimburses for all covered mental health services at 80 per cent just as it does for all other medical services.

RBRVS and Medicare Reimbursement Policies

Because Medicare's Resource-Based Relative Value Scale (RBRVS) system for the payment of clinicians has become the basis of fee schedules, even for commercial carriers, a discussion of coding issues associated with Medicare reimbursement is useful even for those psychiatrists who do not treat Medicare beneficiaries.

Since 1992, the Medicare program has reimbursed physician services based on the Resource-Based Relative Value Scale (RBRVS). RBRVS is a system that allows the mathematical calculation of Relative Value Units (RVUs) for every CPT code. The cost of providing each service described in CPT is divided into three components: physician work, practice expense, and professional liability insurance. RVUs are assigned to each component, then added together and multiplied by a conversion factor that is determined annually by CMS and voted on by Congress. The resulting figure is the Medicare fee for each service. Medicare fees vary slightly throughout the country due to adjustments for geographical differences in resource costs. For instance, the fees in New York are higher than those in Mississippi.

Medicare generally excludes from payment all non-face-to-face services such as telephone calls (including Skype), environmental interventions, record reviews, and case management, although there may be some variation in local payment policies.

The way to avoid delay of payment or audits because of disputes over use of codes that you're not absolutely certain about is to prospectively negotiate with insurers about the use of any codes that are not unquestionably standard.

Conclusions

Careful, correct coding is vital to the practicing psychiatrist. Take it seriously. Not only will correct coding help achieve prompt and appropriate payment for treatment, it will also provide protection from charges of fraud and abuse. Accurate documentation of the services you have provided, and coded for, is the most certain means of protection against allegations of abusive or fraudulent billing. Accurate documentation is also extremely helpful in defending against malpractice allegations. You need to stay current on coding issues.

- Buy and read the AMA's annually published CPT Manual
- Stay in touch with your District Branch and the APA's Office of Healthcare Systems and Financing about coding and billing issues.
- Psychiatrists who provide services under Medicare must educate themselves on policies specific to Medicare. You want to be sure to read any correspondence sent to you by your Medicare contractor.

You should code and bill for all services rendered regardless of local or national payer policies – the developing database may help change payment policies that negatively affect reimbursement of mental health services.

It is important that you not try to game the reimbursement system by manipulating codes inappropriately. Medicare/Medicaid fraud, and insurance fraud in general, is a serious priority of the Justice Department.

Note: Although psychiatrists are likely to use only the codes within the Psychiatry and E/M sections of the CPT Manual to cover the services they provide, the Manual clearly states in its introduction: **"Any procedure or service in any section of this book may be used to designate the services rendered by any qualified physician."**

Recommended Reading

- American Medical Association, *Physicians Current Procedural Terminology*

(published yearly, refer to most current)

To purchase a copy of the AMA 2014 CPT manual call the AMA at 800-621-8335 or go to the AMA online bookstore: https://catalog.ama-assn.org/Catalog/home.jsp .

APA's Web Site, CPT Coding Service, and Additional Resources

APA CPT Coding Service

Look for timely information on coding and documentation issues on the APA's website www.psychiatry.org in the Practice section and in the Psychiatric News Bulletin, which is e-mailed to members weekly. Information specific to the changes that occurred in 2013 can be found at: http://www.psychiatry.org/cptcodingchanges.

The APA is actively involved in ensuring that members are correctly reimbursed for the services they provide. Working closely with the Committee on RBRVS, Codes, and Reimbursement, the APA's Office of Healthcare Systems and Financing (OHSF) has established a CPT Coding Service. Because CPT questions are very specific and often very complex, a protocol has been established for queries to ensure that there will be no misunderstanding.

APA members with CPT coding questions should:

- Write an e-mail or memo with their name, APA member number, city, state, phone number, fax number, and e-mail address.
- State the question or describe the problem thoroughly, but succinctly—a short paragraph is usually all that is necessary.
- Include any relevant correspondence from Medicare carriers, insurance companies, or third-party payers.
- Cite any actions that have been taken relating to the problem, i.e., calls made, letters written
- E-mail (hsf@psych.org), fax (907-703-1089), or mail (Office of Healthcare Systems and Financing, APA, 1000 Wilson Boulevard, # 1825, Arlington, VA, 22209) the question to the attention of Rebecca Yowell.

All questions will be answered as quickly as possible.

Courses/Workshops

APA Annual Meeting Course and Workshop – A CPT coding CME course as well as a CPT workshop are generally held each year at the APA Annual Meeting. Check the APA Annual Meeting program for more information.

APA Medicare Advisory Network

The APA's Office of Healthcare Systems and Financing maintains an online network of psychiatrists who are involved in Medicare policy issues across the country. This network allows the APA's central office to monitor how Medicare is actually working from state to state. It alerts psychiatrists across the United States to issues that are problematic and keeps them apprised as to whether their state's carrier is in compliance with Medicare rules and regulations.

The network's membership has historically been comprised of the psychiatry representatives to each Medicare carrier's Carrier Advisory Committee (CAC). Until very recently Medicare carriers have administrated Part B of Medicare (Part A has been administered by fiscal intermediaries), and the CACs have been mandated by law to ensure that carriers have input from medical practitioners when they establish local Medicare policy, specifically local coverage determinations, or LCDs; (formerly referred to as LMRPs, or local medical review policies). The psychiatry representatives to the CACs are chosen by the APA's District Branches. Medicare has almost completed the transition from carriers and fiscal intermediaries to Medicare Administrative Contractors, which oversee both Parts A and B. Thus far it appears that the CACs are continuing to meet to advise these new entities just as they have Medicare carriers.

The Office of Healthcare Systems and Financing (OHSF) provides staffing for the network and

provides support so that members in all regions can work together when there are issues that need to be addressed. Members of OHSF staff meet as necessary with representatives from the Centers for Medicare and Medicaid Services and with Medicare Medical Directors to solve problems communicated to them by members of the network.

For information on your local representative to the APA Medicare network representative, go to the APA web site at www.psychiatry.org. You can locate the list in the Medicare/Medicaid section under Psychiatric Practice. Medicare questions can also be directed to the attention of Ellen Jaffe in the Office of Healthcare Systems and Financing (HSF) by calling 800-343-4671 or writing her via the HSF e-mail address, hsf@psych.org.

www.psychiatry.org

Psychiatric Services
2012 to 2013 Crosswalk

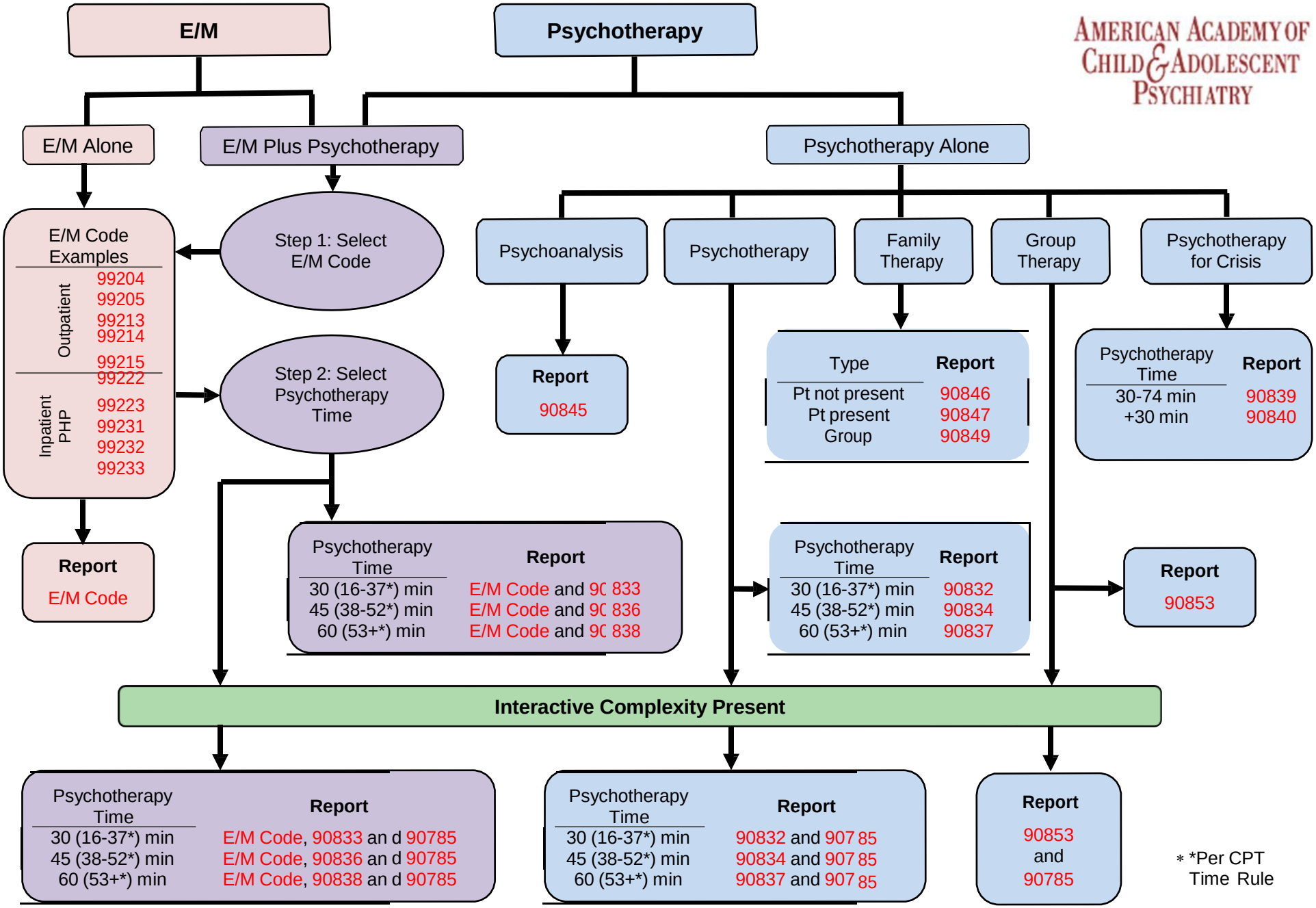
AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY
WWW.AACAP.ORG

2012			2013		
Service	**CPT Code**	**2013 Status**	**Service**	**CPT Code**	**Report with interactive complexity (+90785)**
Diagnostic					
Diagnostic interview examination	90801	DELETED	Diagnostic evaluation (no medical)	90791	When appropriate
			Diagnostic evaluation with medical	**90792**	
Interactive diagnostic interview examination	90802	DELETED	Diagnostic evaluation (no medical)	**90791**	Yes
			Diagnostic evaluation with medical	**90792**	
Psychotherapy					
Individual psychotherapy 20-30 min	90804, 90816	DELETED	Psychotherapy 30 (16-37*) min	**90832**	When appropriate
45-50 min	90806, 90818		45 (38-52*) min	**90834**	
75-80 min	90808, 90821		60 (53+*) min	**90837**	
Interactive individual psychotherapy 20-30 20-30 min	90810, 90823	DELETED	30 (16-37*) min	**90832**	Yes
45-50 min	90812, 90826		45 (38-52*) min	**90834**	
75-80 min	90814, 90828		60 (53+*) min	**90837**	
Psychotherapy with E/M (there is no one-to-one correspondence)					
Individual psychotherapy with E/M, 20-30 min	90805, 90817	DELETED	E/M plus psychotherapy add-on	**E/M code** (selected using key components, *not* time) and one of: **+90833** 30 (16-37*) min **+90836** 45 (38-52*) min **+90838** 60 (53+*) min	When appropriate
45-50 min	90807, 90819				
75-80 min	90809, 90822				
Interactive individual psychotherapy with E/M 20-30 min	90811, 90824	DELETED			Yes
45-50 min	90813, 90827				
75-80 min	90815, 90829				
Other Psychotherapy					
(None)			Psychotherapy for crisis	**90839, +90840**	No
Family psychotherapy	90846, 90847, 90849	RETAINED	Family psychotherapy	**90846, 90847, 90849**	No
Group psychotherapy	90853	RETAINED	Group psychotherapy	**90853**	When appropriate
Interactive group psychotherapy	90857	DELETED			Yes
Other Psychiatric Services					
Pharmacologic management	90862	DELETED	E/M	**E/M code**	No

*Per CPT Time Rule

E/M and Psychotherapy Coding Algorithm

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY



* *Per CPT Time Rule

The changes to the CPT Psychiatry codes were major. The entire coding framework has changed. The APA has based the answers to these FAQs on its general current understanding of the CPT codes and the information available to it. It is possible that as more information becomes available some the information could be outdated. THIS IS NOT LEGAL ADVICE. Members are advised to seek the advice of attorneys specializing in this area of law if for any legal questions.

Q: I understand there are now two codes to use for a standard initial psychiatric diagnostic evaluation, 90791 and 90792. Why was this done?
A: Previously all mental health clinicians use the same initial evaluation codes, 90801 and 90802, even though nonmedical providers could not provide the medical work that was described in those codes. In 2013, psychiatrists can use code 90792, which indicates medical services were provided, while nonmedical providers will use 90791, which does not include medical services. Medical services may consist of any medical activities such as performing elements of a physical exam or considering writing a prescription or modifying psychiatric treatment based on medical comorbidities.

Q: In looking at the 2013 Medicare Physician Fee Schedule, I noticed that Medicare is paying more for CPT code 90791, the code for the psychiatric diagnostic evaluation without medical services, than it is for 90792, the same code *with* medical services. How could this be?
A: These two codes were created to distinguish the work done by psychiatrists from that done by nonphysicians. They replace 90801, which was used by all mental health providers even though its descriptor included medical services that many of them were not qualified to perform. Unfortunately, and completely contrary to the usual procedure for newly created CPT codes, the Centers for Medicare and Medicaid service (CMS) chose to implement the new CPT coding structure for psychiatry without finalizing new values (RVUs) , as is normally the case. Instead, CMS created interim values for the new codes based on the 2012 code values and applied them to the 2013 coding structure. In order to maintain budget neutrality for 2013, CMS reduced the practice expense component for codes billed exclusively by medical professionals even though other changes to the code values were not made, while letting the practice expense value remain the same for nonphysician codes. The rationale given by CMS for this was that those providers now able to bill evaluation and management (E/M) services would benefit from higher practice expense payments any time they billed an E/M code. Oddly, CMS chose to apply this rationale not only to the values for the psychotherapy add-on codes that are used with E/M codes, but also to apply it to the initial diagnostic evaluation (90792) that includes medical services – a service that cannot be billed with an E/M code. As a result of this formula, the total payment for the 90792 is less (by about $25) than that for the 90791 even though the work is greater, the malpractice liability is greater, and the practice expense values are certainly no less than that for all mental health clinicians. Once the values are finalized and the practice expense is calculated equally, 90792 will pay more than 90791. Regardless of this, APA has made it clear to CMS that it is unacceptable for this current inequity to be in place even on an interim basis. This anomaly incentivizes psychiatrists to code differently than they otherwise should. APA has asked CMS in multiple written communiqués and telephone conversations to correct this discrepancy but to date they have stood behind their decision despite the inequity and perverse incentives it has created in valuing a more complex service lower than the same service done without medical services .

Q: I understand that instead of using the previous psychotherapy codes with E/M services (90805, 90807), we now must bill using the appropriate E/M code from the 99xxx series of codes (i.e., 99211, 99212, etc) and a timed add-on code for the psychotherapy. What exactly is an add-on code?
A: An add-on code is a code that can only be used in conjunction with another, primary code and is indicated by the plus symbol (+) in the CPT manual. The add-on code concept was developed to eliminate the redundancy of work that occurs when you provide two services on the same day (i.e., reviewing a patient's medical record, greeting the patient). In the new Psychiatry codes there are three different types of add-on codes: 1.) Timed add-on codes to be used to indicate psychotherapy when it is done with medical evaluation and management; 2.) A code to be used when psychotherapy is done that involves interactive complexity; and 3.) A code to be used with the new crisis therapy code for each 30 minutes beyond the first hour. On the claim form, the add-on code is listed as a second code.

Q: What is an E/M code?
A: The evaluation and management (E/M) codes are found in the first section of the AMA CPT manual. The first two digits of this code set are 99. The E/M codes are generic in the sense that they can be used by all physicians. They describe general medical services. Code selection is based on whether the patient is new or established, the setting (outpatient, inpatient, nursing facility, etc.), and on the complexity of the service provided, which is based on the nature of the presenting problem. There are specific documentation requirements when using these codes. You can download a list of the most frequently used E/M codes as well as information on the documentation requirements on the APA's webpage for CPT Coding Changes (www.psychiatry.org/cptcodingchanges).

Q: I'd never used the CPT evaluation and management codes before, is there somewhere I can find out about how to use them?
A: You can download the chapter on E/M coding from the book *Procedure Coding for Psychiatrists* (the information on the psychiatry codes in this 2011 book is now obsolete, but the information about the E/M codes is current.) The chapter is available on the APA website at www.psychiatry.org/cptcodingchanges as are a number of webinars dealing with E/M coding. APA also has an online CME course on the CPT code changes available free to members at www.apaeducation.org.

Q: What E/M code would I be most likely to use to replace the basic E/M services I've been providing to my patients with whom I do psychotherapy and evaluation and management (for which I used to code 90807)?
A: The most basic E/M service provided by a physician for outpatient work with an established patient is 99212. This would most likely be the appropriate code to use when you see a stable patient. There are specific guidelines for selecting E/M codes published by the Centers for Medicare and Medicaid Services, and a link can be found to these guidelines at http://psychiatry.org/cptcodingchanges. The guidelines mandate elements of history, examination, and medical decision making that must be covered to satisfy the various levels of E/M coding, and you will have to be sure that your documentation fulfills the requirements for 99212 or any other E/M code that you use. The APA has templates on its website to assist with this documentation.

Q: Can I choose the E/M code on the basis of time spent providing counseling and coordination of care and also bill for psychotherapy using the psychotherapy add-on?
A: No, if you are doing psychotherapy in conjunction with an E/M service, you must choose the E/M code on the basis of the work performed, NOT on the basis of time spent providing counseling and coordination of care.

Q: In my outpatient practice I often see patients for medication management and previously used CPT code 90862, which was deleted for 2013. What code will I use in place of 90862?
A: The typical outpatient 90862 is most similar to E/M code 99213. If the patient you are seeing is stable, and really just needs a prescription refill, code 99212 might be a more appropriate crosswalk. If you have a patient with a very complex situation, you might need to use 99214, a higher level E/M code. The E/M codes have documentation guidelines published by the Centers for Medicare and Medicaid Services (CMS) that explain how to determine which level code to choose. There is a link to this information at http://psychiatry.org/cptcodingchanges.

Q: Are the times listed for the add-on psychotherapy codes in addition to the time spent doing the E&M or is the time spent doing the E&M included in the time listed for the psychotherapy?
A: The time listed for psychotherapy add-on code accounts ONLY for the time spent providing psychotherapy. Any time spent providing E/M services should not be included in the psychotherapy add-on time.

Q: I am a solo practitioner and generally see my patients for both E/M and psychotherapy on a weekly basis. Does the E/M code I bill limit the psychotherapy code I can bill?

A: No. The two services are separate. You code and document for whatever level of E/M is warranted by the patient's presenting problem that day and select the add-on psychotherapy code based on the length of time of the psychotherapy provided. The add-on psychotherapy codes are 90833 for 30 minutes, 90836 for 45 minutes, and 90838 for 60 minutes. Since the new psychotherapy codes are not for a range of time, like the old ones, but for a specific time, the CPT "time rule" applies. If the time is more than half the time of the code (i.e., for 90832 this would be 16 minutes) then that code can be used. For up to 37 minutes you would use the 30 minute code; for 38 to 52 minutes, you would use the 45-minute code, 90834; and for 53 minutes and beyond, you would use 90837, the 60-minute code.

