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Billing and Documentation

Behavioral Health and Virtual Services

Enterprise Mid-Revenue Cycle – Onboarding Services

May 2025

Today's Agenda

- Medical Record Documentation
- Documentation Guidelines for Evaluation & Management Services
- Virtual Health Documentation and Coding
- Advance Practice Practitioner (APPs)
- Diagnosis Coding
- Resources
- Appendices
  - Definitions
  - Psychotherapy Services

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Medical Record Documentation Standards

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CMS Definitions

Billing Policies & Guidelines are regulated by:

The **Centers for Medicare & Medicaid Services (CMS)** is a federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program (CHIP), and health insurance portability standards.

Palmetto GBA: North Carolina Local Medicare Carrier – Jurisdiction M. Palmetto GBA also covers Georgia, South Carolina, Virginia, West Virginia and Alabama – Jurisdiction J.

Medical Record Documentation

The medical record entries must include:

- The chief complaint and/or reason for the encounter, relevant history, physical exam findings, and prior diagnostic test results, as well as a review of any relevant labs, x-rays, and other ancillary services
- Assessment, clinical impression or diagnosis
- Plan for care
- Date and verifiable legible identity, manual or electronic signature of the health care professional that provided the service
- An addendum to the medical record should be dated the day the information is added

Medicare Signature Requirements

- Medicare requires that services *provided or ordered* be authenticated by the author. There are two acceptable methods of authentication:
  - Handwritten signature
  - Electronic signature
- When there are multiple authors or contributors to a document, all signatures should be retained so that each individual's contribution is unambiguously identified.

The author of each medical or clinical record entry must be identified in the health record.

Timeliness of Documentation

- Physicians/APPs need to ensure that their documentation of care for our patients is accurate, complete, and available for clinical and financial use by others within a reasonable timeframe
- Documentation of all patient encounters the same day as the visit is ideal, and should be the goal of every physician/APP
- Physician/APP notes must be authenticated (signed, not just saved) in order to be visible to others
- Documentation should be formatted in a manner which allows a physician/APP to rapidly locate an assessment and plan without scrolling through multiple pages of imported data
- Some practices may impose a more rigid standard based on their specialty and/or operational needs

Medicare guidelines:

- Clinicians are encouraged to enter all relevant documents and entries into the medical record **at the time they are rendering the service** in order to maintain an accurate medical record. *Medicare guidelines state that the entry should be in the medical record as soon as practicable after the provision of service.*

Timeliness of Documentation

Effect on Review and Revenue -

- Documentation not completed by the 30th calendar day from the date of the patient encounter:
  - Review – will result in a 100-point deduction for that patient encounter
  - Revenue – is no longer a billable service

- Documentation not started (all possible relevant information brought into the note) within 48 hours of the date of service:
  - Review – will result in best practice education

Medical Necessity

"Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of E/M service when a lower level of service is warranted. The volume of documentation entered in the medical record should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported. The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record."[1]

[1] Medicare Carriers Manual, IOM 100-4, Chapter 12, Section 30.6.1.A

https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c12.pdf

Medical Necessity

An important requirement to receive payment for services is to establish medical necessity by documenting the following facts and findings:

- Severity of the signs/symptoms or diagnosis exhibited by the patient
- Probable outcome for the patient and how that risk equates to the diagnosis being evaluated
- Need for diagnostic studies and/or therapeutic interventions to evaluate the patient's presenting problem or current medical condition
- Accurately reflect the need for and outcome of treatment

EMR Cautions

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EMR Cautions - Cloning

“**The word 'cloning' refers to documentation that is worded exactly like previous entries**. This may also be referred to as ‘copy/paste’, 'cut and paste' or 'carried forward.' Cloned documentation may be handwritten but generally occurs when using a preprinted template or a Promoting Interoperability (PI) Programs electronic record.”

“While these methods of documenting are acceptable, it would not be expected the same patient had the same exact problem, symptoms, and required the exact same treatment or the same patient had the same problem/situation on every encounter. Authorship and documentation in an EHR must be authentic.”

