ADVOCATEHEALTH

BEHAVIORAL HEALTH SERVICES

DEVELOPMENTAL/BEHAVIORAL SCREENING & TESTING: Select test admin codes based on Total Time

CPT Code	CODE DESCRIPTION	
96110	Developmental screening with scoring and documentation, **per standardized instrument** (eg, developmental milestone survey and language delay screen)	
96112	Developmental test administration by physician or other QHP, with interpretation and report, first hour	• Includes assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed
+96113	Each additional 30 minutes (List in addition to code for primary procedure)	

NEUROBEHAVIORAL STATUS EXAM: Select code(s) based on Total Time

CPT Code	CODE DESCRIPTION	
96116	Neurobehavioral Status Exam, by physician or other QHP, first hour	• Includes both face-to-face time with the patient and time interpreting test results and preparing the report • Time spent must be documented
+96121	Each additional hour (List in addition to code for primary procedure)	

PSYCHOLOGICAL & NEUROPSYCHOLOGICAL TESTING EVALUATION SERVICES: Select code(s) based on Total Time

CPT Code	CODE DESCRIPTION	
96130	Psychological testing evaluation services, by physician or other QHP, first hour	• Includes integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; • Time spent must be documented
+96131	Each additional hour (List in addition to code for primary procedure)	
96132	Neuropsychological testing evaluation services, by physician or other QHP, first hour	
+96133	Each additional hour (List in addition to code for primary procedure)	

PSYCHOLOGICAL & NEUROPSYCHOLOGICAL TEST ADMINISTRATION & SCORING: Select code(s) based on Total Time

CPT Code	CODE DESCRIPTION
96136	Psychological or neuropsychological test administration and scoring by physician or other QHP, two or more tests, any method, first 30 min
+96137	Each additional 30 minutes (List in addition to code for primary procedure)
96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method, first 30 min
+96139	Each additional 30 minutes (List in addition to code for primary procedure)
96146	Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only

PSYCHIATRIC DIAGNOSTIC EVALUATION

CPT Code	CODE DESCRIPTION	May be reported with Interactive Complexity (+90785)
90791	Psychiatric Diagnostic Evaluation	Yes
90792	Psychiatric Diagnostic Evaluation with medical services	Yes

INTERACTIVE COMPLEXITY

CPT Code	CODE DESCRIPTION
+90785	Interactive Complexity (List separately in addition to the code for primary procedure)

PSYCHOTHERAPY: Select code based on Total Time

CPT Code	CODE DESCRIPTION	Time Range	May be reported with Interactive Complexity (+90785)
90832	Psychotherapy, 30 minutes with patient	16 – 37 min	Yes
+90833	Psychotherapy, 30 minutes w/patient with E/M		Yes
90834	Psychotherapy, 45 minutes with patient	38 – 52 min	Yes
+90836	Psychotherapy, 45 minutes w/patient with E/M		Yes
90837	Psychotherapy, 60 minutes with patient	53+ min	Yes
+90838	Psychotherapy, 60 minutes w/patient with E/M		Yes
90846	Family psychotherapy w/o patient present, 50 minutes	26+ min	No
90847	Family psychotherapy w/patient present, 50 minutes		No
90849	Multiple-family group psychotherapy		No
90853	Group Psychotherapy (other than multi-family group)		Yes

- Do not report a psychotherapy service of less than 16 minutes duration
- When reporting an E/M code in conjunction with a psychotherapy service, the E/M service should be supported by the medical decision-making. Total time should be used to support the psychotherapy service.