Q: **I take no insurance in my practice, but give my patients invoices for my services, which they submit to their insurance company for reimbursement. I see my patient regularly for psychotherapy along with medical evaluation, and in the past have always coded for the visit with 90807. Under the new coding format, the patient is required to submit a bill with the new codes. I will code using 99212 (since almost all my patients are stable and just require minimal E/M) and 90836, the add-on psychotherapy code for 45 minutes of psychotherapy. My question is, with the new CPT codes, am I required to apportion my fee between these two codes? If so, is there a reasonable way to do this?**
A: It has become clear that most insurers are requiring that you apportion your fee between the two codes. The most reasonable way to do this may be to base how you apportion the fee on the relative value units that Medicare assigns to each of the codes. You can find these RVUs on the APA's website www.psychiatry.org/cptcodingchanges under the heading "RVUs." If you take the total of the RVUs for the two codes you bill and divide that into your total fee, that will give you your practice's fee for 1 RVU. Multiplying this by the RVUs assigned to each code will give you a fee for each code. Many payers base their fee schedules on the RVUs Medicare assigns so the provider may accept this approach.

If the patient's insurer does not use the Medicare RVUs, you could get a copy of the fee schedule used by the patient's insurer for its in-network providers. You can apply the ratio they use for the two codes to your total fee and come up with the ratio that insurer deems is appropriate for the two codes. If the insurer will not provide you with the fee schedule, ask them to provide the ratio between the relevant codes and use that information in your calculation.

Q: I'm a solo practitioner and still file paper claims, how do I fill out the 1500 form to show I've done an E/M service with psychotherapy?
A: The first service reported will be the E/M code, on line 1, and underneath that, on line 2, you will put the add-on code (just the five digits, no plus sign) as a second service. You fill out each line completely, including the fee for each service.

Q: I am a child psychiatrist and, in the past, generally billed using one of the interactive psychotherapy codes. What do I use now?
A: There is now an add-on code, 90785, that can be used with diagnostic evaluation or psychotherapy codes to indicate what is now referred to as "interactive complexity." The concept of interactive complexity has been expanded. See the interactive complexity guide developed by the American Academy of Child and Adolescent Psychiatry at http://psychiatry.org/cptcodingchanges .
Q: I practice at a community mental health center where the billing department has told me that I cannot use E/M codes because "it's not allowed" and because no insurance company, including Medicare, will reimburse for them. I have never understood this and am now wondering whether we will suddenly be able to use E/M codes in 2013 or whether we're going to have trouble getting paid for anything.
A: The CMHC where you work may, for whatever reasons, choose not to bill using E/M codes, and they may have contracts with some insurers that limit them to the codes in the Psychiatry section of CPT. However, Medicare has no stricture against reimbursing psychiatrists for providing E/M services, and under Parity no insurance company should refuse to reimburse psychiatrists when they provide E/M services. Under the new coding framework psychiatrists will have to use E/M codes for the evaluation and management services they provide. Any CMHC that previously excluded them from its billing should have changed its policy by now.

Q: What CPT code would be appropriate for a psychiatrist to bill for the evaluation of a patient in the emergency room setting? Would the ER evaluation and management CPT codes (99281-99291) be appropriate if the patient was already seen by a clinical social worker and the clinical social worker is billing for the psychiatric evaluation by using CPT 90791? Or, would the psychiatrist be allowed to bill for CPT code 90792 on the same day the clinical social worker used CPT 90791?
A: Usually the ER codes would be billed by the ER physician who sees the patient in the ER. The psychiatrist who sees the patient in the ER is doing so as an outpatient consultation. He/she could use the E/M outpatient consult codes (99241-99245) or 90792. (If the patient has Medicare, you can't bill the consult codes, but can use the outpatient E/M new patient visit codes, 99201-99205, instead, or 90792). If both a social worker and a psychiatrist each did a complete evaluation on a patient, the social worker could bill a 90791 and the psychiatrist a 90792. That said. Although you could code this way, it is likely that many payers would question why it was necessary for both clinicians to do an initial evaluation and they may not be willing to reimburse for both. If the patient is admitted to the inpatient psychiatry service, the psychiatrist would use the initial hospital care E/M codes (99221-99225), which would cover both the consult and initial psychiatric evaluation.

Q: What are the RVUs (including malpractice, practice expense, and work components) associated with the new codes? Without that information it is hard to decide what to charge for them.
A: Although RVUs for the codes were recommended to the Centers for Medicare and Medicaid Services by the AMA RUC based on surveys that were done for the new codes. CMS chose to give interim values to the new and revised CPT codes that had been reviewed. In the Final Rule for the 2013 Medicare Physician Fee Schedule, CMS said it would l finalize the values once all of the codes had been surveyed and valued by the RUC. This has occurred and final RVUs should be listed in the 2014 Medicare Fee Schedule. A table with the 2013 RVUs (the interim values) can be found at www.psychiatry.org/cptcodingchanges.

Q: Is the 90863 code for RNs to use?
A: 90863 is *only* for use by those few psychologists licensed to prescribe in Louisiana and New Mexico but who, as nonmedical clinicians, are not qualified to bill evaluation and management codes. 90863 is not recognized by Medicare.

Q: Can prescribing psychologists use E/M codes?
A: No, that is why code 90863 was created.

Q: Where in the CPT code manual does it state that 90863 is for prescribing psychologists only? (I don't find this reading the information provided on page 486.)
A: CPT is not provider specific, so this is not specifically stated. However, the rationale behind the development of that code was to accommodate those few psychologists who could prescribe, but by law cannot bill an E/M service.

Q: If during an evaluation or a follow-up session, meds are NOT prescribed, but the patient is assessed as to whether meds would be appropriate, can we still consider that an E/M?
A: Yes, E/M codes describe any manner of medical work and not just the prescription of medication.

Q: If the psychiatrist sees the patient and does 30 minutes of combined psychotherapy and medication management, and then the patient sees a social worker for 30 minutes of psychotherapy alone, what should they bill?
A: You would bill the work performed (E/M and the appropriate psychotherapy code for the psychiatrist; 30 minute psychotherapy code for the social worker). However, it's important to understand that the payer determines whether or not those codes can be billed on the same day for the same patient.

Q: Do you recommend using the E/M new patient codes or 90792?

A: You could use either. There may be times, based and the presenting problem and the complexity of the work performed, when a higher level E/M code may be more appropriate.

Q: What is the difference between Psychotherapy with E/M versus E/M with Psychotherapy?
A: Nothing, they both describe work that includes E/M and psychotherapy services, which is reported using a different coding schema in 2013. The new coding is meant to allow more accurate accounting of the E/M services provided.

Q: I am in-network for several insurance companies and they don't seem to be dealing correctly with the new coding. One of them is paying me less than it did last year even though I am providing the same service, albeit using different coding, and another is saying I should collect two copays from my patients even though I know this is wrong. What can I do?
A: Many insurers were handling claims inappropriately at the beginning of 2013, but have since adjusted their systems to comply with the new coding. If you are still having problems, please contact the APA's Practice Management HelpLine at 800-343-4671 or email us at hsf@psych.org .

Q: What are the times for the various E/M codes for established patients, and is there any reason you couldn't use the 50% counseling and coordination of care for every follow up visit if it applies?
A: Correct coding requires that you choose the code that most closely represents the work performed. If more than 50% of your E/M service involves counseling and coordination of care, you can choose the code on the basis of time. You cannot choose the E/M code on the basis of counseling and coordination of care if you also bill a psychotherapy service for the same visit. We must also warn you that consistently billing using high level E/M codes on the basis of counseling and coordination of care may often elicit an audit from Medicare or commercial insurers. In fact, Medicare announced that in 2013 it will be auditing claims for 99215 on the basis of frequency.

Q: What constitutes "counseling and coordination of care"?
A: Counseling, as defined by CPT, is a discussion with a patient and/or family concerning one or more of the following areas:

- Diagnostic results, impressions, and/or recommended diagnostic studies
- Prognosis
- Risks and benefits of management (treatment) options
- Instructions for management (treatment) and/or follow-up
- Importance of compliance with chosen management (treatment) options
- Risk factor reduction
- Patient and family education

Q: Is 30 minutes now the minimum face to face time for psychotherapy with a patient?
A: 30 minutes is the lowest timed psychotherapy code. Under the CPT time rule, the 30-minute code can be billed for sessions between 16 and 37 minutes.

Q: What has happened to the family therapy codes, 90846, 90847?
A: They are still there, nothing has changed.

Q: Family members of a man with serious mental illness who is not a patient of mine have asked to see me for assistance with navigating the mental health system on behalf of the patient and for help in dealing with the patient at home. I was thinking of using 90846 and calling it Family Therapy without the patient present, but since the patient is not part of my practice this seems questionable.
A: You are not required to use CPT codes any time you provide medical services, although they are required for billing purposes. Since this is not a service that would be covered by health insurance, there is really no reason to code for this encounter. What is important is that you set the fee with the

family in advance, and then provide them with a simple bill for counseling and assistance regarding the family member with mental illness.

Q: What is the difference between a new outpatient E/M visit versus an established outpatient visit; 99201 vs 99211?
A: You only use the new outpatient visit code when this is the first time you've ever treated the patient or it has been more than three years since you or anyone in your practice of the same specialty or subspecialty has seen the patient.

Q: If you are a small psychiatric office and purchasing CPT books, would it be best to purchase AMA CPT or ICD-9-CM VOL 1-3? Bundles are cheaper.
A: We would suggest purchasing the AMA CPT book so you have reference to the complete set of coding guidelines developed for the new codes psychiatrists will be using. The DSM uses ICD diagnostic codes, and the DSM-5 provides both the ICD-9-CM codes, which are in use now, and the ICD-10-CM codes, which will go into effect for use in the U.S. in October, 2014.

Q: Are there visit note templates that have been developed for psychiatrists to easily check off the bullets necessary for E/M coding?
A: Templates are available on the APA website at www.psychiatry.org/cptcodingchanges.

Q: Does 90792 cover deciding and prescribing medications in the session?
A: Yes, that could be one component of the medical service that differentiates 90792 from 90791.

Q: Are there specific requirements for 90792, and are there other codes for new patients beyond 90791 and 90792?
A: The documentation requirements for the 90792 are really the same as the documentation for 90801. The only difference is you will want to be sure to list any of the medical work when billing the 90792. Psychiatrists and others who can bill E/M codes may also choose to bill an initial evaluation with the appropriate E/M code.

AMA's CODING AND DOCUMENTATION PRINCIPLES

- The medical record should be complete and legible.
- The documentation of each patient encounter should include the date; reason for the encounter; appropriate history and physical examination; review of laboratory, x-ray data, and other ancillary services when appropriate; assessment; and plan for care, including discharge plan if appropriate.
- Past and present diagnoses should be accessible to the treating and/or consulting physician.
- The reasons for and results of x-rays, laboratory tests, and other ancillary services should be documented or included in the medical record.
- The patient's progress, including response to treatment, change in treatment, change in diagnosis, and patient noncompliance, should be documented.
- The written plan for care should include, when appropriate, treatments and medications, specifying frequency and dosage; any referrals and consultations; patients/family education; and specific instructions for follow-up.
- The documentation should support the intensity of the patient evaluation and/or the treatment, including thought processes and the complexity of medical decision making.
- All entries to the medical record should be dated and authenticated.
- Physicians' Current Procedural Terminology (CPT)/International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes reported on the health insurance claim form or billing statement should reflect the documentation in the medical record.

SELECTED SECTIONS FROM THE 2011 PROCEDURE CODING HANDBOOK FOR PSYCHIATRISTS, FOURTH EDITION

- Codes and Documentation for Evaluation and Management Services
- 1997 CMS Documentation Guidelines for Evaluation and Management Services (Abridged and Modified for Psychiatric Services)
- Additional Items: Sample documentation for codes 99213 – 99215
- Vignettes for Evaluation and Management Codes
- Most Frequently Missed Items in Evaluation and Management (E/M) Documentation

4

Codes and Documentation for Evaluation and Management Services

The evaluation and management (E/M) codes were introduced in the 1992 update to the fourth edition of *Physicians' Current Procedural Terminology* (CPT). These codes cover a broad range of services for patients in both inpatient and outpatient settings. In 1995 and again in 1997, the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services, or CMS) published documentation guidelines to support the selection of appropriate E/M codes for services provided to Medicare beneficiaries. The major difference between the two sets of guidelines is that the 1997 set includes a single-system psychiatry examination (mental status examination) that can be fully substituted for the comprehensive, multisystem physical examination required by the 1995 guideline. Because of this, it clearly makes the most sense for mental health practitioners to use the 1997 guidelines (see Appendix E). A practical 27-page guide from CMS on how to use the documentation guidelines can be found at http://www.cms.hhs.gov/MLNProducts/downloads/eval_mgmt_serv_guide.pdf. The American Medical Association's CPT manual also provides valuable information in the introduction to its E/M section. Clinicians currently have the option of using the 1995 or 1997 CMS documentation guidelines for E/M services, although for mental health providers the 1997 version is the obvious choice.

The E/M codes are generic in the sense that they are intended to be used by all physicians, nurse-practitioners, and physician assistants and to be used in primary and specialty care alike. All of the E/M codes are available to you for reporting your services. Psychiatrists frequently ask, "Under what clinical circumstances would you use the office or other outpatient service E/M codes in lieu of the psychiatric evaluation and psychiatric therapy codes?" The decision

to use one set of codes over another should be based on which code most accurately describes the services provided to the patient. The E/M codes give you flexibility for reporting your services when the service provided is more medically oriented or when counseling and coordination of care is being provided more than psychotherapy. (See p. 44 for a discussion of counseling and coordination of care).

Appendix K provides national data on the distribution of E/M codes selected by psychiatrists within the Medicare program. Please note that although there are many codes available to use for reporting services, the existence of the codes in the CPT manual does not guarantee that insurers will reimburse you for the services designated by those codes. Some insurers mandate that psychiatrists and other mental health providers only bill using the psychiatric codes (90801 – 90899). It is always smart to check with the payer when there are alternatives available for coding.

THE E/M CODES

- E/M codes are used by all physician specialties and all other duly licensed health providers.
- The definitions of ***new patient*** and ***established patient*** are important because of the extensive use of these terms throughout the guidelines in the E/M section. **A *new patient* is defined as one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group within the past 3 years. An *established patient* is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group within the past 3 years.** When a physician is on call covering for another physician, the decision as to whether the patient is new or established is determined by the relationship of the covering physician to the physician group that has provided care to the patient for whom the coverage is now being provided. If the doctor is in the same practice, even though she has never seen the patient before, the patient is considered established. There is no distinction made between new and established patients in the emergency department.

  The other terms used in the E/M descriptors are equally as important. The terms that follow are vital to correct E/M coding (complete definitions for them can be found under Steps 4 and 5 later in this chapter):

  - Problem-focused history
  - Detailed history
  - Expanded problem-focused history
  - Comprehensive history

  - Problem-focused examination
  - Detailed examination
  - Expanded problem-focused examination
  - Comprehensive examination

  - Straightforward medical decision making
  - Low-complexity medical decision making
  - Moderate-complexity medical decision making
  - High-complexity medical decision making
- E/M codes have three to five levels of service based on increasing amounts of work.
- Most E/M codes have time elements expressed as the time "typically" spent face-to-face with the patient and/or family for outpatient care or unit floor time for inpatient care.
- For each E/M code it is noted that "Counseling and/or coordination of care with other providers or agencies is provided consistent with the nature of the problem(s) and the patient's and/or family's needs." ***When this counseling and coordination of care accounts for more than 50% of the time spent, the typical time given in the code descriptor may be used for selecting the appropriate code rather than the other factors.*** (See p. 44 for a discussion of counseling and coordination of care.)
- The 1995 and 1997 CMS documentation guidelines for E/M codes have become the basis for sometimes draconian compliance requirements for clinicians who treat Medicare beneficiaries. Commercial payers have adopted elements of the documentation system in a variable manner. ***The fact is that the documentation guidelines cannot be ignored by practitioners.*** To do so would place the practitioner at risk for audits, civil actions by payers, and perhaps even criminal charges and prosecution by federal agencies.

SELECTING THE LEVEL OF E/M SERVICE

The following are step-by-step instructions that guide you through the code selection process when providing services defined by E/M codes. Code selection is made based on the work performed.

Step 1: Select the Category and Subcategory of E/M Service

Table 4 – 1 lists the E/M services most likely to be used by psychiatrists. This table provides only a partial list of services and their codes. For the full list of E/M codes [and the coding guidelines] you will need to refer to the CPT manual.

TABLE 4–1. **EVALUATION AND MANAGEMENT CODES MOST LIKELY TO BE USED BY PSYCHIATRISTS**

	CATEGORY/SUBCATEGORY	CODE NUMBERS
	New patient	99201–99205
	Established patient	99211–99215
	Hospital observational services	
	Observation care discharge services	99217
	Initial observation care	99218–99220
	Hospital inpatient services	
	Initial hospital care	99221–99223
	Subsequent hospital care	99231–99233
	Hospital discharge services	99238–99239
	Consultations[1]	
	Office consultations	99241–99245
	Inpatient consultations	99251–99255
	Emergency department services	
	Emergency department services	99281–99288
	Nursing facility services	
	Initial nursing facility care	99304–99306
	Subsequent nursing facility care	99307–99310
	Domiciliary, rest home, or custodial care services	
	New patient	99324–99328
	Established patient	99334–99337
	Home services	
	New patient	99341–99345
	Established patient	99347–99350
	Team conference services	
	Team conferences with patient/family[2]	99366
	Team conferences without patient/family	99367
	Behavior change interventions	
	Smoking and tobacco use cessation	99406–99407
	Alcohol and/or substance abuse structured screening and brief intervention	99408–99409
	Non-face-to-face physician services[3]	
	Telephone services	99441–99443
	On-line medical evaluation	99444
NEW	Interprofessional telephone/internet consultations	99446-99449
	Basic life and/or disability evaluation services	99450
	Work-related or medical disability evaluation services	99455–99456
	Complex chronic care coordination services	99487-99489
	Transitional Care Management Services	
	Transitional Care management services	99495-99495

[1]Medicare no longer recognizes these codes.

[2]For team conferences with the patient/family present, physicians should use the appropriate evaluation and management code in lieu of a team conference code.

[3]Medicare covers only face-to-face services.

Step 2: Review the Descriptors and Reporting Instructions for the E/M Service Selected

Most of the categories and many of the subcategories of E/M services have special guidelines or instructions governing the use of the codes. For example, under the description of initial hospital care for a new or established patient, the CPT manual indicates that the inpatient care level of service reported by the admitting physician should include the services related to the admission that he or she provided in other sites of service as well as in the inpatient setting. E/M services that are provided on the same date in sites other than the hospital and that are related to the admission should *not* be reported separately.

Examples of Descriptors for CPT Codes Used Most Frequently by Psychiatrists
99221—Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components: • A detailed or comprehensive history • A detailed or comprehensive examination • Medical decision making that is straightforward or of low complexity Counseling and/or coordination of care with other providers or agencies is provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.
99222—Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components: • A comprehensive history • A comprehensive examination • Medical decision making of moderate complexity Counseling and/or coordination of care with other providers or agencies is provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.
99223—Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components: • A comprehensive history • A comprehensive examination • Medical decision making of high complexity Counseling and/or coordination of care with other providers or agencies is provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.

Step 3: Review the Service Descriptors and the Requirements for the Key Components of the Selected E/M Service

Almost every category or subcategory of E/M service lists the required level of history, examination, or medical decision making for that particular code. (See the list of codes later in the chapter.)

For example, for E/M code 99223 the service descriptor is "Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components" and the code requires

- Comprehensive history
- Comprehensive examination
- Medical decision making of high complexity

Each of these components are described in Steps 4, 5, and 6.