Palmetto GBA

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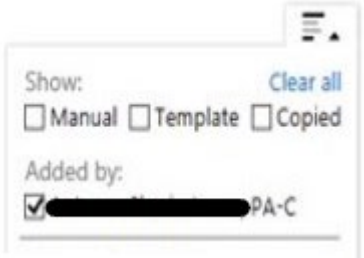
EMR Cautions – Prepopulated Templates

Prepopulation is the entry of history, exam and/or MDM components into the medical record prior to the arrival of the patient.

- Prepopulation is strongly discouraged by Audits & Investigations Professional.
- If a clinician chooses to prepopulate documentation, only accurate, relevant historical elements or the shell of a template should be documented.
- Review of Systems (ROS), exam findings and/or MDM should not be documented prior to the patient visit.

EMR Cautions – Hover Function

The EMR has the capability to allow users to hover over the documentation to identify who has contributed information to each visit's documentation.



Diabetes
Hypoglycemia symptoms include headaches and nervousness/anxiousness. Associated symptoms include fatigue.

Ms [redacted] returns for f/u of DM II with HTN and neuropathy.
Has been fair since her visit in May 2022.
Sugar is high today because she had 2 hot chocolates this morning.

Copied by [redacted], PA-C
at 11/28/2022 11:05 AM
from Progress Notes by [redacted], PA-C at 5/23/2022 12:10 PM

Be cautious of ancillary staff documenting any elements of E/M services other than those allowed by CMS.

- For example: ancillary staff opening templates that include elements of physical exam and/or MDM.

EMR Cautions – Voice Recognition Technology

- Exercise caution when using voice recognition technology (e.g., “Dragon”).
- Voice-dictated notes are held to the same standards as those generated by any other means.
- Physicians/APPs are responsible for proofreading all elements of their note to ensure accuracy.
- The use of phrases (disclaimers) meant to excuse a physician/APP’s responsibility for errors in the medical record by attributing these to technological problems provide no protection from consequences of documentation errors.

This note was dictated with Dragon voice recognition technology and may contain erroneous phrases or words.
There may be some typographical errors generated by the transcription software that may have been missed despite a reasonable effort to identify and correct them. Please contact me if further clarification is needed.
This document was created using the aid of voice recognition Dragon dictation software, please excuse any sound alike substitutions, typographic, or transcription errors. Efforts have been made to correct these dictation errors; however, some may persist, and this does not reflect the standard of medical care. If there are any questions, please do not hesitate to contact me for clarification.

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Documentation Guidelines for Evaluation and Management Services

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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

Enterprise Mid-Revenue Cycle – SE Region: 06/01/2024

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

BH Services Matrix

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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	

BH Services Matrix

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Evaluation and Management (E/M) Services Guiding Principles

1. Do what is medically necessary

2. Document what you do

3. Bill for what you document

4. Ensure that billing accurately reflects the clinician who rendered the service

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Definition of a New Patient

CMS and the AMA CPT® definitions of a new patient align to indicate that:

*A **new** patient is one who has not received any professional (face-to-face) services (E/M, surgical procedures) from the physician/qualified health care professional or another physician/ qualified health care professional of the same specialty and belonging to the same group practice, within the past three years.*