PSYCHOTHERAPY FOR CRISIS

CPT Code	TIME	DOCUMENTATION REQUIREMENTS
Use psychotherapy code	**Less than** 30 minutes	✓ Psychotherapy for crisis of less than 30 minutes total duration on a given date should be reported with Psychotherapy codes 90832 or 90833
90839 (once per date)	30-74 minutes	Treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma **Documentation should include:** ✓ Details of an urgent assessment provided to a patient that presented in a high level of distress with a life-threatening or highly complex psychiatric crisis that required immediate attention ✓ Total time spent face-to-face with the patient and/or family, without distraction and without providing services to another patient during the same time period
+90840	Each additional 30 minutes	

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OFFICE VISITS – NEW: Select E/M code based on Medical Decision Making or Total Time

CPT Code	HISTORY AND EXAM Documentation Guidelines	Medical Decision Making	Total Time
99202	Requires a medically appropriate history and/or examination	Straightforward	15
99203	Requires a medically appropriate history and/or examination	Low	30
99204	Requires a medically appropriate history and/or examination	Moderate	45
99205	Requires a medically appropriate history and/or examination	High	60

OFFICE VISITS – ESTABLISHED: Select E/M code based on Medical Decision Making or Total Time

CPT Code	HISTORY AND EXAM Documentation Guidelines		Medical Decision Making	Total Time
99211 Non-MD visit (e.g. RN, Pharmacist)	May not require the presence of a MD or APC MD must review note and co-sign	EXAMPLE QUALIFYING VISITS: * BP checks * Glucose checks * + PPD reading Document interval history & vitals – discuss results **Services should be medically necessary and appropriately documented in the medical record.**		N/A
99212	Requires a medically appropriate history and/or examination		Straightforward	10
99213	Requires a medically appropriate history and/or examination		Low	20
99214	Requires a medically appropriate history and/or examination		Moderate	30
99215	Requires a medically appropriate history and/or examination		High	40

OUTPATIENT CONSULTATIONS Report using I-Codes (I1702 – I1705) / (I1712 – I1715)

NEW / ESTABLISHED: Select code based on Medical Decision Making or Total Time

CPT Code	HISTORY AND EXAM Documentation Guidelines	Medical Decision Making	Total Time
99242	Requires a medically appropriate history and/or examination	Straightforward	20
99243	Requires a medically appropriate history and/or examination	Low	30
99244	Requires a medically appropriate history and/or examination	Moderate	40
99245	Requires a medically appropriate history and/or examination	High	55

EMERGENCY ROOM VISITS: Select E/M code based on Medical Decision Making

CPT Code	HISTORY AND EXAM Documentation Guidelines	Medical Decision Making
99281	May not require the presence of a MD or APC	N/A
99282	Requires a medically appropriate history and/or examination	Straightforward
99283	Requires a medically appropriate history and/or examination	Low
99284	Requires a medically appropriate history and/or examination	Moderate
99285	Requires a medically appropriate history and/or examination	High

INPATIENT CONSULTATIONS Report using I-codes (I1722 – I1725)

NEW / ESTABLISHED: Select code based on Medical Decision Making or Total Time

CPT Code	HISTORY AND EXAM Documentation Guidelines	Medical Decision Making	Total Time
99252	Requires a medically appropriate history and/or examination	Straightforward	35
99253	Requires a medically appropriate history and/or examination	Low	45
99254	Requires a medically appropriate history and/or examination	Moderate	60
99255	Requires a medically appropriate history and/or examination	High	80

INITIAL INPATIENT or OBSERVATION CARE

Select E/M code based on Medical Decision Making or Total Time

CPT Code	HISTORY AND EXAM Documentation Guidelines	Medical Decision Making	Total Time
99221	Requires a medically appropriate history and/or examination	Straightforward or Low	40
99222	Requires a medically appropriate history and/or examination	Moderate	55
99223	Requires a medically appropriate history and/or examination	High	75

SUBSEQUENT INPATIENT or OBSERVATION CARE

Select E/M code based on Medical Decision Making or Total Time

CPT Code	HISTORY AND EXAM Documentation Guidelines	Medical Decision Making	Total Time
99231	Requires a medically appropriate history and/or examination	Straightforward or Low	25
99232	Requires a medically appropriate history and/or examination	Moderate	35
99233	Requires a medically appropriate history and/or examination	High	50