Step 4: Determine the Extent of Work Required in Obtaining the History

The extent of the history obtained is driven by clinical judgment and the nature of the presenting problem. Four levels of work are associated with history taking. They range from the simplest to the most complete and include the components listed in the sections that follow.

The elements required for each type of history are depicted in Table 4 – 2. Note that each history type requires more information as you read down the left-hand column. For example, a problem-focused history requires the documentation of the chief complaint (CC) and a brief history of present illness (HPI), and a detailed history requires the documentation of a CC, an extended HPI, an extended review of systems (ROS), and a pertinent past, family, and/or social history (PFSH).

The extent of information gathered for a history is dependent on clinical judgment and the nature of the presenting problem. Documentation of patient history includes some or all of the following elements.

A. Chief Complaint (CC)

The chief complaint is a concise statement that describes the symptom, problem, condition, diagnosis, or reason for the patient encounter. It is usually stated in the patient's own words. For example, "I am anxious, feel depressed, and am tired all the time."

B. History of Present Illness (HPI)

The history of present illness is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. HPI elements are:

- Location (e.g., feeling depressed)
- Quality (e.g., hopeless, helpless, worried)
- Severity (e.g., 8 on a scale of 1 to 10)
- Duration (e.g., it started 2 weeks ago)

TABLE 4–2. **ELEMENTS REQUIRED FOR EACH TYPE OF HISTORY**

TYPE OF HISTORY	CHIEF COMPLAINT	HISTORY OF PRESENT ILLNESS	REVIEW OF SYSTEMS	PAST, FAMILY, AND/OR SOCIAL HISTORY
Problem focused	Required	Brief	N/A	N/A
Expanded problem focused	Required	Brief	Problem pertinent	N/A
Detailed	Required	Extended	Extended	Pertinent
Comprehensive	Required	Extended	Complete	Complete

- Timing (e.g., worse in the morning)
- Context (e.g., fired from job)
- Modifying factors (e.g., feels better with people around)
- Associated signs and symptoms (e.g., loss of appetite, loss of weight, loss of sexual interest)

There are two types of HPIs, *brief* and *extended:*

1. *Brief* includes documentation of one to three HPI elements. In the following example, three HPI elements—location, severity, and duration—are documented:
   - CC: Patient complains of depression.
   - Brief HPI: Patient complains of feeling severely depressed for the past 2 weeks.
2. *Extended* includes documentation of at least four HPI elements or the status of at least three chronic or inactive conditions. In the following example, five HPI elements—location, severity, duration, context, and modifying factors—are documented:
   - CC: Patient complains of depression.
   - Extended HPI: Patient complains of feelings of depression for the past 2 weeks. Lost his job 3 weeks ago. Is worried about finances. Trouble sleeping, loss of appetite, and loss of sexual interest. Rates depressive feelings as 8/10.

C. REVIEW OF SYSTEMS (ROS)

The review of systems is an inventory of body systems obtained by asking a series of questions in order to identify signs and/or symptoms that the patient may be experiencing or has experienced. The following systems are recognized:

- Constitutional (e.g., temperature, weight, height, blood pressure)
- Eyes
- Ears, nose, mouth, throat
- Cardiovascular
- Respiratory

- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

There are three levels of ROS:

1. ***Problem pertinent,*** which inquires about the system directly related to the problem identified in the HPI. In the following example, one system—psychiatric—is reviewed:
   - CC: Depression.
   - ROS: Positive for appetite loss and weight loss of 5 pounds (gastrointestinal/constitutional).
2. ***Extended,*** which inquires about the system directly related to the problem(s) identified in the HPI and a limited number (two to nine) of additional systems. In the following example, two systems—constitutional and neurological—are reviewed:
   - CC: Depression.
   - ROS: Patient reports a 5-lb weight loss over 3 weeks and problems sleeping, with early morning wakefulness.
3. ***Complete,*** which inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional (minimum of 10) body systems. In the following example, 10 signs and symptoms are reviewed:
   - CC: Patient complains of depression.
   - ROS:
     a. Constitutional: Weight loss of 5 lb over 3 weeks
     b. Eyes: No complaints
     c. Ear, nose, mouth, throat: No complaints
     d. Cardiovascular: No complaints
     e. Respiratory: No complaints
     f. Gastrointestinal: Appetite loss
     g. Urinary: No complaints
     h. Skin: No complaints
     i. Neurological: Trouble falling asleep, early morning awakening
     j. Psychiatric: Depression and loss of sexual interest

D. Past, Family, and/or Social History (PFSH)

There are three basic history areas required for a complete PFSH:

1. Past medical/psychiatric history: Illnesses, operations, injuries, treatments

2. Family history: Family medical history, events, hereditary illnesses
3. Social history: Age-appropriate review of past and current activities

The data elements of a textbook psychiatric history, listed below, are substantially more complete than the elements required to meet the threshold for a comprehensive or complete PFSH:

- Family history
- Birth and upbringing
- Milestones
- Past medical history
- Past psychiatric history
- Educational history
- Vocational history
- Religious background
- Dating and marital history
- Military history
- Legal history

The two levels of PFSH are:

1. *Pertinent,* which is a review of the history areas directly related to the problem(s) identified in the HPI. The pertinent PFSH must document one item from any of the three history areas. In the following example, the patient's past psychiatric history is reviewed as it relates to the current HPI:
   - Patient has a history of a depressive episode 10 years ago successfully treated with Prozac. Episode lasted 3 months.
2. *Complete.* At least one specific item from two of the three basic history areas must be documented for a complete PFSH for the following categories of E/M services:
   - Office or other outpatient services, established patient
   - Emergency department
   - Domiciliary care, established patient
   - Home care, established patient

   At least one specific item from each of the three basic history areas must be documented for the following categories of E/M services:
   - Office or other outpatient services, new patient
   - Hospital observation services
   - Hospital inpatient services, initial care
   - Consultations
   - Comprehensive nursing facility assessments
   - Domiciliary care, new patient
   - Home care, new patient

Documentation of History. Once the level of history is determined, documentation of that level of HPI, ROS, and PFSH is accomplished by listing the required number of elements for each of the three components (see Table 4 – 3).

TABLE 4–3. **PATIENT HISTORY TAKING**

Level of history is achieved when all four of the four criteria for each element are completed for that level.	**LEVELS**			
	Problem focused	**Expanded problem focused**	**Detailed**	**Comprehensive**
ELEMENT	**CRITERIA**			
Chief complaint (always required): Should include a brief statement, usually in the patient's own words; symptom(s); problem; condition; diagnosis; and reason for the encounter	Chief complaint	Chief complaint	Chief complaint	Chief complaint
History of the present illness: A chronological description of the development of the patient's present illness • Associated signs and symptoms • Context • Duration • Location • Modifying factors • Quality • Severity • Timing	Brief, one to three bullets	Brief, one to three bullets	Extended, four or more bullets	Extended, four or more bullets
Review of systems: An inventory of body systems to identify signs and/or symptoms • Allergic, immunologic • Cardiovascular • Constitutional (fever, weight loss) • Ears, nose, mouth, throat • Endocrine • Eyes • Gastrointestinal • Genitourinary • Hematologic, lymphatic • Integumentary (skin, breast) • Musculoskeletal • Neurological • Psychiatric • Respiratory	None	Pertinent to problem, one system	Extended, two to nine systems	Complete, 10 or more systems or some systems with statement "all others negative"
Past, family, and/or social history: Chronological review of relevant data • Past history: Illnesses, operations, injuries, treatments • Family history: Family medical history, events, hereditary illnesses • Social history: Age-appropriate review of past and current activities	None	None	Pertinent, one history area	Complete, two or three history areas

An ROS and/or PFSH taken during an earlier visit need not be rerecorded if there is evidence that it has been reviewed and any changes to the previous information have been noted. The ROS may be obtained by ancillary staff or may be provided on forms completed by the patient. The clinician must review the ROS, supplement and/or confirm the pertinent positives and negatives, and document the review. By doing so, the clinician takes medical-legal responsibility for the accuracy of the data. If the condition of the patient prevents the clinician from obtaining a history, the clinician should describe the patient's condition or the circumstances that precluded obtaining the history. **Failure to provide and record the required number of elements of the ROS for the level of history designated is the most frequently cited deficiency in audits of clinicians' mental health records.**

See Appendix H for examples of templates that provide a structure that will ensure that the clinician's note and documentation requirements are met. The Attending Physician Admitting Note template for initial hospital case with a complete history qualifies for a comprehensive level of history. The Attending Physician Subsequent Care template for inpatient subsequent care or outpatient established care contains the required elements for three levels of inpatient subsequent care or five levels of outpatient established care.

Step 5: Determine the Extent of Work in Performing the Examination

The mental status examination of a patient is considered a single system examination. The elements of the examination are provided in Table 4 – 4. This definition of what composes a mental status examination was jointly published by the American Medical Association and Health Care Financing Administration (now CMS) in 1997. There are four levels of work associated with performing a mental status examination.

Table 4 – 4 is a summary of the four levels of examination and the number of bullets (elements) required for each level. Template examples for the mental status examination are illustrated in Appendix H. **Failure to provide and record the required number of constitutional elements (including vital signs) is the second most frequently cited deficiency in audits of clinicians' medical records.**

Step 6: Determine the Complexity of Medical Decision Making

Medical decision making is the complex task of establishing a diagnosis and selecting treatment and management options. **Medical decision making is closely tied to the nature of the presenting problem.** A *presenting problem* is a disease, symptom, sign, finding, complaint, or other reason for the encounter having been initiated.

- *Minimal*—A problem that may or may not require physician presence, but the services provided are under physician supervision.
- *Self-limited or minor*—A problem that is transient, runs a definite course, and is unlikely to permanently alter health status.

TABLE 4–4. **CONTENT AND DOCUMENTATION REQUIREMENTS FOR THE SINGLE SYSTEM PSYCHIATRIC EXAMINATION**

SYSTEM/BODY AREA AND ELEMENTS OF EXAMINATION	CRITERIA			
Constitutional • Measurement of *any three of the following seven vital signs* (may be measured and recorded by ancillary staff): 1. Sitting or standing blood pressure 2. Supine blood pressure 3. Pulse rate and regularity 4. Respiration 5. Temperature 6. Height 7. Weight • General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)	One to five elements identified by a bullet	At least six elements identified by a bullet	At least nine elements identified by a bullet	*Perform All* elements identified by a bullet; document all elements in the **shaded areas** (Constitutional and Psychiatric) and at least one element in the musculoskeletal area
Musculoskeletal • Assessment of muscle strength and tone, **or** • Examination of gait and station				
Psychiatric *Description of patient's* • Speech, including rate, volume, articulation, coherence, and spontaneity, with notation of abnormalities (e.g., perseveration, paucity of language) • Thought processes, including rate of thoughts, content of thoughts (e.g., logical versus illogical, tangential), abstract reasoning, and computation • Associations (e.g., loose tangential, circumstantial, intact) • Abnormal psychotic thoughts, including hallucinations, delusions, preoccupation with violence, homicidal or suicidal ideation, and obsessions • Mood and affect (e.g., depression, anxiety, agitation, hypomania, lability) • Judgment (e.g., concerning everyday activities and social situations) and insight (e.g., concerning psychiatric condition) *Complete mental status examination, including* • Orientation to time, place, and person • Recent and remote memory • Attention span and concentration • Language (e.g., naming objects, repeating phrases) • Fund of knowledge (e.g., awareness of current events, past history, vocabulary)				
Level of examination is achieved when the number of criteria specified for a given level is met	**Problem focused**	**Expanded problem focused**	**Detailed**	**Comprehensive**

- *Low severity*—A problem of low morbidity, no risk of mortality, and expectation of full recovery with no residual functional incapacity.
- *Moderate severity*—A problem with moderate risk of morbidity and/or mortality without treatment, uncertain outcome, and probability of prolonged functional impairment.
- *High severity*—A problem of high to extreme morbidity without treatment, moderate to high risk of mortality without treatment, and/or probability of severe, prolonged functional impairment.

Medical decision making is based on three sets of data:

1. *The number of diagnoses and management options:* As specified in Table 4 – 5, this is the first step in determining the type of medical decision making.

TABLE 4–5. **NUMBER OF DIAGNOSES AND MANAGEMENT OPTIONS**

	MINIMAL	LIMITED	MULTIPLE	EXTENSIVE
Diagnoses	One established	One established [and] one rule-out or differential	Two rule-out or differential	More than two rule-out or differential
Problem(s)	Improved	Stable Resolving	Unstable Failing to change	Worsening Marked change
Management options	One or two	Two or three	Three changes in treatment plan	Four or more changes in treatment plan

Note. To qualify for a given type of decision making, two of three elements must be met or exceeded.

2. *The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed:* Table 4 – 6 lists the elements and criteria that determine the level of decision making for this set of data.

TABLE 4–6. **AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED**

	MINIMAL	LIMITED	MODERATE	EXTENSIVE
Medical data	One source	Two sources	Three sources	Multiple sources
Diagnostic tests	Two	Three	Four	More than four
Review of results	Confirmatory review	Confirmation of results with another physician	Results discussed with physician performing tests	Unexpected results, contradictory reviews, requires additional reviews

Note. To qualify for a given type of decision making, two of three elements must be met or exceeded.

3. *Risk of complications and/or morbidity or mortality as well as comorbidities:* As with the two previous tables, Table 4 – 7 provides the elements and criteria used to rate this particular data set.

TABLE 4–7. **TABLE OF RISK**

LEVEL OF RISK	PRESENTING PROBLEM(S)	DIAGNOSTIC PROCEDURE(S) ORDERED	MANAGEMENT OPTIONS SELECTED
Minimal	One self-limited problem (e.g., medication side effect)	Laboratory tests requiring venipuncture Urinalysis	Reassurance
Low	Two or more self-limited or minor problems or one stable, chronic illness (e.g., well-controlled depression) or acute uncomplicated illness (e.g., exacerbation of anxiety disorder)	Psychological testing Skull film	Psychotherapy Environmental intervention (e.g., agency, school, vocational placement) Referral for consultation (e.g., physician, social worker)
Moderate	One or more chronic illness with mild exacerbation, progression, or side effects of treatment or two or more stable chronic illnesses or undiagnosed new problem with uncertain prognosis (e.g., psychosis)	Electroencephalogram Neuropsychological Testing	Prescription drug management Open-door seclusion Electroconvulsive therapy, inpatient, outpatient, routine; no comorbid medical conditions
High	One or more chronic illnesses with severe exacerbation, progression, or side effect of treatment (e.g., schizophrenia) or acute illness with threat to life (e.g., suicidal or homicidal ideation)	Lumbar puncture Suicide risk assessment	Drug therapy requiring intensive monitoring (e.g., tapering diazepam for patient in withdrawal) Closed-door seclusion Suicide observation Electroconvulsive therapy; patient has comorbid medical condition (e.g., cardiovascular disease) Rapid intramuscular neuroleptic administration Pharmacological restraint

Source. Modified from CMS 1997 Guidelines for Psychiatry Single System Exam.

Determining the Overall Level of Medical Decision Making

Table 4 – 8 provides a grid that includes the components of the three preceding tables and level of complexity for each of those three components. The overall level of decision making is decided by placing the level of each of the three components into the appropriate box in a manner that allows them to be summed up to rate the overall decision making as *straightforward, low complexity, moderate complexity,* or *high complexity.*

Documentation

The use of templates, either preprinted forms or embedded in an electronic patient record (see Appendix H), is an efficient means of addressing the documentation of decision making. Rather than counting or scoring the elements of the three components and actually filling out a grid like the one in the Table 4 – 8, a template can be constructed in collaboration with the compliance officer of your practice or institution to include prompts that capture the required data necessary to document complexity. Solo practitioners may require the assistance of their specialty association or a consultant to develop appropriate templates.

The templates in Appendix H fulfill the documentation requirements for both clinical and compliance needs. The fifth page of the Attending Physician Admission Note template includes all of the elements necessary for addressing Step 6 of the E/M decision-making process. Similarly, the second page of the daily note for inpatient or outpatient care also includes the elements for documenting medical decision making.

Remember: Clinically, there is a close relationship between the nature of the presenting problem and the complexity of medical decision making. For example:

- Patient A comes in for a prescription refill—straightforward decision making
- Patient B presents with suicidal ideation—decision making of high complexity

TABLE 4–8. **Elements and Type of Medical Decision Making**

	TYPE OF DECISION MAKING			
	Straightforward	**Low complexity**	**Moderate complexity**	**High complexity**
Number of diagnoses or management options (Table 4–5)	Minimal	Limited	Multiple	Extensive
Amount and/or complexity of data to be reviewed (Table 4–6)	Minimal or none	Limited	Moderate	Extensive
Risk of complications and/or morbidity or mortality (Table 4–7)	Minimal	Low	Moderate	High

Note. To qualify for a given type of decision making, two of three elements must be met or exceeded.

Step 7: Select the Appropriate Level of E/M Service

As noted earlier, each category of E/M service has three to five levels of work associated with it. Each level of work has a descriptor of the service and the required extent of the three key components of work. For example:

99223 **Descriptor:** Initial hospital care, per day for the evaluation and management of a patient, which requires these three key components:

- A comprehensive history
- A comprehensive examination
- Medical decision making that is of high complexity

For new patients, the three key components (history, examination, and medical decision making) must meet or exceed the stated requirements to qualify for each level of service for office visits, initial hospital care, office consultations, initial inpatient consultations, confirmatory consultations, emergency department services, comprehensive nursing facility assessments, domiciliary care, and home services.

For established patients, two of the three key components (history, examination, and medical decision making) must meet or exceed the stated requirements to qualify for each level of service for office visits, subsequent hospital care, follow-up inpatient consultations, subsequent nursing facility care, domiciliary care, and home care.

When Counseling and Coordination of Care Account for More Than 50% of the Face-to-Face Physician–Patient Encounter

When counseling and coordination of care account for more than 50% of the face-to-face physician – patient encounter, then time becomes the key or controlling factor in selecting the level of service. Note that counseling or coordination of care must be documented in the medical record. The definitions of counseling, coordination of care, and time follow.

Counseling is a discussion with a patient or the patient's family concerning one or more of the following issues:

- Diagnostic results, impressions, and/or recommended diagnostic studies
- Prognosis
- Risks and benefits of management (treatment) options
- Instructions for management (treatment) and/or follow-up
- Importance of adherence to chosen management (treatment) options
- Risk factor reduction
- Patient and family education

Coordination of care is not specifically defined in the E/M section of the CPT manual. A working definition of the term could be as follows: Services provided by the physician responsible for the direct care of a patient when he or she coordinates or controls access to care or initiates or supervises other healthcare ser-

vices needed by the patient. Outpatient coordination of care must be provided face-to-face with the patient. Coordination of care with other providers or agencies without the patient being present on that day is reported with the case management codes.

TIME

For the purpose of selecting the level of service, time has two definitions.

1. For office and other outpatient visits and office consultations, ***intraservice time*** (time spent by the clinician providing services with the patient and/or family present) is defined as face-to-face time. Pre- and post-encounter time (non-face-to-face time) is not included in the average times listed under each level of service for either office or outpatient consultative services. The work associated with pre- and post-encounter time has been calculated into the total work effort provided by the physician for that service.
2. Time spent providing inpatient and nursing facility services is defined as ***unit/floor time***. Unit/floor time includes all work provided to the patient while the psychiatrist is on the unit. This includes the following:
   - Direct patient contact (face-to-face)
   - Review of charts
   - Writing of orders
   - Writing of progress notes
   - Reviewing test results
   - Meeting with the treatment team
   - Telephone calls
   - Meeting with the family or other caregivers
   - Patient and family education

Work completed before and after direct patient contact and presence on the unit/floor, such as reviewing X-rays in another part of the hospital, has been included in the calculation of the total work provided by the physician for that service. Unit/floor time may be used to select the level of inpatient services by matching the total unit/floor time to the average times listed for each level of inpatient service. For instance:

99221 **Descriptor:** Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components:

- A detailed or comprehensive history
- A detailed or comprehensive examination
- Medical decision making that is straightforward or of low complexity

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.

Table 4 – 9 provides an example of an auditor's worksheet employed in making the decision of whether to use time in selecting the level of service. The three questions are prompts that assist the auditor (usually a nurse reviewer) in assessing whether the clinician 1) documented the length of time of the patient encounter, 2) described the counseling or coordination of care, and 3) indicated that more than half of the encounter time was for counseling or coordination of care.

Important: If you elect to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter should be documented and the record should describe the counseling and/or services or activities performed to coordinate care.

TABLE 4–9. **CHOOSING LEVEL BASED ON TIME**

	YES	NO
Does documentation reveal total time? Time: Face-to-face in outpatient setting; unit/floor in inpatient setting		
Does documentation describe the content of counseling or coordinating care?		
Does documentation suggest that more than half of the total time was counseling or coordinating of care?		

Note. If all answers are yes, select level based on time.

For examples and vignettes of code selection in specific clinical settings, see Chapter 5.

EVALUATION AND MANAGEMENT CODES MOST LIKELY TO BE USED BY PSYCHIATRISTS AND OTHER APPROPRIATELY LICENSED MENTAL HEALTH PROFESSIONALS

It is vital to read the explanatory notes in the CPT manual for an accurate understanding of when each of these codes should be used.

Note: For each of the following codes it is noted that: "Counseling and/or coordination of care with other providers or agencies is provided consistent with the nature of the problem(s) and the patient's and/or family's needs." As stated earlier, when this counseling and coordination of care accounts for more than 50% of the time spent, the typical time given in the code descriptor may be used for selecting the appropriate code rather than the other factors.

Office or Other Outpatient Services

New Patient

***99201*—The three following components are required:**

- Problem-focused history
- Problem-focused examination
- Medical decision making that is straightforward

Presenting problem(s): Self-limited or minor

Typical time: 10 minutes face-to-face with patient and/or family

***99202*—The three following components are required:**

- Expanded problem-focused history
- Expanded problem-focused examination
- Medical decision making that is straightforward

Presenting problem(s): Low to moderate severity
Typical time: 20 minutes face-to-face with patient and/or family

***99203*—The three following components are required:**

- Detailed history
- Detailed examination
- Medical decision making of low complexity

Presenting problem(s): Moderate severity

Typical time: 30 minutes face-to-face with patient and/or family

***99204*—The three following components are required:**

- Comprehensive history
- Comprehensive examination
- Medical decision making of moderate complexity

Presenting problem(s): Moderate to high severity
Typical time: 45 minutes face-to-face with patient and/or family

***99205*—The three following components are required:**

- Comprehensive history
- Comprehensive examination
- Medical decision making of high complexity

Presenting problem(s): Moderate to high severity

Typical time: 60 minutes face-to-face with patient and/or family

Established Patient

***99211*—This code is used for a service that may not require the presence of a physician. Presenting problems are minimal, and 5 minutes is the typical time that would be spent performing or supervising these services.**

***99212*—Two of the three following components are required:**

- Problem-focused history
- Problem-focused examination
- Medical decision making that is straightforward

Presenting problem(s): Self-limited or minor

Typical time: 10 minutes face-to-face with patient and/or family

***99213*—Two of the three following components are required:**

- Expanded problem-focused history
- Expanded problem-focused examination
- Medical decision making of low complexity

Presenting problem(s): Low to moderate severity

Typical time: 15 minutes face-to-face with patient and/or family

***99214*—Two of the three following components are required:**

- Detailed history
- Detailed examination
- Medical decision making of moderate complexity

Presenting problem(s): Moderate to high severity

Typical time: 25 minutes face-to-face with patient and/or family

***99215*—Two of the three following components are required:**

- Comprehensive history
- Comprehensive examination
- Medical decision making of high complexity

Presenting problem(s): Moderate to high severity

Typical time: 40 minutes face-to-face with patient and/or family

Hospital Observational Services

Observation Care Discharge Services

***99217*—This code is used to report all services provided on discharge from "observation status" if the discharge occurs after the initial date of "observation status."**

Initial Observation Care

***99218*—The three following components are required:**

- Detailed or comprehensive history
- Detailed or comprehensive examination
- Medical decision making of straightforward or of low complexity

Presenting problem(s): Low severity
Typical time: None listed

***99219*—The three following components are required:**

- Comprehensive history
- Comprehensive examination
- Medical decision making of moderate complexity

Presenting problem(s): Moderate severity

Typical time: None listed

***99220*—The three following components are required:**

- Comprehensive history
- Comprehensive examination
- Medical decision making of high complexity

Presenting problem(s): High severity
Typical time: None listed

Hospital Inpatient Services

Services provided in a partial hospitalization setting would also use these codes. (With the elimination of the consultation codes as of January 1, 2010, CMS has created a new modifier A1, that is used to denote the admitting physician.)

Initial Hospital Care for New or Established Patient

***99221*—The three following components are required:**

- Detailed or comprehensive history
- Detailed or comprehensive examination
- Medical decision making that is straightforward or of low complexity

Presenting problem(s): Low severity

Typical time: 30 minutes at the bedside or on the patient's floor or unit

***99222*—The three following components are required:**

- Comprehensive history
- Comprehensive examination
- Medical decision making of moderate complexity

Presenting problem(s): Moderate severity

Typical time: 50 minutes at the bedside or on the patient's floor or unit

***99223*—The three following components are required:**

- Comprehensive history
- Comprehensive examination
- Medical decision making of high complexity

Presenting problem(s): High severity

Typical time: 70 minutes at the bedside or on the patient's floor or unit

Subsequent Hospital Care

***99231*—Two of the three following components are required:**

- Problem-focused interval history
- Problem-focused examination
- Medical decision making that is straightforward or of low complexity

Presenting problem(s): Patient usually stable, recovering, or improving
Typical time: 15 minutes at the bedside or on the patient's floor or unit

***99232*—Two of the three following components are required:**

- Expanded problem-focused interval history
- Expanded problem-focused examination
- Medical decision making of moderate complexity

Presenting problem(s): Patient responding inadequately to therapy or has developed a minor complication
Typical time: 25 minutes at the bedside or on the patient's floor or unit

***99233*—Two of the three following components are required:**

- Detailed interval history
- Detailed examination
- Medical decision making of high complexity

Presenting problem(s): Patient unstable or has developed a significant new problem
Typical time: 35 minutes at the bedside or on the patient's floor or unit

Hospital Discharge Services

***99238*—Time: 30 minutes or less**

***99239*—Time: More than 30 minutes**

Consultations

Medicare no longer pays for the consultation codes. When coding for Medicare or for commercial carriers that have followed Medicare's lead, 90801 may be used for both inpatient and outpatient consults. Psychiatrists who choose to use E/M codes to report outpatient consults should use the outpatient new patient codes (99201 – 99205). For inpatient consults, the codes to use are hospital inpatient services, initial hospital care for new or established patients (99221 – 99223). For consults in nursing homes, initial nursing facility care codes should be used (99304 – 99306); if the consult is of low complexity, the subsequent nursing facility codes may be used (99307 – 99310). As with all E/M codes, the selection of the specific code is based on the complexity of the case and the amount of work required. Medicare has created a new modifier, A1, to denote the admitting physician so that more than one physician may use the initial hospital care codes.

Office or Other Outpatient Consultations

***99241*—The three following components are required:**

- Problem-focused history
- Problem-focused examination
- Medical decision making that is straightforward

Presenting problem(s): Self-limited or minor

Typical time: 15 minutes face-to-face with patient and/or family

***99242*—The three following components are required:**

- Expanded problem-focused history
- Expanded problem-focused examination
- Medical decision making that is straightforward

Presenting problem(s): Low severity

Typical time: 30 minutes face-to-face with patient and/or family

***99243*—The three following components are required:**

- Detailed history
- Detailed examination
- Medical decision making of low complexity

Presenting problem(s): Moderate severity

Typical time: 40 minutes face-to-face with patient and/or family

***99244*—The three following components are required:**

- Comprehensive history
- Comprehensive examination
- Medical decision making of moderate complexity

Presenting problem(s): Moderate to high severity

Typical time: 60 minutes face-to-face with patient and/or family

***99245*—The three following components are required:**

- Comprehensive history
- Comprehensive examination
- Medical decision making of high complexity

Presenting problem(s): Moderate to high severity

Typical time: 80 minutes face-to-face with patient and/or family

Inpatient Consultations

***99251*—The three following components are required:**

- Problem-focused history
- Problem-focused examination
- Medical decision making that is straightforward

Presenting problem(s): Self-limited or minor

Typical time: 20 minutes at the bedside or on the patient's floor or unit

***99252*—The three following components are required:**

- Expanded problem-focused history
- Expanded problem-focused examination
- Medical decision making that is straightforward

Presenting problem(s): Low severity

Typical time: 40 minutes at the bedside or on the patient's floor or unit

***99253*—The three following components are required:**

- Detailed history
- Detailed examination
- Medical decision making of low complexity

Presenting problem(s): Moderate severity

Typical time: 55 minutes at the bedside or on the patient's floor or unit

***99254*—The three following components are required:**

- Comprehensive history
- Comprehensive examination
- Medical decision making of moderate complexity

Presenting problem(s): Moderate to high severity

Typical time: 80 minutes at the bedside or on the patient's floor or unit

***99255*—The three following components are required:**

- Comprehensive history
- Comprehensive examination
- Medical decision making of moderate complexity

Presenting problem(s): Moderate to high severity

Typical time: 110 minutes at the bedside or on the patient's floor or unit

Emergency Department Services

No distinction is made between new and established patients in this setting. There are no typical times provided for emergency E/M services.

***99281*—The three following components are required:**

- Problem-focused history
- Problem-focused examination
- Medical decision making that is straightforward

Presenting problem(s): Self-limited or minor

***99282*—The three following components are required:**

- Expanded problem-focused history
- Expanded problem-focused examination
- Medical decision making of low complexity

Presenting problem(s): Low or moderate severity

***99283*—The three following components are required:**

- Expanded problem-focused history
- Expanded problem-focused examination
- Medical decision making of moderate complexity

Presenting problem(s): Moderate severity

***99284*—The three following components are required:**

- Detailed history
- Detailed examination
- Medical decision making of moderate complexity

Presenting problem(s): High severity

***99285*—The three following components are required:**

- Comprehensive history
- Comprehensive examination
- Medical decision making of high complexity

Presenting problem(s): High severity and pose(s) an immediate and significant threat to life or physiological function

Nursing Facility Services

Initial Nursing Facility Care

***99304*—The three following components are required:**

- Detailed or comprehensive history
- Detailed or comprehensive examination
- Medical decision making that is straightforward or of low complexity

Problem(s) requiring admission: Low severity

Typical time: 25 minutes with patient and/or family or caregiver

***99305*—The three following components are required:**

- Comprehensive history
- Comprehensive examination
- Medical decision making of moderate complexity

Problem(s) requiring admission: Moderate severity
Typical time: 35 minutes with patient and/or family or caregiver

***99306*—The three following components are required:**

- Comprehensive history
- Comprehensive examination
- Medical decision making of high complexity

Problem(s) requiring admission: High severity
Typical time: 45 minutes with patient and/or family or caregiver

Subsequent Nursing Facility Care

***99307*—Two of the three following components are required:**

- Problem-focused interval history
- Problem-focused examination
- Medical decision making that is straightforward

Presenting problem(s): Patient usually stable, recovering, or improving
Typical time: 10 minutes with patient and/or family or caregiver

***99308*—Two of the three following components are required:**

- Expanded problem-focused interval history
- Expanded problem-focused examination
- Medical decision making of low complexity

Presenting problem(s): Patient usually responding inadequately to therapy or has developed a minor complication
Typical time: 15 minutes with patient and/or family or caregiver

***99309*—Two of the three following components are required:**

- Detailed interval history
- Detailed examination
- Medical decision making of moderate complexity

Presenting problem(s): Patient usually has developed a significant complication or a significant new problem
Typical time: 25 minutes with patient and/or family or caregiver

***99310*—Two of the three following components are required:**

- Comprehensive interval history
- Comprehensive examination
- Medical decision making of high complexity

Presenting problem(s): Patient may be unstable or may have developed a significant new problem requiring immediate physician attention
Typical time: 35 minutes with patient and/or family or caregiver

Nursing Facility Discharge Services

***99315*—Time: 30 minutes or less**

***99316*—Time: More than 30 minutes**

Annual Nursing Facility Assessment

***99318*—The three following components are required:**

- Detailed interval history
- Comprehensive examination
- Medical decision making of low to moderate complexity

Presenting problem(s): Patient usually stable, recovering, or improving
Typical time: 30 minutes with patient and/or family or caregiver

Domiciliary, Rest Home, or Custodial Care Services

The following codes are used to report E/M services in a facility that provides room, board, and other personal services, usually on a long-term basis. They are also used in assisted living facilities.

NEW PATIENT

***99324*—The three following components are required:**

- Problem-focused history
- Problem-focused examination
- Medical decision making that is straightforward

Presenting problem(s): Low severity

Typical time: 20 minutes with patient and/or family or caregiver

***99325*—The three following components are required:**

- Expanded problem-focused history
- Expanded problem-focused examination
- Medical decision making of low complexity

Presenting problem(s): Moderate severity

Typical time: 30 minutes with patient and/or family or caregiver

***99326*—The three following components are required:**

- Detailed history
- Detailed examination
- Medical decision making of moderate complexity

Presenting problem(s): Moderate to high severity
Typical time: 45 minutes with patient and/or family or caregiver

***99327*—The three following components are required:**

- Comprehensive history
- Comprehensive examination
- Medical decision making of moderate complexity

Presenting problem(s): High severity
Typical time: 60 minutes with patient and/or family or caregiver

***99328*—The three following components are required:**

- Comprehensive history
- Comprehensive examination
- Medical decision making of high complexity

Presenting problem(s): Patient usually has developed a significant new problem requiring immediate physician attention

Typical time: 75 minutes with patient and/or family or caregiver

Established Patient

***99334*—Two of the three following components are required:**

- Problem-focused interval history
- Problem-focused examination
- Medical decision making that is straightforward

Presenting problem(s): Self-limited or minor

Typical time: 15 minutes with patient and/or family or caregiver

***99335*—Two of the three following components are required:**

- Expanded problem-focused interval history
- Expanded problem-focused examination
- Medical decision making of low complexity

Presenting problem(s): Low to moderate severity

Typical time: 25 minutes with patient and/or family or caregiver

***99336*—Two of the three following components are required:**

- Detailed interval history
- Detailed examination
- Medical decision making of moderate complexity

Presenting problem(s): Moderate to high severity

Typical time: 40 minutes with patient and/or family or caregiver

***99337*—Two of the three following components are required:**

- Comprehensive interval history
- Comprehensive examination
- Medical decision making of moderate to high complexity

Presenting problem(s): Patient may be unstable or has developed a significant new problem requiring immediate physician attention

Typical time: 60 minutes with patient and/or family or caregiver

Home Services

These codes are used for E/M services provided to a patient in a private residence, in other words, for home visits.

New Patient

***99341*—The three following components are required:**

- Problem-focused history
- Problem-focused examination
- Medical decision making that is straightforward

Presenting problem(s): Low severity

Typical time: 20 minutes face-to-face with patient and/or family

***99342*—The three following components are required:**

- Expanded problem-focused history
- Expanded problem-focused examination
- Medical decision making of low complexity

Presenting problem(s): Moderate severity

Typical time: 30 minutes face-to-face with patient and/or family

***99343*—The three following components are required:**

- Detailed history
- Detailed examination
- Medical decision making of moderate complexity

Presenting problem(s): Moderate to high severity
Typical time: 45 minutes face-to-face with patient and/or family

***99344*—The three following components are required:**

- Comprehensive history
- Comprehensive examination
- Medical decision making of moderate complexity

Presenting problem(s): High severity

Typical time: 60 minutes face-to-face with patient and/or family

***99345*—The three following components are required:**

- Comprehensive history
- Comprehensive examination
- Medical decision making of high complexity

Presenting problem(s): Patient unstable or has developed a significant new problem that requires immediate physician attention
Typical time: 75 minutes face-to-face with patient and/or family

Established Patient

***99347*—Two of the three following components are required:**

- Problem-focused interval history
- Problem-focused examination
- Medical decision making that is straightforward

Presenting problem(s): Self-limited or minor

Typical time: 15 minutes face-to-face with patient and/or family

***99348*—Two of the three following components are required:**

- Expanded problem-focused interval history
- Expanded problem-focused examination
- Medical decision making of low complexity

Presenting problem(s): Low to moderate severity

Typical time: 25 minutes face-to-face with patient and/or family

***99349*—Two of the three following components are required:**

- Detailed interval history
- Detailed examination
- Medical decision making of moderate complexity

Presenting problem(s): Moderate to high severity

Typical time: 40 minutes face-to-face with patient and/or family

***99350*—Two of the three following components are required:**

- Comprehensive interval history
- Comprehensive examination
- Medical decision making of moderate to high complexity

Presenting problem(s): Moderate to high severity—patient may be unstable or may have developed a significant new problem requiring immediate physician attention

Typical time: 60 minutes face-to-face with patient and/or family

Case Management Services

Medical Team Conferences

99366*—To be used when patient and/or family is present
Physicians should use the appropriate code from the "Evaluation and Management" section when reporting this service.

***99367*—To be used when there is no face-to-face contact with the patient and/or family**

Preventive Medicine Services

Counseling Risk Factor Reduction and Behavior Change Intervention

***99406*—Time: 3–10 minutes**

***99407*—Time: More than 10 minutes**

***99408*—Time: 15–30 minutes, includes the administration of an alcohol and/or substance abuse screening tool and brief intervention**

***99409*—Time: 30 minutes or more**

Non-Face-to-Face Services

Medicare does not pay for these.

Telephone Services

***99441*—Time: 5–10 minutes of medical discussion**

***99442*—Time: 11–20 minutes of medical discussion**

***99443*—Time: 21–30 minutes of medical discussion**

On-Line Medical Evaluation

***99444*—For an established patient, guardian, or healthcare provider; may not have originated from a related E/M service provided within the previous 7 days.**

Special Evaluation and Management Services

Medicare does not pay for these.

BASIC LIFE AND/OR DISABILITY EVALUATION SERVICES

***99450*—The four following elements are required:**

- Measurement of height, weight, and blood pressure
- Completion of a medical history following a life insurance pro forma
- Collection of blood sample and/or urinalysis complying with "chain of custody" protocols
- Completion of necessary documentation/certificates

WORK-RELATED OR MEDICAL DISABILITY EVALUATION SERVICES

***99455*—Work-related medical disability examination done by the treating physician; the five following elements are required:**

- Completion of medical history commensurate with the patient's condition
- Performance of an examination commensurate with the patient's condition
- Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment
- Development of future medical treatment plan
- Completion of necessary documentation/certificates, and report

***99456*—Work-related medical disability examination done by provider other than the treating physician. Must include the same five elements listed for previous code.**

This is just a partial list of codes found in the "Evaluation and Management" section of the CPT manual. We advise all psychiatrists and other mental health clinicians to purchase a copy of the manual to ensure access to information on the full range of codes.