HOSPITAL INPATIENT or OBSERVATION DISCHARGE SERVICES

CPT Code	Discharge	Documentation Requirements	TIME MAY INCLUDE
99238	30 MINUTES **OR LESS**	Requires documentation of time in note	✓ Final Exam ✓ Discussion of hospital stay ✓ Preparation of discharge records, Rx and referral forms ✓ Instructions for cont. care to all relevant caregivers (even if the time spent by the MD is not continuous)
99239	**MORE THAN** 30 MINUTES	Requires documentation of time in note	

HOSPITAL INPATIENT or OBSERVATION Admitted and Discharged on the SAME Calendar Date

Select E/M code based on Medical Decision Making or Total Time

CPT Code	HISTORY AND EXAM Documentation Guidelines	Medical Decision Making	Total Time
99234	Requires a medically appropriate history and/or examination	Straightforward or Low	45
99235	Requires a medically appropriate history and/or examination	Moderate	70
99236	Requires a medically appropriate history and/or examination	High	85

E/M Visit Code Criteria

To qualify for a particular level of medical decision making, two of the three MDM elements for that level of medical decision making must be met or exceeded

Elements of Medical Decision Making

Level of MDM	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed + Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity or Mortality of Patient Management
Straightforward	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
Low	**Low** • 2 or more self-limited or minor problems; **OR** • 1 stable chronic illness; **OR** • 1 acute, uncomplicated illness or injury **OR** • 1 stable acute illness **OR** • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	**Limited** *(Must meet the requirements of at least 1 of the 2 categories)* **Category 1: Tests and documents** • Any combination of 2 from the following: • Review of prior external note(s) from each unique source; • Review of the result(s) of each unique test; • Ordering of each unique test **OR** **Category 2: Assessment requiring an independent historian(s)** (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	**Low risk of morbidity from additional diagnostic testing or treatment** Examples only: • Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives
Moderate	**Moderate** • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; **OR** • 2 or more stable chronic illnesses; **OR** • 1 undiagnosed new problem with uncertain prognosis; **OR** • 1 acute illness with systemic symptoms; **OR** • 1 acute complicated injury	**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • Any combination of 3 from the following: • Review of prior external note(s) from each unique source; • Review of the result(s) of each unique test; • Ordering of each unique test; • Assessment requiring an independent historian(s) **OR** **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **OR** **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**Moderate risk of morbidity from additional diagnostic testing or treatment** Examples only: • Prescription drug management • IV fluids with additives • Therapeutic nuclear medicine • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Closed treatment of fracture or dislocation without manipulation • Diagnosis or treatment significantly limited by social determinants of health
High	**High** • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; **OR** • 1 acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive** *(Must meet the requirements of at least 2 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • Any combination of 3 from the following: • Review of prior external note(s) from each unique source; • Review of the result(s) of each unique test; • Ordering of each unique test; • Assessment requiring an independent historian(s) **OR** **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **OR** **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**High risk of morbidity from additional diagnostic testing or treatment** Examples only: • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital-level care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Decision regarding parenteral controlled substances

Time Based E/M

Total clinician time on the date of the encounter: Time includes both the face-to-face and non-face-to-face time personally spent by the physician or APC on the day of the encounter (includes time in activities that require the physician or APC and does not include time in activities normally performed by clinical staff).

Physician/Advance Practice Clinician time includes the following activities, when performed:

- preparing to see the patient (e.g., review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record
- independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- care coordination (not separately reported)

- Document the total amount of encounter time in minutes
- Documentation must clearly describe what was performed (e.g., obtaining history, performing exam, counseling/education, ordering tests/medications, referrals/coordination of care).

Encompass SmartPhrase (MW Region): .TIMELOS

Encompass SmartPhrase (SE region): .TimeAttestation