[End]

Appendix E

1997 CMS Documentation Guidelines for Evaluation and Management Services (Abridged and Modified for Psychiatric Services)

I. INTRODUCTION

A. What Is Documentation and Why Is It Important?

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history, including past and pres- ent illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high-quality care. The medical record facilitates:

- the ability of the physician and other healthcare professionals to evaluate and plan the patient's immediate treatment, and to monitor his or her healthcare over time;
- communication and continuity of care among physicians and other health- care professionals involved in the patient's care;
- accurate and timely claims review and payment;
- appropriate utilization review and quality of care evaluations; and
- collection of data that may be useful for research and education.

An appropriately documented medical record can reduce many of the "hassles" associated with claims processing and may serve as a legal document to verify the care provided, if necessary.

B. What Do Payers Want and Why?

Because payers have a contractual obligation to enrollees, they may require reasonable documentation that services are consistent with the insurance coverage provided. They may request information to validate:

- the site of service;
- the medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or
- that services provided have been accurately reported.

II. GENERAL PRINCIPLES OF MEDICAL RECORD DOCUMENTATION

The principles of documentation listed here are applicable to all types of medical and surgical services in all settings. For evaluation and management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service, and the patient's status. The general principles listed here may be modified to account for these variable circumstances in providing E/M services.

1. The medical record should be complete and legible.
2. The documentation of each patient encounter should include:

a. reason for the encounter and relevant history, physical examination find- ings, and prior diagnostic test results;
b. assessment, clinical impression, or diagnosis;
c. plan for care; and
d. date and legible identity of the observer.

3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
4. Past and present diagnoses should be accessible to the treating and/or consulting physician.
5. Appropriate health risk factors should be identified.
6. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.
7. The Current Procedural Terminology (CPT) and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

III. DOCUMENTATION OF E/M SERVICES

This publication provides definitions and documentation guidelines for the three key components of E/M services and for visits that consist predominantly of counseling or coordination of care. The three *key* components—history, examination, and medical decision making—appear in the descriptors for office and other outpatient services, hospital observation services, hospital inpatient services, consultations, emergency department services, nursing facility services, domiciliary care services, and home services. While some of the text of CPT has been repeated in this publication, the reader should refer to CPT for the complete descriptors for E/M services and instructions for selecting a level of service. Documentation guidelines are identified by the symbol ***DG.***

The descriptors for the levels of E/M services recognize seven components that are used in defining the levels of E/M services:

- History
- Examination
- Medical decision making
- Counseling
- Coordination of care
- Nature of presenting problem
- Time

The first three of these components (i.e., history, examination, and medical decision making) are the key components in selecting the level of E/M services. In the case of visits that consist predominantly of counseling or coordination of care, time is the key or controlling factor to qualify for a particular level of E/M service.

Because the level of E/M service is dependent on two or three key compo- nents, performance and documentation of one component (e.g., examination) at the highest level does not necessarily mean that the encounter in its entirety qualifies for the highest level of E/M service.

These Documentation Guidelines for E/M services reflect the needs of the typical adult population. For certain groups of patients, the recorded information may vary slightly from that described here. Specifically, the medical records of infants, children, adolescents, and pregnant women may have additional or modified information recorded in each history and examination area.

As an example, newborn records may include under history of the present ill- ness the details of mother's pregnancy and the infant's status at birth; social his- tory will focus on family structure; and family history will focus on congenital anomalies and hereditary disorders in the family. In addition, the content of a pediatric examination will vary with the age and development of the child. Al- though not specifically defined in these documentation guidelines, these patient group variations on history and examination are appropriate.

A. Documentation of History

The levels of E/M services are based on four types of history (problem focused, expanded problem focused, detailed, and comprehensive). Each type of history includes some or all of the following elements:

- Chief complaint (CC)
- History of present illness (HPI)
- Review of systems (ROS)
- Past, family, and/or social history (PFSH)

The extent of HPI, ROS, and PFSH that is obtained and documented is de- pendent on clinical judgment and the nature of the presenting problem(s).

The chart below shows the progression of the elements required for each type of history. To qualify for a given type of history all three elements in the table must be met. (A CC is indicated at all levels.)

History of present illness (HPI)	Review of systems (ROS)	Past, family, and/or social history	Type of history
Brief	N/A	N/A	Problem focused
Brief	Problem pertinent	N/A	Expanded problem focused
Extended	Extended	Pertinent	Detailed
Extended	Complete	Complete	Comprehensive

DG: *The CC, ROS, and PFSH may be listed as separate elements of history or may be included in the description of the history of the present illness.*

DG: *An ROS and/or a PFSH obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his or her own record or in an institutional setting or group practice where many physicians use a common record. The review and update may be documented by*

- *describing any new ROS and/or PFSH information or noting there has been no change in the information; and*
- *noting the date and location of the earlier ROS and/or PFSH.*

DG: *The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.*

DG: *If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance that precludes obtaining a*

history.

Definitions and specific documentation guidelines for each of the elements of history are listed in the following sections.

CHIEF COMPLAINT (CC)

The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter, usually stated in the patient's words.

DG: *The medical record should clearly reflect the CC.*

HISTORY OF PRESENT ILLNESS (HPI)

The HPI is a chronological description of the development of the patient's pres- ent illness from the first sign and/or symptom or from the previous encounter to the present. It includes the following elements:

- Location
- Quality
- Severity
- Duration
- Timing
- Context
- Modifying factors
- Associated signs and symptoms

Brief and *extended* HPIs are distinguished by the amount of detail needed to accurately characterize the clinical problem(s).
A *brief* HPI consists of one to three elements of the HPI.

DG: *The medical record should describe one to three elements of the present illness.*

An *extended* HPI consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions.

DG: *The medical record should describe at least four elements of the present ill- ness or the status of at least three chronic or inactive conditions.*

REVIEW OF SYSTEMS (ROS)

An ROS is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced.
For purposes of the ROS, the following systems are recognized:

- Constitutional symptoms (e.g., fever, weight loss)
- Eyes
- Ears, nose, mouth, throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)

- Neurological
- Psychiatric
- Endocrine
- Hematological/Lymphatic
- Allergic/Immunologic

A *problem pertinent* ROS inquires about the system directly related to the problem(s) identified in the HPI.

DG: *The patient's positive responses and pertinent negatives for the system related to the problem should be documented.*

An *extended* ROS inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems.

DG: *The patient's positive responses and pertinent negatives for two to nine systems should be documented.*

A *complete* ROS inquires about the system(s) directly related to the problem(s) identified in the HPI *plus* all additional body systems.

DG: *At least 10 organ systems must be reviewed. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least 10 systems must be individually documented.*

PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)

The PFSH consists of a review of three areas:

- Past history (the patient's past experiences with illnesses, operations, injuries, and treatments)
- Family history (a review of medical events in the patient's family, including diseases that may be hereditary or place the patient at risk)
- Social history (an age-appropriate review of past and current activities)

For certain categories of E/M services that include only an interval history, it is not necessary to record information about the PFSH. Those categories are subsequent hospital care, follow-up inpatient consultations, and subsequent nursing facility care.

A *pertinent* PFSH is a review of the history area(s) directly related to the problem(s) identified in the HPI.

DG: *At least one specific item from any of the three history areas must be documented for a pertinent PFSH.*

A *complete* PFSH is of a review of two or all three of the PFSH history areas, depending on the category of the E/M service. A review of all three history areas is required for services that by their nature include a comprehensive assessment or reassessment of the patient. A review of two of the three history areas is sufficient for other services.

DG: *At least one specific item from two of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services, established patient; emergency department; domiciliary care, established patient; and home care, established patient.*

DG: *At least one specific item from each of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services, new patient; hospital observation services; hospital inpatient services, initial care; consultations; comprehensive nursing facility assessments; domiciliary care, new patient; and home care, new patient.*

B. Documentation of Examination

The levels of E/M services are based on four types of examination:

- *Problem focused*—A limited examination of the affected body area or organ system.
- *Expanded problem focused*—A limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s).
- *Detailed*—An extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s).
- *Comprehensive*—A general multisystem examination or complete examination of a single organ system and other symptomatic or related body area(s) or organ system(s).

These types of examinations have been defined for general multisystem and the following single organ systems:

- Cardiovascular
- Ears, nose, mouth, and throat
- Eyes
- Genitourinary (female)
- Genitourinary (male)
- Hematological/Lymphatic/Immunological
- Musculoskeletal
- Neurological
- **Psychiatric**
- Respiratory
- Skin

A general multisystem examination or a single organ system examination may be performed by any physician regardless of specialty. The type (general multisystem or single organ system) and content of examination are selected by the examining physician and are based upon clinical judgment, the patient's history, and the nature of the presenting problem(s).

The content and documentation requirements for each type and level of examination are summarized here and described in detail in the tables that appear later in this appendix. In the first table (see pp. 123), organ systems and body areas recognized by CPT for purposes of describing examinations are shown in the left column. The content, or individual elements, of the examination pertaining to that body area or organ system are identified by bullets (•) in the right column.

Parenthetical examples "(e.g., …)" have been used for clarification and to provide guidance regarding documentation. Documentation for each element must satisfy any numeric requirements (such as "Measurement of *any three of the following seven* …") included in the description of the element. Elements with multiple components but with no specific numeric requirement (such as "Examination of *liver* and *spleen*") require documentation of at least one component. It is possible for a given examination to be expanded beyond what is de- fined here. When that occurs, findings related to the additional systems and/or areas should be documented.

DG: *Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of "abnormal" without elaboration is insufficient.*

DG: *Abnormal or unexpected findings of the examination of any asymptomatic body area(s) or organ system(s) should be described.*

DG: *A brief statement or notation indicating "negative" or "normal" is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).*

[DELETED: GUIDELINES FOR "GENERAL MULTI-SYSTEM EXAMINATIONS"]

SINGLE ORGAN SYSTEM EXAMINATIONS

The single organ system examinations recognized by CPT are described in detail. **[*Authors' note:* We are only including the psychiatric examination.]** Variations among these examinations in the organ systems and body areas identified in the left columns and in the elements of the examinations described in the right columns reflect differing emphases among specialties. To qualify for a given level of single organ system examination, the following content and documentation requirements should be met:

- *Problem focused examination*—Should include performance and documentation of one to five elements identified by a bullet (•), whether in a box with a *shaded* or *unshaded* border.

- *Expanded problem focused examination*—Should include performance and documentation of at least six elements identified by a bullet (•), whether in a box with a *shaded* or *unshaded* border.

- *Detailed examination*—Examinations other than the eye and psychiatric examinations should include performance and documentation of at least 12 elements identified by a bullet (•), whether in box with a *shaded* or *unshaded* border.

- Eye and psychiatric examinations should include the performance and documentation of at least nine elements identified by a bullet (•), whether in a box with a *shaded* or *unshaded* border.

- *Comprehensive examination*—Should include performance of all elements identified by a bullet (•), whether in a shaded or unshaded box. Documentation of every element in each box with a shaded border and at least one element in each box with an *unshaded* border is expected.

CONTENT AND DOCUMENTATION REQUIREMENTS

[DELETED: CONTENT AND DOCUMENTATION REQUIREMENTS FOR GENERAL MULTI-SYSTEM EXAMINATION AND ALL SINGLE-SYSTEM REQUIREMENTS OTHER THAN PSYCHIATRY]

[Single System] PSYCHIATRIC EXAMINATION

SYSTEM/ BODY AREA	ELEMENTS OF EXAMINATION
Constitutional	• Measurement of any **three** of the following **seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (may be measured and recorded by ancillary staff) • General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	
Eyes	
Ears, Nose, Mouth, and Throat	
Neck	
Respiratory	
Cardiovascular	
Chest (Breasts)	
Gastrointestinal (Abdomen)	
Genitourinary	
Lymphatic	
Musculoskeletal	• Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements • Examination of gait and station
Extremities	
Skin	
Neurological	
Psychiatric	• Description of speech, including rate, volume, articulation, coherence, and spontaneity with notation of abnormalities (e.g., perseveration, paucity of language) • Description of thought processes, including rate of thoughts; content of thoughts (e.g., logical vs. illogical, tangential); abstract reasoning; and computation • Description of associations (e.g., loose, tangential, circumstantial, intact) • Description of abnormal or psychotic thoughts, including hallucinations, delusions, preoccupation with violence, homicidal or suicidal ideation, and obsessions • Description of the patient's judgment (e.g., concerning everyday activities and social situations) and insight (e.g., concerning psychiatric condition) Complete mental status examination, including • Orientation to time, place, and person • Recent and remote memory • Attention span and concentration • Language (e.g., naming objects, repeating phrases) • Fund of knowledge (e.g., awareness of current events, past history, vocabulary) • Mood and affect (e.g., depression, anxiety, agitation hypomania, lability)

CONTENT AND DOCUMENTATION REQUIREMENTS [for single system psychiatric exam]

LEVEL OF EXAMINATION	PERFORM AND DOCUMENT
Problem focused	**One to five** elements identified by a bullet.
Expanded problem focused	**At least six** elements identified by a bullet.
Detailed	**At least nine** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in each box with a *shaded* border and at least one element in each box with an *unshaded* border.

C. Documentation of the Complexity of Medical Decision Making

The levels of E/M services recognize four types of medical decision making: straightforward, low complexity, moderate complexity, and high complexity. *Medical decision making* refers to the complexity of establishing a diagnosis and/ or selecting a management option as measured by:

- the number of possible diagnoses and/or the number of management options that must be considered;
- the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and
- the risk of significant complications, morbidity, and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

The following chart shows the progression of the elements required for each level of medical decision making. To qualify for a given type of decision making, **two of the three elements in the table must be either met or exceeded.**

Number of diagnoses or management options	Amount or complexity of data to be reviewed	Risk of complications and/or morbidity or mortality	Type of decision making
Minimal	Minimal or none	Minimal	***Straightforward***
Limited	Limited	Low	***Low complexity***
Multiple	Moderate	Moderate	***Moderate complexity***
Extensive	Extensive	High	***High complexity***

Each of the elements of medical decision making is described below.

NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS

The number of possible diagnoses and/or the number of management options that must be considered is based on the number and types of problems addressed during the encounter, the complexity of establishing a diagnosis, and the management decisions that are made by the physician.
Generally, decision making with respect to a diagnosed problem is easier than that for an identified but undiagnosed problem. The number and type of diagnostic

tests employed may be an indicator of the number of possible diagnoses. Problems that are improving or resolving are less complex than those that are worsening or failing to change as expected. The need to seek advice from others is another indicator of the complexity of diagnostic or management problems.

DG: *For each encounter, an assessment, clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.*

- *For a presenting problem with an established diagnosis, the record should reflect whether the problem is a) improved, well controlled, resolving, or re- solved or b) inadequately controlled, worsening, or failing to change as expected.*

- *For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of differential diagnoses or as a "possible," "probable," or "rule out" (R/O) diagnosis.*

DG: *The initiation of, or changes in, treatment should be documented. Treat- ment includes a wide range of management options including patient instruc- tions, nursing instructions, therapies, and medications.*

DG: *If referrals are made, consultations requested, or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom the advice is requested.*

AMOUNT AND COMPLEXITY OF DATA TO BE REVIEWED

The amount and complexity of data to be reviewed are based on the types of di- agnostic testing ordered or reviewed. A decision to obtain and review old medical records and/or obtain history from sources other than the patient increases the amount and complexity of data to be reviewed.

Discussion of contradictory or unexpected test results with the physician who performed or interpreted the test is an indication of the complexity of data be- ing reviewed. On occasion the physician who ordered a test may personally review the image, tracing, or specimen to supplement information from the physician who prepared the test report or interpretation; this is another indication of the complexity of data being reviewed.

DG: *If a diagnostic service (test or procedure) is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service (e.g., laboratory work or X-ray) should be documented.*

DG: *The review of laboratory, radiology, and/or other diagnostic tests should be documented. A simple notation such as "white blood cells elevated" or "chest X- ray unremarkable" is acceptable. Alternatively, the review may be documented by initialing and dating the report containing the test results.*

DG: *A decision to obtain old records or to obtain additional history from the family, caretaker, or other source to supplement that obtained from the patient should be documented.*

DG: *Relevant findings from the review of old records and/or the receipt of additional history from the family, caretaker, or other source to supplement that obtained from the patient*

should be documented. If there is no relevant information beyond that already obtained, that fact should be documented. A notation of "old records reviewed" or "additional history obtained from family" without elaboration is insufficient.

***DG:** The results of discussion of laboratory, radiology, or other diagnostic tests with the physician who performed or interpreted the study should be documented.*

***DG:** The direct visualization and independent interpretation of an image, tracing, or specimen previously or subsequently interpreted by another physician should be documented.*

RISK OF SIGNIFICANT COMPLICATIONS, MORBIDITY, AND/OR MORTALITY

The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the presenting problem(s), the diagnostic procedure(s), and the possible management options.

***DG:** Comorbidities/Underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.*

***DG:** If a surgical or invasive diagnostic procedure is ordered, planned, or scheduled at the time of the E/M encounter, the type of procedure (e.g., laparoscopy) should be documented.*

***DG:** If a surgical or invasive diagnostic procedure is performed at the time of the E/M encounter, the specific procedure should be documented.*

***DG:** The referral for or decision to perform a surgical or invasive diagnostic pro- cedure on an urgent basis should be documented or implied.*

The table on p. 128 may be used to help determine whether the risk of sig- nificant complications, morbidity, and/or mortality is *minimal, low, moderate,* or *high.* Because the determination of risk is complex and not readily quantifi- able, the table includes common clinical examples rather than absolute mea- sures of risk. The assessment of risk of the presenting problem(s) is based on the risk related to the disease process anticipated between the present encounter and the next one. The assessment of risk of selecting diagnostic procedures and management options is based on the risk during and immediately following any procedures or treatment. **The highest level of risk in any one category (presenting problem[s], diagnostic procedure[s], or management options) determines the overall risk.**

D. Documentation of an Encounter Dominated by Counseling or Coordination of Care

In the case in which counseling and/or coordination of care dominates (more than 50%) the physician/patient and/or family encounter (face-to-face time in the office or other or outpatient setting, floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E/M services.

***DG:** If the physician elects to report the level of service based on counseling and/ or coordination of care, the total length of time of the encounter (face-to-face or floor time, as appropriate) should be documented, and the record should de- scribe the counseling and/or activities to coordinate care.*

TABLE OF RISK
(MODIFIED FOR PSYCHIATRY FROM THE 1997 CMS GUIDELINES)

LEVEL OF RISK	PRESENTING PROBLEM(S)	DIAGNOSTIC PROCEDURE(S) ORDERED	MANAGEMENT OPTIONS SELECTED
Minimal	1 self-limited problem (e.g., medication side effect)	Laboratory tests requiring venipuncture Urinalysis	Reassurance
Low	2 or more self-limited or minor problems; or 1 stable chronic illness (e.g., well-controlled depressions); or Acute uncomplicated illness (e.g., exacerbation of anxiety disorder)	Psychological testing Skull film	Psychotherapy Environmental intervention (e.g., agency, school, vocational placement) Referral for consultation (e.g., physician, social worker)
Moderate	1 or more chronic illnesses with mild exacerbation, progression, or side effects of treatment; or 2 or more stable chronic illnesses; or Undiagnosed new problem with uncertain prognosis (e.g., psychosis)	Electroencephalogram Neuropsychological testing	Prescription drug management Open-door seclusion ECT, inpatient, outpatient, routine; no comorbid medical conditions
High	1 or more chronic illnesses with severe exacerbation, progression, or side effect of treatment (e.g., schizophrenia); or Acute illness with threat to life (e.g., suicidal or homicidal ideation)	Lumbar puncture Suicide risk assessment	Drug therapy requiring intensive monitoring (e.g., tapering diazepam for patient in withdrawal) Closed-door seclusion Suicide observation ECT; patient has comorbid medical condition (e.g., cardiovascular disease) Rapid intramuscular neuroleptic administration Pharmacological restraint (e.g., droperidol)

History

Chief Complaint (CC)	History of Present Illness (HPI)	Past, Family, Social History (PFSH)	Review of Systems (ROS)
Reason for the visit	Location; Severity; Timing; Quality; Duration; Context; Modifying Factors; Associated signs and symptoms	Past medical; Family medical; Social	Constitutional; Eyes; Ears, Nose, Mouth, and Throat; Cardiovascular; Respiratory; Genitourinary; Musculoskeletal; Gastrointestinal; Skin/Breast; Neurological; Psychiatric; Endocrine; Hematologic/Lymphatic; Allergic/Immunologic

CC	HPI	PFSH	ROS	History Type
Yes	*Brief* (1-3 elements or 1-2 chronic conditions)	N/A	N/A	Problem focused (PF)
			Problem pertinent (1 system)	Expanded problem focused (EPF)
	Extended (4 elements or 3 chronic conditions)	*Pertinent* (1 element)	*Extended* (2-0 systems)	Detailed (DET)
		Complete (2 elements (est) or 3 elements (new/initial)	*Complete* (10-14 systems)	Comprehensive (COMP)

Examination

System/Body Area	Examination
Constitutional	• 3/7 vital signs: sitting or standing BP, supine BP, pulse rate and regularity, respiration, temperature, height, weight • General appearance
Musculoskeletal	• Muscle strength and tone • Gait and station
Psychiatric	• Speech • Thought process • Associations • Abnormal/psychotic thoughts • Judgment and insight • Orientation • Recent and remote memory • Attention and concentration • Language • Fund of knowledge • Mood and affect

Examination Elements	Examination Type
1-5 bullets	Problem focused (PF)
At least 6 bullets	Expanded problem focused (EPF)
At least 9 bullets	Detailed (DET)
All bullets in Constitutional and Psychiatric (shaded) boxes and 1 bullet in Musculoskeletal (unshaded) box	Comprehensive (COMP)

Med Dec Making

Medical Decision Making Element	Determined by
Number of diagnoses or management options	Problem points chart
Amount and/or complexity of data to be reviewed	Data points chart
Risk of significant complications, morbidity, and/or mortality	Table of risk

Problem Points

Category or Problems/Major New Symptoms	Points per problem
Self-limiting or minor (stable, improved, or worsening (max=2)	1
Established problem (to examining physician); stable or improved	1
Established problem (to examining physician); worsening	2
New problem (to examining physician); no additional workup or diagnostic procedures ordered (max=1)	3
New problem (to examining physician); additional workup planned*	4
*Additional workup does not include referring patient to another physician for future care	

Medical Decision Making

Data Points

Categories of Data to be Reviewed (max=1 for each)	Points
Review and/or order of clinical lab tests	1
Review and/or order of tests in the radiology section of CPT	1
Review and/or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than patient	1
Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider	2
Independent visualization of image, tracing, or specimen itself (not simply review report)	2

Table of Risk

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	One self-limited or minor problem	Venipuncture; EKG; urinalysis	Rest
Low	Two or more self-limited or minor problems; One stable chronic illness; Acute uncomplicated illness	Arterial puncture	OTC drugs
Moderate	One or more chronic illnesses with mild exacerbation, progression, or side effects; Two or more stable chronic illnesses; Undiagnosed new problem with uncertain prognosis; Acute illness with systemic symptoms		Prescription drug management
High	One or more chronic illnesses with severe exacerbation, progression, or side effects; Acute or chronic illnesses that pose a threat to life or bodily function		Drug therapy requiring intensive monitoring for toxicity

	Problem Points	Data Points	Risk	Complexity of Medical Decision Making
2/3 elements must be met or exceeded:	0-1	0-1	Minimal	*Straightforward*
	2	2	Low	*Low*
	3	3	Moderate	*Moderate*
	4	4	High	*High*

CPT Codes

New Patient Office
(requires 3 of 3)

CPT Code	History	Exam	MDM
99201	PF	PF	Straightforward
99202	EPF	EPF	Straightforward
99203	DET	DET	Low
99204	COMP	COMP	Moderate
99205	COMP	COMP	High

Established Patient Office
(requires 2 of 3)

CPT Code	History	Exam	MDM
99211	N/A	N/A	N/A
99212	PF	PF	Straightforward
99213	EPF	EPF	Low
99214	DET	DET	Moderate
99215	COMP	COMP	High

Initial Hospital/PHP
(requires 3 of 3)

CPT Code	History	Exam	MDM
99221	DET	DET	Straightforward
99222	COMP	COMP	Moderate
99223	COMP	COMP	High

Subsequent Hospital/PHP
(requires 2 of 3)

CPT Code	History	Exam	MDM
99231	PF	PF	Straightforward
99232	EPF	EPF	Moderate
99233	DET	DET	High

Evaluation and Management (E/M) Patient Examples

Office, Established Patient

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IMPORTANT

The sample progress notes below meet criteria for the specified E/M code, but do ***not*** necessarily meet criteria for the multiple other purposes (e.g., clinical, legal) of documentation. For illustration, the documentation meets requirements specified by the codes for the exact levels of each of the 3 key components. In practice, criteria for these codes may be met by documenting only 2 of 3 of the key components at or above the level required by the code.

SERVICES SHOULD ALWAYS BE MEDICALLY NECESSARY.

99213		***Office visit for a 9-year-old male, established patient, with ADHD. Mild symptoms and minimal medication side effects.***	***Office visit for a 27-year-old female, established patient, with stable depression and anxiety. Intermittent moderate stress.***	
HISTORY	CC	9-year-old male seen for follow up visit for ADHD. Visit attended by patient and mother; history obtained from both.	27-year-old female seen for follow up visit for depression and anxiety. Visit attended by patient.	**HISTORY:** *Expanded Problem Focused*
	HPI	Grades are good (associated signs and symptoms) but patient appears distracted (quality) in class (context). Lunch appetite poor but eating well at other meals. **HPI scoring**: 3 elements = *Brief*	Difficulty at work but coping has been good. Minimal (severity) situational sadness (quality) and anxiety when stressed (context). **HPI scoring**: 3 elements = *Brief*	
	PFSH	N/A	N/A	
	ROS	Psychiatric: denies depression, anxiety, sleep problems **ROS scoring**: 1 system = *Problem-pertinent*	Psychiatric: no sadness, anxiety, irritability **ROS scoring**: 1 system = *Problem-pertinent*	
EXAM	Const	Appearance: appropriate dress, comes to office easily	Appearance: appropriate dress, appears stated age N/A	**EXAM:** *Expanded Problem Focused*
	MS	N/A		
	Psych	Speech: normal rate and tone; Thought content: no SI/HI or psychotic symptoms; Associations: intact; Orientation: x 3; Mood and affect: euthymic and full and appropriate **Examination scoring**: 6 elements = *Expanded problem-focused*	Speech: normal rate and tone; Thought content: no SI/HI or psychotic symptoms; Associations: intact; Orientation: x 3; Mood and affect: euthymic and full and appropriate; Judgment and insight: good **Examination scoring**: 7 elements = *Expanded problem-focused*	
MEDICAL DECISION MAKING		**Problem 1**: ADHD **Comment**: Relatively stable; mild symptoms **Plan**: Renew stimulant script and increase dose; Return visit in 2 months	**Problem 1**: Depression **Comment**: Stable **Plan**: Renew SSRI script at the same dose; Return visit in 3 months **Problem 2**: Anxiety **Comment**: Stable **Plan**: Same dose of SSRI	**MEDICAL DECISION MAKING:** *Low Complexity*
	Prob	**Problem scoring**: 1 established problem, stable (1); total of 1 = *Minimal*	**Problem scoring**: 2 established problems, stable (1 for each = 2); total of 2 = *Limited*	
	Data	**Data scoring**: Obtain history from someone other than patient (2); total of 2 = *Limited*	**Data scoring**: None = *Minimal*	
	Risk	**Risk scoring**: Chronic illness with mild exacerbation, progression, or side effects; and Prescription drug management = *Moderate*	**Risk scoring**: Two stable chronic illnesses; and Prescription drug management = *Moderate*	

Evaluation and Management (E/M) Patient Examples

99214	***Office visit for a 13-year-old male, established patient, with depression, anxiety, and anger outbursts.***	***Office visit for a 70-year-old male, established patient, with stable depression and recent mild forgetfulness.***	
HISTORY CC	13-year-old male seen for follow up visit for mood and behavior problems. Visit attended by patient and father; history obtained from both.	70-year-old male seen for follow up visit for depression. Visit attended by patient and daughter; history obtained from both.	**HISTORY:** *Detailed*
HPI	Patient and father report increasing (timing), moderate (severity) sadness (quality) that seems to be present only at home (context) and tends to be associated with yelling and punching the walls (associated signs and symptoms) at greater frequency, at least once per week when patient frustrated. Anxiety has been improving and intermittent, with no evident trigger (modifying factors). **HPI scoring**: 6 elements = *Extended*	Patient and daughter report increasing distress related to finding that he has repeatedly lost small objects (e.g., keys, bills, items of clothing) over the past 2-3 months (duration). Patient notices intermittent (timing), mild (severity) forgetfulness (quality) of people's names and what he is about to say in a conversation. There are no particular stressors (modifying factors) and little sadness (associated signs and symptoms). **HPI scoring**: 6 elements = *Extended*	
PFSH	Attending 8th grade without problem; fair grades **PFSH scoring**: 1 element: social = *Pertinent*	Less attention to hobbies **PFSH scoring**: 1 element: social = *Pertinent*	
ROS	Psychiatric: no problems with sleep or attention; Neurological: no headaches **ROS scoring**: 2 systems = *Extended*	Psychiatric: no problems with sleep or anger; Neurological: no headaches, dizziness, or weakness **ROS scoring**: 2 systems = *Extended*	
EXAM Const	Appearance: appropriate dress, appears stated age	Appearance: appropriate dress, appears stated age	**EXAM:** *Detailed*
MS	N/A	Muscle strength and tone: normal	
Psych	Speech: normal rate and tone; Thought process: logical; Associations: intact; Thought content: no SI/HI or psychotic symptoms; Orientation: x 3; Attention and concentration: good; Mood and affect: euthymic and full and appropriate ; Judgment and insight: good **Examination scoring**: 9 elements = *Detailed*	Speech: normal rate and tone; Thought process: logical; Associations: intact; Thought content: no SI/HI or psychotic symptoms; Orientation: x 3; Attention and concentration: unable to focus on serial 7s; Mood and affect: euthymic and full and appropriate; Recent and remote memory: mild struggle with telling history and remembered 1/3 objects **Examination scoring**: 10 elements = *Detailed*	
MEDICAL DECISION MAKING	**Problem 1**: Depression **Comment**: Worsening; appears associated with lack of structure **Plan**: Increase dose of SSRI; write script; CBT therapist; Return visit in 2 weeks **Problem 2**: Anxiety **Comment**: Improving **Plan**: Patient to work with therapist on identifying context **Problem 3**: Anger outbursts **Comment**: Worsening; related to depression but may represent mood dysregulation **Plan**: Call therapist to obtain additional history; consider a mood stabilizing medication if no improvement in 1-2 months	**Problem 1**: Depression **Comment**: Stable; few symptoms **Plan**: Continue same dose of SSRI; write script Return visit in 1 month **Problem 2**: Forgetfulness **Comment**: New; mildly impaired attention and memory **Plan**: Brain MRI; consider referral to a neurologist if persists	**MEDICAL DECISION MAKING:** *Moderate Complexity*
Prob	**Problem scoring**: 2 established problems, worsening (2 for each problem = 4); 1 established problem, improving (1); total of 5 = *Extensive*	**Problem scoring**: 1 established problem, stable (1); 1 new problem with additional workup (4); total of 5 = *Extensive*	
Data	**Data scoring**: Obtain history from other (2); Decision to obtain history from other (1); total of 3 = *Multiple*	**Data scoring**: Order of test in the radiology section of CPT (1); Obtain history from other (2); total of 3 = *Multiple*	
Risk	**Risk scoring**: One or more chronic illnesses with mild exacerbation, progression; and Prescription drug management = *Moderate*	**Risk scoring**: Undiagnosed new problem with uncertain prognosis; and Prescription drug management = *Moderate*	

Evaluation and Management (E/M) Patient Examples

99215		***Office visit for an established adolescent patient with history of bipolar disorder treated with lithium; seen on urgent basis at family's request because of severe depressive symptoms.***	***Office visit for a 25-year-old male, established patient with a history of schizophrenia, who has been seen bi-monthly but is complaining of auditory hallucinations.***	
HISTORY	CC	17-year-old male seen for urgent visit for depression. Visit attended by patient and parents; history obtained from all 3.	25-year-old male seen for follow up visit for schizophrenia. Visit attended by patient.	**HISTORY:** *Comprehensive*
	HPI	Patient doing well until 2 days ago (timing) when, for no apparent reason (context), he refused to leave his bed and appeared extremely (severity) and continuously depressed (quality); he is sleeping more and eating little (associated signs and symptoms). **HPI scoring**: 5 elements = *Extended*	The patient reports doing well until 1 week ago (duration) when he stayed up all night to finish a term paper (context). He has slept poorly (severity) since (timing) and, 2 days ago, began hearing fairly continuous voices (quality) telling him that people plan to shoot him. Attention and organization were good up until this past week (associated signs and symptoms). **HPI scoring**: 6 elements = *Extended*	
	PFSH	Stopped attending school; family history of suicide is noted from patient's initial evaluation **PFSH scoring**: Family and social (2 elements) = *Complete*	Doing well in third year of graduate school. Chart notes no family psychiatric history. **PFSH scoring**: Family and social (2 elements) =*Complete*	
	ROS	Psychiatric: no problems with anxiety or anger; Neurological: no headaches; All other systems reviewed and are negative. **ROS scoring**: All systems = *Complete*	Psychiatric: denies symptoms of depression or mania; Neurological: no headaches; All other systems reviewed and are negative. **ROS scoring**: All systems = *Complete*	
EXAMINATION	Const	VS: BP (sitting) 120/70, P 90 and regular, R 20; Appearance: appropriate dress, appears stated age	VS: BP (sitting) 115/70, P 86 and regular, Ht 5'10", Wt 180 lbs; Appearance: appropriate dress, appears stated age	**EXAMINATION:** *Comprehensive*
	MS	Gait and station: normal	Gait and station: normal	
	Psych	Speech: sparse and slow; Thought process: logical; Associations: intact; Thought content: hopelessness, thinks of suicide, no HI or psychotic symptoms; Orientation: x 3; Attention and concentration: impaired; Mood and affect: depressed and constricted; Judgment and insight: poor; Fund of knowledge: good; Recent and remote memory: good; Language: able to repeat phrases **Examination scoring**: All elements of constitutional and psychiatric and 1 element of musculoskeletal = *Comprehensive*	Speech: normal rate and tone; Thought process: logical; Associations: intact; Thought content: auditory hallucinations and paranoid ideation, no SI/HI; Orientation: x 3; Attention and concentration: impaired; Mood and affect: euthymic and full and appropriate; Judgment and insight: good; Fund of knowledge: good; Recent and remote memory: good; Language: able to repeat phrases **Examination scoring**: All elements of constitutional and psychiatric and 1 element of musculoskeletal = *Comprehensive*	
MEDICAL DECISION MAKING	Prob	**Problem 1**: Bipolar disorder **Comment**: Major relapse **Plan**: Continue current dose of Lithium for the moment **Problem 2**: Suicidality **Comment**: New **Plan**: Refer to hospital; confer with hospitalist once patient is admitted **Problem scoring**: 1 established problem, worsening (2); 1 new problem (3); total of 5 = *Extensive*	**Problem 1**: Psychosis **Comment**: Major relapse **Plan**: Increase dose of antipsychotic; write script; hold off on hospital admission as patient historically very adherent; return for visit in 1 day **Problem 2**: Insomnia **Comment**: Sleep deprivation may have triggered the psychosis relapse **Plan**: Change to a more powerful hypnotic; write script **Problem 3**: ADHD **Comment**: Appears stable **Plan**: Continue same dose of non-stimulant medication **Problem scoring**: 1 established problem, stable (1); 2 established problems, worsening (2 for each problem = 4); total of 5 = *Extensive*	**MEDICAL DECISION MAKING:** *High Complexity*
	Data	**Data scoring**: Obtain history from other (2); total of 2 = *Limited*	**Data scoring**: None = *Minimal*	
	Risk	**Risk scoring**: Chronic illness with severe exacerbation; and Illness that poses a threat to life = *High*	**Risk scoring**: Chronic illness with severe exacerbation = *High*	

Appendix F

Vignettes for Evaluation and Management Codes

OFFICE VISIT, NEW PATIENT

99203 A 27-year-old woman with a history of depression who is visiting the area is seen in an initial office visit. She is currently under treatment in her hometown. His- tory taking focuses on a review of her past psychiatric history, present illness, and interval history since her last visit to her treating psychiatrist. Her medication his- tory is reviewed, as is her side-effect history. A mental status examination focuses on her current affective state, ability to attend and concentrate, and insight. A prescription for an antidepressant is provided, along with education on its use and side effects.

Explanation for code choice: Although a new patient to the examining psychiatrist, this patient has an existing treatment source. The psychiatrist obtains a detailed history and performs a detailed mental status examination. (A de- tailed history requires a detailed [two to nine elements] review of symptoms.) The provision of a prescription requires medical decision making of low com- plexity.

99205 A 38-year-old man brought by his parents for evaluation of paranoid delusions and alcohol abuse is seen in an initial office visit. History taking focuses on the family history of mental illness. The past medical and psychiatric history, his- tory of present illness, and social history of the patient are taken. The results of a mental status examination reveal a poorly groomed individual, poor eye con- tact, no spontaneity to speech, flat affect, no hallucinations, paranoid delusions about the police, no suicidal/homicidal ideation, and intact cognitive status. The patient has no history of current medical problems. The patient denies alcohol use. The parents are interviewed and provide a history of the patient that includes at least 5 years of binge drinking. Routine blood studies are ordered. The patient's vital signs are taken. A prescription for a neuroleptic is given, and education about medication is provided to the patient and the parents. Referrals to a dual-diagnosis treatment program and Alcoholics Anonymous are made.

Explanation for code choice: This initial evaluation requires complex medical decision making because of the psychotic symptoms in the context of alcohol abuse. The psychiatrist must complete a comprehensive history and examination. The comprehensive history includes a complete review of systems.

OFFICE VISIT, ESTABLISHED PATIENT

99213 A 42-year-old male established patient with a history of bipolar II disorder, last seen 2 months prior, is seen for an office visit. Interval history taking focuses on the presence/absence of symptoms, the patient's level of social/vocational function, and the patient's adherence to the medication regimen. A mental status examination focuses on the patient's affective state. The patient's lithium blood level is reviewed. The side effects of the medication are reviewed, and prescriptions for the same medications are provided.

Explanation for code choice: In order to make a decision about medications, the psychiatrist must do an expanded problem-focused history and examination. An expanded problem-focused history includes one to three elements of a review of systems. The actual medical decision to continue the medication regimen is of low complexity.

HOSPITAL INPATIENT SERVICES—INITIAL HOSPITAL CARE

99221 A 32-year-old woman is seen for initial hospital care. The woman had been discharged from the same psychiatric unit 3 days earlier after a 5-day stay precipitated by threats of suicide in the context of alcohol intoxication. The patient had received diagnoses of adjustment disorder with depressed mood and suicidal ideation, alcohol abuse, and mixed personality disorder with borderline features. Her interval history revealed that the patient had returned home after discharge from the hospital and within 24 hours became involved in verbally violent arguments with her husband, drank an unspecified amount of vodka, and threatened to kill him. Her blood alcohol level in the emergency department is 160 mg/dL. The results of a physical examination are within normal limits, as are the results of the remainder of the laboratory studies. The results of a toxicology screening are negative. The mental status examination reveals a patient who is crying, angry, and accusing her husband of infidelity. She is difficult to redirect, and her affect is labile and irritable. Her mood is depressed. She shows no psychotic symptoms and is cognitively intact. She demonstrates little to no insight. The patient is admitted to the hospital voluntarily. The social work staff is asked to provide an evaluation of the husband and the family situation. Discharge planning is begun.

Explanation for code choice: The lowest level of initial hospital care is appropriate because this is a readmission with no change in the history database and because the medical decision making is straightforward.

99222 A 40-year-old man discharged 12 days before the current admission with a diagnosis of schizophrenia had been given instructions to attend follow-up visits at an outpatient clinic to monitor his neuroleptic medication. He now presents with auditory hallucinations and paranoid ideation with violent thoughts toward his neighbors. His interval history reveals that he never attended the outpatient clinic and that he immediately discontinued taking the neuroleptic medication after discharge. The patient's brother reports that the patient's symptoms reappeared 4 days before the current admission. The patient also has a history of diabetes mellitus controlled by oral medications and had discontinued taking his diabetes medication. A mental status examination reveals a poorly groomed individual with auditory hallucinations that are threatening toward the patient and paranoid delusions that involve neighbors trying to hurt him. He admits to violent thoughts toward his neighbors and states that he might have to harm or kill them. He appears to be cognitively intact. A physical examination reveals a moderately obese individual. The results of his laboratory studies are normal except for an elevated glucose level. The results of repeat finger-stick tests indicate glucose levels above 400 mg/dL. A new neuroleptic regimen is begun for the patient. The treatment team devises a strategy to help the patient's family assist him in adhering to this regimen after discharge.

Explanation for code choice: Although this case is also a readmission, the nature of the presenting problem involves psychotic symptoms, violent thoughts, and symptomatic diabetes. The level of history taking and examination are comprehensive, and the medical decision making is moderately complex.

99223 Initial psychiatric hospital services are provided for a 17-year-old female transferred from the medical intensive care unit after treatment for ingestion of a large amount of acetaminophen and aspirin. Her family history reveals that her mother and a maternal uncle have been treated for depression. The patient has been doing poorly in school for 6 months and has been experimenting with drugs and alcohol. She has been rebellious at home, and 2 months ago she reported that she might be pregnant. One week before her admission, her boyfriend of 1 year left her for another schoolmate. She has no history of significant medical or surgical problems. Her last menstrual period was 3 weeks ago. The patient is admitted voluntarily. A mental status examination reveals a barely cooperative, sullen teenager whose speech is not spontaneous but is logical and coherent. She shows no psychotic symptoms. The patient refuses to comment on current suicidal thoughts or ideation. She is cognitively intact. The results of a physical examination and laboratory tests are all within normal limits. The social work staff is asked to assess the patient's family situation. The patient is placed on close observation as a suicide precaution.

Explanation for code choice: Suicidal behaviors always require highly complex medical decision making supported by a comprehensive history and comprehensive mental status examination. Be sure to complete a full review of systems.

99223 Initial hospital care is provided for a 35-year-old woman with a 3-month history of withdrawn, bizarre behavior. Two days before her admission she became disorganized and aggressive toward her family and started talking to herself. Her

family history reveals a maternal grandfather with a diagnosis of schizophrenia. The patient had two prior episodes of psychosis and had received a diagnosis of schizophrenia. She dropped out of treatment 5 – 6 months ago, and since then she has not taken any medications. There are no current medical or surgical problems. The patient is admitted involuntarily. The results of a mental status examina- tion reveal the patient to be uncooperative and poorly groomed and to make poor eye contact. Her speech is rambling and tangential. The patient appears to be responding to internal stimuli and is easily distracted and blocked. Her affect is flat and blunted. The patient is oriented to time, place, and person. The results of a physical examination and laboratory tests are within normal limits. The pa- tient is placed on every-15-minute observation status. She is assessed for neuroleptic treatment. The social work staff is asked to assess the family situation. The occupational therapy/recreational therapy staff is asked to assess the patient's ability to perform activities of daily living.

Explanation for code choice: This is an example of a typical admission for a patient with a major psychiatric disorder and severe acute symptoms. The history and mental status examination must be comprehensive. A complete review of systems is required, and the medical decision making is highly complex.

99223 Initial hospital care is provided for an 8-year-old boy whose parents requested admission because of a 1-week history of repeated attempts to cut and hit himself. The patient's family history reveals that his father is in treatment for bipolar disorder. The patient is the second of three children. The siblings are reported to be doing well. The parents admit to having recent marital problems for which they have sought counseling. The patient is described as generally well behaved but moody with a bad temper. His schoolwork has been deteriorating for the past 3 months, and there have been reports of minor behavioral misconduct. One week before admission, the parents denied the patient a puppy. Since then he has been out of control and has been cutting, scratching, and hitting himself. A mental status examination reveals a withdrawn, depressed-appearing child who answers all questions with yes or no. He is cognitively intact. A physical examination reveals scratches and bruises over the patient's arms and legs. The results of laboratory studies are within normal limits. The social work staff is asked to begin a family assessment. The patient is placed on close observation.

Explanation for code choice: The out-of-control self-harm behavior requires highly complex medical decision making supported by a complete review of systems and a comprehensive history and examination.

99223 Initial hospital care is provided for a 75-year-old man with a 2-month history of depression, a 2-week history of auditory hallucinations, and recent suicidal ideation. The patient has a history of diabetes mellitus and is dehydrated. The psychiatric history focuses on past history of episodes of depression, family history of depression, and the patient's current social support system. A mental status examination reveals poor grooming, poor eye contact, lack of spontaneity, slowed speech, psychomotor retardation, depressed affect, present suicidal ideation with no plan, and auditory hallucinations telling the patient that he is no good. The patient is cognitively intact. The patient is admitted voluntarily. A medical consul-

tation is requested. Complete blood count, SMA-12, and thyroid laboratory tests are ordered. The patient and the family are instructed about the probable need for electroconvulsive therapy. The consent process for electroconvulsive therapy is explained, and signatures are obtained. Exploration of discharge placement is begun. The patient is placed on close observation as a suicide precaution.

Explanation for code choice: Severe depression with psychotic symptoms and suicidal ideation in an elderly patient requires a comprehensive history and examination as well as a complete review of systems. Treatment considerations, taking into account medical comorbidities and including electroconvulsive therapy, demand highly complex medical decision making.

HOSPITAL INPATIENT SERVICES—SUBSEQUENT HOSPITAL CARE

99231 A 14-year-old female admitted for depression and suicidal ideation is seen in a subsequent hospital visit. The patient has been in the hospital for 12 days and is behaviorally stable. Her condition is improving. The attending psychiatrist interviews the patient; meets with the treatment team; reviews notes prepared by nursing, occupational therapy/recreational therapy, and social work staff; writes an order for as-needed medication for headache; and writes the daily progress note.

Explanation for code choice: This level of subsequent hospital care is appropriate because the patient is stable and approaching discharge. The medical decision making for this day's work is straightforward.

99232 A 36-year-old man admitted for hallucinations and delusions and now in his third hospital day is seen for a subsequent hospital visit. The attending psychiatrist interviews the patient, takes an interval history, does a mental status examination, and then meets with the treatment team. The team reviews notes prepared by nursing, occupational therapy/recreational therapy, and social work staff. The attending psychiatrist orders an increase in the patient's neuroleptic medication. The attending psychiatrist discusses discharge planning with social work staff, talks with the patient's mother by phone, and writes the daily progress note.

Explanation for code choice: This example of subsequent hospital care is typical of a mid-hospital-course day of work. The history and examination are at the expanded problem-focused level, and the medical decision making is moderately complex. The expanded problem-focused history requires one to three elements of a review of systems.

99233 A 72-year-old man admitted for depression with suicidal ideation and paranoid delusions is seen for a subsequent hospital visit. The patient is in his seventh hospital day. The attending psychiatrist interviews the patient and does a mental status examination, noting minor changes in orientation. The attending psychiatrist meets with the treatment team and reviews notes prepared by nursing, occupational therapy/recreational therapy, and social work staff. Although the patient is taking antidepressants, the team does not believe the patient has shown

progress. His sleep and appetite are poor, and he must be encouraged to shower and groom. The attending psychiatrist reviews discharge planning with social work staff and writes the daily progress note. Later the same day the attending psychiatrist is notified that the patient has become combative with staff and is confused and disoriented. The attending psychiatrist returns to the unit and orders as-needed lorazepam and open-door seclusion. The patient's vital signs are taken, and a modest increase in temperature is observed. The attending psychiatrist orders a medical consultation and an evaluation for the fever and prepares an addendum to the progress note.

Explanation for code choice: The reason the highest level of subsequent hospital care is recommended in this case is the abrupt change in mental state requiring a return to the unit and a detailed evaluation of the situation, with a detailed examination and medical decision making of high complexity. Although the subsequent hospital care codes require only two of the three key components, it is not a bad idea to do a detailed (two to nine elements) review of systems when using these codes.

OFFICE OR OTHER OUTPATIENT CONSULTATIONS

Note: As of January 1, 2010, Medicare does not reimburse for these codes. See Chapter 4 for alternative coding.

99244 A 7-year-old boy referred by his pediatrician is seen in an initial office consultation. The patient was referred because of his short attention span, easy distractibility, and hyperactivity. The history taken during the parents' interview focuses on the patient's family history and psychosocial context, the mother's pregnancy, the patient's early childhood development, and the parents' description of the onset and progression of the symptoms and behaviors. The mental status examination focuses on the patient's affective state, ability to attend and concentrate during the evaluation and observation, and behavior during the session. The patient is scheduled for neuropsychological testing and a return visit with his parents.

Explanation for code choice: The consultation requires a comprehensive history and examination. The medical decision making is moderately complex. Do not forget that a review of systems is required.

99245 An 81-year-old woman referred by her internist is seen in an initial office consultation for evaluation of her mental state. Her family had reported her activity as being markedly decreased and that she was having difficulty maintaining independent self-care. The patient's history reveals that she has congestive heart failure and chronic obstructive pulmonary disease that is in fair control. She had two episodes of depression in her 50s and was treated successfully with antidepressants. The patient reports feelings of general malaise, loss of interest, trouble sleeping, decreased appetite, and problems with memory over a 4-week period. The patient denies awareness of an inability to maintain her home or independent self-care. A mental status examination reveals a poorly groomed, cooperative woman

with moderate psychomotor retardation and no speech abnormalities. She appears sad and expresses feelings of depression and has flat affect. Her Mini-Mental State Examination score is 25 of 30 points, with poor recall, attention and concentration deficits, and distortion of figure drawing. A family member is interviewed and confirms most of the history. Neuropsychological testing is ordered, and the patient's case is discussed with the referring physician.

Explanation for code choice: This case involves mental disorder with significant comorbid medical conditions. The medical decision making is highly complex, supported by a comprehensive history and examination. The history must include a complete review of systems.

INITIAL INPATIENT CONSULTATIONS

Note: As of January 1, 2010, Medicare does not reimburse for these codes. See Chapter 4 for alternative coding.

99253 An initial hospital consultation is provided for a 35-year-old woman referred by obstetrics/gynecology staff after she had a normal vaginal delivery and had asked to talk to a psychiatrist about feelings of depression. A review of her chart reveals an uncomplicated neonatal course and a normal delivery of a healthy baby girl. History taking focuses on symptom onset and progression and the patient's current family/social context. The patient reports that her husband is out of work and is drinking and arguing with her frequently. Two other children are doing well. A mental status examination reveals a cooperative, friendly individual with normal speech, moderately depressed mood (which she relates to her marital stress), full affect, and no psychotic or anxiety symptoms. She is cognitively intact. Her insight is fair, and her judgment is intact. Her desire for marital counseling is supported, and she is given a referral for this service.

Explanation for code choice: This consultation for a medically stable patient required a detailed history and examination. The medical decision making is of low complexity. The history must include a detailed review of systems (two to nine elements).

99254 An initial hospital consultation is provided for a 19-year-old female referred by department of medicine staff after treatment for ingestion of acetaminophen and alcohol. A review of her chart reveals that symptomatic management was used to treat ingestion of alcohol (her blood alcohol level was 120 mg/dL) and a nonlethal amount of acetaminophen. The patient has no history of medical or surgical problems. History provided by the patient includes a recent breakup with her boyfriend of 3 years, loss of her job, and fighting with her mother. Her family history includes alcohol abuse by the father and two brothers. The patient reports that she has experimented with street drugs, has used alcohol regularly since age 16 years, and has had a history of binge drinking. There is no history of blackouts or delirium tremens. The patient has no current legal problems. A mental status examination reveals a cooperative individual with good eye con-

tact. She asks "When can I get out of here?" and states "I did a stupid thing." The patient is remorseful, and her affect is bright, with a moderate level of depression. She is cognitively intact. She expresses concerns about her boyfriend and states that she probably needs some counseling. She agrees to treatment of alcohol abuse. The patient is cleared for discharge and given a referral to a community psychiatry program for dually diagnosed patients.

Explanation for code choice: The suicide attempt was committed impulsively, and the patient is remorseful and ready for outpatient follow-up. A detailed history and examination are performed, and medical decision making is moderately complex. The history must include a complete review of systems.

99255 An initial hospital consultation is provided for an 82-year-old man referred by department of medicine staff because of bizarre behavior that resulted in his requiring a sitter. The patient has high blood pressure, renal insufficiency, congestive heart failure, and chronic obstructive pulmonary disease. He is taking 12 medications, including as-needed lorazepam and haloperidol for "behavioral control." Notes prepared by nursing staff indicate that the patient has periods of lucidity intermixed with confused, uncooperative behavior, usually in the evenings. The patient began receiving antibiotics in the previous 12 hours for a urinary tract infection. The social worker reports that the patient lives with his wife and was in good health and maintained a wide range of activities before this admission. The wife reports some slippage in the patient's memory, but the patient denies that there are any problems whatsoever. The mental status examination reveals the patient to be resting in his hospital bed and receiving intravenous fluids and intranasal oxygen. The patient is irritable, and his irritability increases during the course of the evaluation. He denies any psychological symptoms. The patient knows who he is and where he is but does not know the day, the date, or the month. He cannot do serial 7s. The patient reports having had a visit by several of his children the night before, but nursing staff report no such visit took place. The findings are reviewed with the nursing staff and the attending physician. Lorazepam is discontinued, and orientation strategies are discussed with the nursing staff and the attending physician.

Explanation for code choice: This case is typical for an acute geriatric medical admission: multiple comorbidities and multiple medications complicated by delirium. The consulting psychiatrist must do a comprehensive history and examination. The medical decision making is highly complex. The history must include a complete review of systems.

Appendix G

Most Frequently Missed Items in Evaluation and Management (E/M) Documentation

National Government Services, Inc.
1333 Brunswick Avenue
Lawrenceville, New Jersey 08648

A CMS Contracted Agent

Most Frequently Missed Items in Evaluation and Management (E/M) Documentation

History

- History is too brief and lacks the reason for the encounter or minimal documentation of the reason for the encounter.
- Documentation for the Review of Systems is too minimal.
- If billing for a Complete Review of Systems – either must individually document ten (10) or more systems **OR** may document pertinent (some) systems and make the statement in the progress note "all other systems negative."
- Lacks any documentation in support of why elements of the history or the entire history was unobtainable; would also apply to documenting the work done to attempt to obtain history from sources other than the patient if it was unobtainable from the patient.
- Insufficient documentation of the Past, Family and Social history; no reference to dates or any documentation to support obtaining the information.
- If you wish to refer to a Review of Systems and/or a PFSH documented in a progress note of a previous date and update it with today's information (e.g., unchanged from ROS of 1/4/07 except patient has stopped smoking) – you must specifically indicate the previous date you are referring to in today's note and you must include a photocopy of the previous ROS or PFSH you have referred to if you are asked to send documentation for today's note. Make sure your staff is also aware of this if they will photocopy and send documentation to Medicare.

Physical Exam

- Physical exam documentation is too brief.
- 1997 Specialty exams, billed at the comprehensive level, do not meet all of the required elements for that level.
- For the 1995 Comprehensive exam – required to count ONLY organ systems and not body areas; must be eight (8) or more organ systems only.
- Can choose to perform and document either the 1995 or 1997 physical exam but findings show that most physicians do better with documentation based upon the 1995 guidelines.

Medical Decision Making

- Lack of sufficient evidence that labs, X-rays, etc., were performed to credit in this section (Amount and/or Complexity of Data Reviewed or in Table of Risk of Complications and/or Morbidity or Mortality).
- Lack of sufficient documentation of items which could be credited to Reviewed Data (Amount and/or Complexity of Data Reviewed) such as the decision to obtain old records or obtain history from someone other than the patient, review and summarization of old records, discussion of case with another health care provider.
- Remember, in this section, need only two (2) elements of the three and need only the highest, single item available and appropriate in one box of the chart for Risk of Complications and/or Morbidity or Mortality.

Time Based Codes

- In choosing a code based upon time for counseling and coordination of care, total time may be documented but there is not quantification that more than 50 percent of the time was spent on counseling and there is also no documentation of what the coordination of care was or what the counseling was.
- No documentation of time for critical care.
- No documentation of time for discharge day management.

General

- Missing the order for a consultation in hospitals and SNFs.
- Illegible documentation.
- Lack of a physician signature on the note.
- Missing patient names.
- Incorrect dates of service.
- Lack of any note for a billed date of service.
- Lack of the required two (2) or three (3) key elements to bill an E/M service.

EXAMPLES OF RELATIVE VALUE UNITS (RVUs) (2014)

ADDENDUM B. CY 2014 RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING FINAL MEDICARE PAYMENTS

CPT CODE	DESCRIPTION	WORK RVU	NON-FAC PE RVU	FAC PE RVU	MP RVU	NON-FAC RVU TOTAL	NON-FACILITY TOTAL Payment	FAC RVU TOTAL	FACILITY TOTAL Payment
90785	Psytx complex interactive	0.11	0.02	0.02	0.01	0.14	$ 4.76	0.14	$ 4.76
90791	Psych diagnostic evaluation	2.80	1.52	0.53	0.11	4.43	$ 150.72	3.44	$ 117.04
90792	Psych diag eval w/med srvcs	2.96	0.58	0.48	0.11	3.65	$ 124.18	3.55	$ 120.78
90832	Psytx pt&/family 30 minutes	1.25	0.54	0.14	0.05	1.84	$ 62.60	1.44	$ 48.99
90833	Psytx pt&/fam w/e&m 30 min	0.98	0.20	0.19	0.04	1.22	$ 41.51	1.21	$ 41.17
90834	Psytx pt&/family 45 minutes	1.89	0.41	0.20	0.07	2.37	$ 80.63	2.16	$ 73.49
90836	Psytx pt&/fam w/e&m 45 min	1.60	0.32	0.32	0.06	1.98	$ 67.37	1.98	$ 67.37
90837	Psytx pt&/family 60 minutes	2.83	0.53	0.32	0.11	3.47	$ 118.06	3.26	$ 110.91
90838	Psytx pt&/fam w/e&m 60 min	2.56	0.54	0.52	0.10	3.20	$ 108.87	3.18	$ 108.19
90839	Psytx crisis initial 60 min	0.00	0.00	0.00	0.00	0.00	$ -	0.00	$ -
90840	Psytx crisis ea addl 30 min	0.00	0.00	0.00	0.00	0.00	$ -	0.00	$ -
90845	Psychoanalysis	1.79	0.35	0.33	0.07	2.21	$ 75.19	2.19	$ 74.51
90846	Family psytx w/o patient	1.83	0.27	0.40	0.07	2.17	$ 73.83	2.30	$ 78.25
90847	Family psytx w/patient	2.21	0.31	0.42	0.08	2.60	$ 88.46	2.71	$ 92.20
90849	Multiple family group psytx	0.59	0.38	0.22	0.03	1.00	$ 34.02	0.84	$ 28.58
90853	Group psychotherapy	0.59	0.10	0.10	0.03	0.72	$ 24.50	0.72	$ 24.50
90863	Pharmacologic mgmt w/psytx	0.00	0.00	0.00	0.00	0.00	$ -	0.00	$ -
90865	Narcosynthesis	2.84	1.99	0.71	0.11	4.94	$ 168.07	3.66	$ 124.52
90867	Tcranial magn stim tx plan	0.00	0.00	0.00	0.00	0.00	$ -	0.00	$ -
90868	Tcranial magn stim tx deli	0.00	0.00	0.00	0.00	0.00	$ -	0.00	$ -
90869	Tcran magn stim redetemine	0.00	0.00	0.00	0.00	0.00	$ -	0.00	$ -
90870	Electroconvulsive therapy	2.50	2.65	0.57	0.11	5.26	$ 178.96	3.18	$ 108.19
90875	Psychophysiological therapy	1.20	0.84	0.49	0.08	2.12	$ 72.13	1.77	$ 60.22
90876	Psychophysiological therapy	1.90	1.10	0.77	0.12	3.12	$ 106.15	2.79	$ 94.92
90880	Hypnotherapy	2.19	0.55	0.35	0.08	2.82	$ 95.94	2.62	$ 89.14
90882	Environmental manipulation	0.00	0.00	0.00	0.00	0.00	$ -	0.00	$ -
90885	Psy evaluation of records	0.97	0.39	0.39	0.07	1.43	$ 48.65	1.43	$ 48.65
90887	Consultation with family	1.48	0.99	0.60	0.10	2.57	$ 87.44	2.18	$ 74.17
90889	Preparation of report	0.00	0.00	0.00	0.00	0.00	$ -	0.00	$ -
90899	Psychiatric service/therapy	0.00	0.00	0.00	0.00	0.00	$ -	0.00	$ -
96101	Psycho testing by psych/phys	1.86	0.50	0.26	0.07	2.43	$ 82.68	2.19	$ 74.51
96102	Psycho testing by technician	0.50	2.01	0.13	0.03	2.54	$ 86.42	0.66	$ 22.46

CPT CODE	DESCRIPTION	WORK RVU	NON-FAC PE RVU	FAC PE RVU	MP RVU	NON-FAC RVU TOTAL	NON-FACILITY TOTAL Payment	FAC RVU TOTAL	FACILITY TOTAL Payment
96103	Psycho testing admin by comp	0.51	1.52	0.21	0.03	2.06	$ 70.09	0.75	$ 25.52
96105	Assessment of aphasia	1.75	0.98	0.98	0.04	2.77	$ 94.24	2.77	$ 94.24
96110	Developmental screen	0.00	0.26	0.26	0.01	0.27	$ 9.19	0.27	$ 9.19
96111	Developmental test extend	2.60	0.97	0.76	0.16	3.73	$ 126.91	3.52	$ 119.76
96116	Neurobehavioral status exam	1.86	0.66	0.48	0.10	2.62	$ 89.14	2.44	$ 83.02
96118	Neuropsych tst by psych/phys	1.86	0.77	0.25	0.07	2.70	$ 91.86	2.18	$ 74.17
96119	Neuropsych testing by tec	0.55	1.62	0.09	0.01	2.18	$ 74.17	0.65	$ 22.11
96120	Neuropsych tst admin w/comp	0.51	2.48	0.19	0.03	3.02	$ 102.75	0.73	$ 24.84
96125	Cognitive test by hc pro	1.70	1.40	1.40	0.07	3.17	$ 107.85	3.17	$ 107.85
99201	Office/outpatient visit new	0.48	0.77	0.24	0.04	1.29	$ 43.89	0.76	$ 25.86
99202	Office/outpatient visit new	0.93	1.19	0.44	0.07	2.19	$ 74.51	1.44	$ 48.99
99203	Office/outpatient visit new	1.42	1.62	0.65	0.14	3.18	$ 108.19	2.21	$ 75.19
99204	Office/outpatient visit new	2.43	2.18	1.11	0.23	4.84	$ 164.67	3.77	$ 128.27
99205	Office/outpatient visit new	3.17	2.55	1.40	0.27	5.99	$ 203.80	4.84	$ 164.67
99211	Office/outpatient visit est	0.18	0.41	0.07	0.01	0.60	$ 20.41	0.26	$ 8.85
99212	Office/outpatient visit est	0.48	0.77	0.20	0.04	1.29	$ 43.89	0.72	$ 24.50
99213	Office/outpatient visit est	0.97	1.10	0.42	0.07	2.14	$ 72.81	1.46	$ 49.67
99214	Office/outpatient visit est	1.50	1.54	0.65	0.10	3.14	$ 106.83	2.25	$ 76.55
99215	Office/outpatient visit est	2.11	1.95	0.92	0.14	4.20	$ 142.90	3.17	$ 107.85
99217	Observation care discharge	1.28	0.72	0.72	0.08	2.08	$ 70.77	2.08	$ 70.77
99218	Initial observation care	1.92	0.80	0.80	0.12	2.84	$ 96.63	2.84	$ 96.63
99219	Initial observation care	2.60	1.10	1.10	0.17	3.87	$ 131.67	3.87	$ 131.67
99220	Initial observation care	3.56	1.51	1.51	0.24	5.31	$ 180.66	5.31	$ 180.66
99221	Initial hospital care	1.92	0.82	0.82	0.18	2.92	$ 99.35	2.92	$ 99.35
99222	Initial hospital care	2.61	1.13	1.13	0.22	3.96	$ 134.73	3.96	$ 134.73
99223	Initial hospital care	3.86	1.67	1.67	0.29	5.82	$ 198.01	5.82	$ 198.01
99224	Subsequent observation care	0.76	0.32	0.32	0.06	1.14	$ 38.79	1.14	$ 38.79
99225	Subsequent observation care	1.39	0.60	0.60	0.07	2.06	$ 70.09	2.06	$ 70.09
99226	Subsequent observation care	2.00	0.87	0.87	0.11	2.98	$ 101.39	2.98	$ 101.39
99231	Subsequent hospital care	0.76	0.31	0.31	0.05	1.12	$ 38.11	1.12	$ 38.11
99232	Subsequent hospital care	1.39	0.59	0.59	0.08	2.06	$ 70.09	2.06	$ 70.09
99233	Subsequent hospital care	2.00	0.85	0.85	0.12	2.97	$ 101.05	2.97	$ 101.05
99234	Observ/hosp same date	2.56	1.08	1.08	0.22	3.86	$ 131.33	3.86	$ 131.33
99235	Observ/hosp same date	3.24	1.37	1.37	0.22	4.83	$ 164.33	4.83	$ 164.33
99236	Observ/hosp same date	4.20	1.75	1.75	0.29	6.24	$ 212.30	6.24	$ 212.30
99238	Hospital discharge day	1.28	0.73	0.73	0.07	2.08	$ 70.77	2.08	$ 70.77
99239	Hospital discharge day	1.90	1.07	1.07	0.11	3.08	$ 104.79	3.08	$ 104.79
99241	Office consultation	0.64	0.66	0.24	0.07	1.37	$ 46.61	0.95	$ 32.32
99242	Office consultation	1.34	1.10	0.51	0.14	2.58	$ 87.78	1.99	$ 67.71

CPT CODE	DESCRIPTION	WORK RVU	NON-FAC PE RVU	FAC PE RVU	MP RVU	NON-FAC RVU TOTAL	NON-FACILITY TOTAL Payment	FAC RVU TOTAL	FACILITY TOTAL Payment
99243	Office consultation	1.88	1.46	0.71	0.18	3.52	$ 119.76	2.77	$ 94.24
99244	Office consultation	3.02	1.96	1.14	0.22	5.20	$ 176.92	4.38	$ 149.02
99245	Office consultation	3.77	2.30	1.38	0.29	6.36	$ 216.39	5.44	$ 185.09
99251	Inpatient consultation	1.00	0.32	0.32	0.07	1.39	$ 47.29	1.39	$ 47.29
99252	Inpatient consultation	1.50	0.52	0.52	0.12	2.14	$ 72.81	2.14	$ 72.81
99253	Inpatient consultation	2.27	0.84	0.84	0.15	3.26	$ 110.91	3.26	$ 110.91
99254	Inpatient consultation	3.29	1.23	1.23	0.18	4.70	$ 159.91	4.70	$ 159.91
99255	Inpatient consultation	4.00	1.62	1.62	0.24	5.86	$ 199.37	5.86	$ 199.37
99281	Emergency dept visit	0.45	0.12	0.12	0.03	0.60	$ 20.41	0.60	$ 20.41
99282	Emergency dept visit	0.88	0.23	0.23	0.07	1.18	$ 40.15	1.18	$ 40.15
99283	Emergency dept visit	1.34	0.32	0.32	0.10	1.76	$ 59.88	1.76	$ 59.88
99284	Emergency dept visit	2.56	0.59	0.59	0.22	3.37	$ 114.66	3.37	$ 114.66
99285	Emergency dept visit	3.80	0.83	0.83	0.30	4.93	$ 167.73	4.93	$ 167.73
99304	Nursing facility care init	1.64	0.91	0.91	0.14	2.69	$ 91.52	2.69	$ 91.52
99305	Nursing facility care init	2.35	1.27	1.27	0.20	3.82	$ 129.97	3.82	$ 129.97
99306	Nursing facility care init	3.06	1.54	1.54	0.23	4.83	$ 164.33	4.83	$ 164.33
99307	Nursing fac care subseq	0.76	0.48	0.48	0.04	1.28	$ 43.55	1.28	$ 43.55
99308	Nursing fac care subseq	1.16	0.76	0.76	0.07	1.99	$ 67.71	1.99	$ 67.71
99309	Nursing fac care subseq	1.55	0.98	0.98	0.08	2.61	$ 88.80	2.61	$ 88.80
99310	Nursing fac care subseq	2.35	1.40	1.40	0.14	3.89	$ 132.35	3.89	$ 132.35
99315	Nursing fac discharge day	1.28	0.74	0.74	0.08	2.10	$ 71.45	2.10	$ 71.45
99316	Nursing fac discharge day	1.90	1.01	1.01	0.10	3.01	$ 102.41	3.01	$ 102.41
99324	Domicil/r-home visit new pat	1.01	0.52	0.52	0.07	1.60	$ 54.44	1.60	$ 54.44
99325	Domicil/r-home visit new pat	1.52	0.69	0.69	0.10	2.31	$ 78.59	2.31	$ 78.59
99326	Domicil/r-home visit new pat	2.63	1.21	1.21	0.16	4.00	$ 136.09	4.00	$ 136.09
99327	Domicil/r-home visit new pat	3.46	1.66	1.66	0.22	5.34	$ 181.68	5.34	$ 181.68
99328	Domicil/r-home visit new pat	4.09	1.87	1.87	0.24	6.20	$ 210.94	6.20	$ 210.94
99334	Domicil/r-home visit est pat	1.07	0.60	0.60	0.07	1.74	$ 59.20	1.74	$ 59.20
99335	Domicil/r-home visit est pat	1.72	0.90	0.90	0.10	2.72	$ 92.54	2.72	$ 92.54
99336	Domicil/r-home visit est pat	2.46	1.26	1.26	0.14	3.86	$ 131.33	3.86	$ 131.33
99337	Domicil/r-home visit est pat	3.58	1.72	1.72	0.23	5.53	$ 188.15	5.53	$ 188.15
99339	Domicil/r-home care supervis	1.25	0.92	0.92	0.08	2.25	$ 76.55	2.25	$ 76.55
99340	Domicil/r-home care supervis	1.80	1.23	1.23	0.12	3.15	$ 107.17	3.15	$ 107.17
99341	Home visit new patient	1.01	0.51	0.51	0.07	1.59	$ 54.10	1.59	$ 54.10
99342	Home visit new patient	1.52	0.66	0.66	0.11	2.29	$ 77.91	2.29	$ 77.91
99343	Home visit new patient	2.53	1.05	1.05	0.18	3.76	$ 127.93	3.76	$ 127.93
99344	Home visit new patient	3.38	1.63	1.63	0.22	5.23	$ 177.94	5.23	$ 177.94
99345	Home visit new patient	4.09	1.95	1.95	0.26	6.30	$ 214.34	6.30	$ 214.34
99347	Home visit est patient	1.00	0.53	0.53	0.07	1.60	$ 54.44	1.60	$ 54.44

CPT CODE	DESCRIPTION	WORK RVU	NON-FAC PE RVU	FAC PE RVU	MP RVU	NON-FAC RVU TOTAL	NON-FACILITY TOTAL Payment	FAC RVU TOTAL	FACILITY TOTAL Payment
99348	Home visit est patient	1.56	0.76	0.76	0.10	2.42	$ 82.34	2.42	$ 82.34
99349	Home visit est patient	2.33	1.20	1.20	0.14	3.67	$ 124.86	3.67	$ 124.86
99350	Home visit est patient	3.28	1.60	1.60	0.22	5.10	$ 173.52	5.10	$ 173.52
99354	Prolonged service office	1.77	0.98	0.77	0.11	2.86	$ 97.31	2.65	$ 90.16
99355	Prolonged service office	1.77	0.92	0.69	0.11	2.80	$ 95.26	2.57	$ 87.44
99356	Prolonged service inpatient	1.71	0.81	0.81	0.11	2.63	$ 89.48	2.63	$ 89.48
99357	Prolonged service inpatient	1.71	0.80	0.80	0.11	2.62	$ 89.14	2.62	$ 89.14
99358	Prolong service w/o contact	2.10	0.89	0.89	0.14	3.13	$ 106.49	3.13	$ 106.49
99359	Prolong serv w/o contact add	1.00	0.45	0.45	0.07	1.52	$ 51.71	1.52	$ 51.71
99360	Physician standby services	1.20	0.49	0.49	0.08	1.77	$ 60.22	1.77	$ 60.22
99366	Team conf w/pat by hc prof	0.82	0.36	0.33	0.05	1.23	$ 41.85	1.20	$ 40.83
99367	Team conf w/o pat by phys	1.10	0.45	0.45	0.07	1.62	$ 55.12	1.62	$ 55.12
99368	Team conf w/o pat by hc pro	0.72	0.29	0.29	0.04	1.05	$ 35.72	1.05	$ 35.72
99374	Home health care supervision	1.10	0.86	0.45	0.07	2.03	$ 69.07	1.62	$ 55.12
99375	Home health care supervision	1.73	1.20	0.70	0.11	3.04	$ 103.43	2.54	$ 86.42
99377	Hospice care supervision	1.10	0.86	0.45	0.07	2.03	$ 69.07	1.62	$ 55.12
99378	Hospice care supervision	1.73	1.20	0.70	0.11	3.04	$ 103.43	2.54	$ 86.42
99379	Nursing fac care supervision	1.10	0.86	0.45	0.07	2.03	$ 69.07	1.62	$ 55.12
99380	Nursing fac care supervision	1.73	1.20	0.70	0.11	3.04	$ 103.43	2.54	$ 86.42
99406	Behav chng smoking 3-10 min	0.24	0.16	0.10	0.01	0.41	$ 13.95	0.35	$ 11.91
99407	Behav chng smoking > 10 min	0.50	0.26	0.20	0.03	0.79	$ 26.88	0.73	$ 24.84
99408	Audit/dast 15-30 min	0.65	0.32	0.26	0.04	1.01	$ 34.36	0.95	$ 32.32
99409	Audit/dast over 30 min	1.30	0.58	0.53	0.08	1.96	$ 66.69	1.91	$ 64.98
99429	Unlisted preventive service	0.00	0.00	0.00	0.00	0.00	$ -	0.00	$ -
99441	Phone e/m phys/qhp 5-10 min	0.25	0.14	0.10	0.01	0.40	$ 13.61	0.36	$ 12.25
99442	Phone e/m phys/qhp 11-20 min	0.50	0.24	0.20	0.03	0.77	$ 26.20	0.73	$ 24.84
99443	Phone e/m phys/qhp 21-30 min	0.75	0.35	0.30	0.05	1.15	$ 39.13	1.10	$ 37.43
99444	Online e/m by phys/qhp	0.00	0.00	0.00	0.00	0.00	$ -	0.00	$ -
99450	Basic life disability exam	0.00	0.00	0.00	0.00	0.00	$ -	0.00	$ -
99455	Work related disability exam	0.00	0.00	0.00	0.00	0.00	$ -	0.00	$ -
99456	Disability examination	0.00	0.00	0.00	0.00	0.00	$ -	0.00	$ -
99487	Cmplx chron care w/o pt vsit	1.00	1.35	1.35	0.06	2.41	$ 82.00	2.41	$ 82.00
99488	Cmplx chron care w/ pt vsit	2.50	2.73	2.73	0.17	5.40	$ 183.72	5.40	$ 183.72
99489	Complx chron care addl30 min	0.50	0.68	0.68	0.03	1.21	$ 41.17	1.21	$ 41.17
99495	Trans care mgmt 14 day disch	2.11	2.57	1.71	0.14	4.82	$ 163.99	3.96	$ 134.73
99496	Trans care mgmt 7 day disch	3.05	3.55	2.56	0.20	6.80	$ 231.36	5.81	$ 197.67
99499	Unlisted e&m service	0.00	0.00	0.00	0.00	0.00	$ -	0.00	$ -

American Psychiatric Association CPT Coding Service and Additional Resources

Look for timely information on coding and documentation issues in *Psychiatric News* and on APA's website at www.psychiatry.org/cptcodingchanges.

CPT CODING SERVICE

The American Psychiatric Association (APA) maintains a CPT coding service to answer its members' specific coding questions, and the association is actively involved in making sure that members are correctly reimbursed for the services they provide. Working closely with the Committee on RBRVS, Codes, and Reimbursements, the APA's Office of Healthcare Systems and Financing (OHSF) established the CPT coding service to help members with their individual questions. Because CPT questions are very specific and often very complex, a protocol has been established for queries to ensure that there will be no misunderstanding.

APA members with CPT coding questions should:

1. Create an e-mail or memo with their name, APA member number, city, state, phone number, fax number, and e-mail address.
2. State the question or describe the problem thoroughly, but succinctly—a short paragraph is usually all that is necessary.
3. Include any relevant correspondence from Medicare carriers, insurance companies, or third-party payers.
4. Cite any actions that have been taken relating to the problem, i.e., calls made or letters written.
5. Send the question to the attention of Rebecca Yowell by e-mail (hsf@psych.org), fax (703–907–1089), or regular mail (Office of Healthcare Systems and Financing, APA, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209).

All questions will be answered as quickly as possible.

MEDICARE

A list of Medicare Carriers is available through APA's Web site http://www.psychiatry.org/practice/managing-a-practice/medicare under the heading "Enrollment." Links to LCDs (local coverage policy documents) for Medicare are available through the CMS Web site (http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx).

COURSES / WORKSHOPS

A CPT coding course and a CPT workshop are generally held each year at the APA's Annual Meeting. Check the APA Annual Meeting program for more information.

APA members with questions about Medicare can direct them to the attention of Ellen Jaffe in OHSF by calling 800–343–4671 or writing her at the OHSF e-mail address, hsf@psych.org.

OTHER MEMBERSHIP ORGANIZATIONS

Mental health clinicians who are not members of the APA should contact their own member specialty societies. These organizations may have CPT resources similar to those available through the APA. Organizations that may be of interest include:

- American Nurses Association
  www.nursingworld.org; 800–274–4262 or 202–651–7000
- American Psychiatric Nurses Association
  www.apna.org; 703–243–2443
- American Psychological Association
  www.apa.org; 800–374–2721 or 202–336–5500
- National Association of Social Workers
  www.naswdc.org; 202–336–8200