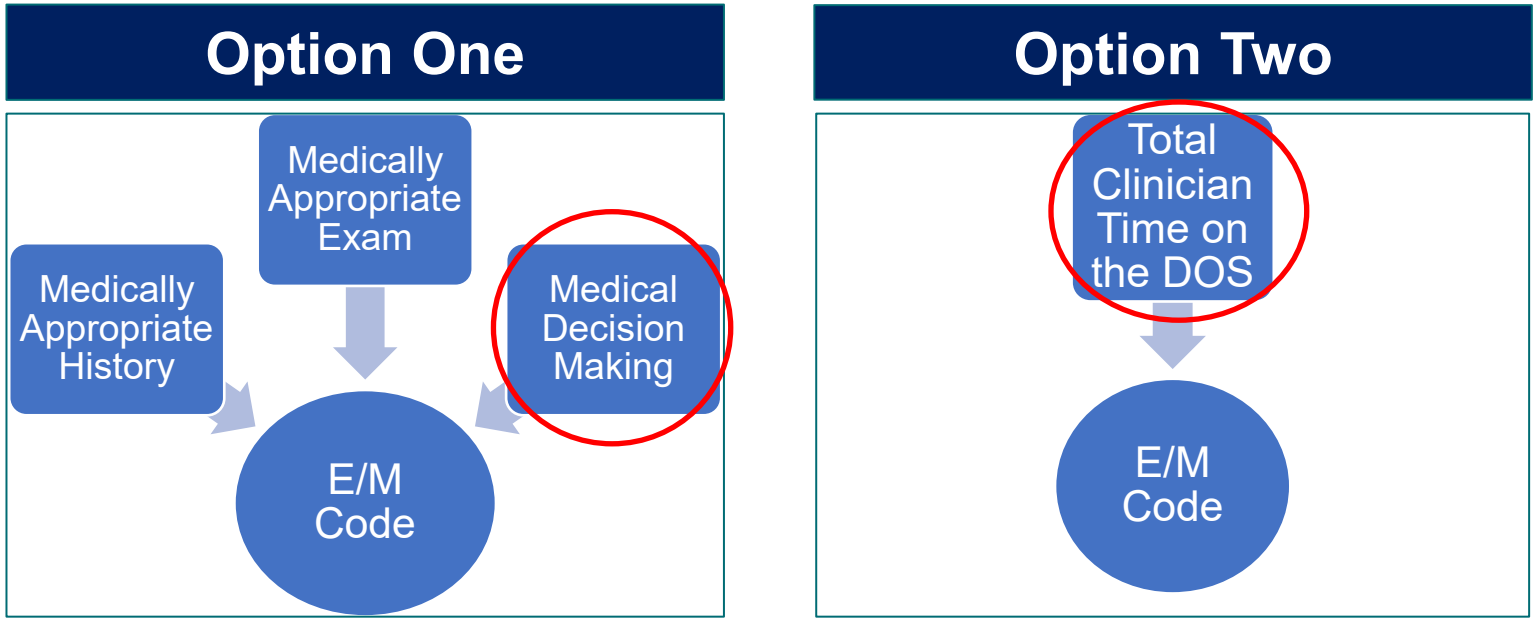
The CMS definition of a group practice states that physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician.

History and/or Physical Exam

- History (HPI, ROS, PFSH) and/or Physical Exam
  - Are no longer considered key components of evaluation and management services and therefore, no longer utilized in determining the level of service for these visits.
  - Documentation should include a medically appropriate history and/or physical exam.
- The nature and extent of the history and/or physical exam is determined by the clinician.
- The documentation of history and/or physical exam helps to describe the severity of the condition being treated.
- While a certain number of history and/or physical exam elements are not required to support the level of service, the chief complaint should always be documented to establish the reason for the visit.

Evaluation and Management Code Selection

E/M codes are determined by one of two options*



*ED codes can only be determined using MDM (Option One)

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Chief Complaint

A concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter.

- EVERY encounter must have a chief complaint
- Establishes the medical necessity for the visit
- Usually stated in the patient's own words
  - Not necessarily an acute condition; follow up of chronic conditions is permitted and should be specific to the condition of the patient
- In the hospital outpatient or inpatient setting:
  - Day 3 of an inpatient hospital stay, i.e., "Continued care of [condition]"

Evaluation and Management Services

Based on Medical Decision Making

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Evaluation and Management Service Selection Based on Medical Decision-Making (MDM)

The medical record must include the documentation of the chief complaint and a medically appropriate history and/or physical examination.

- To support a given code level, **2 out of 3 elements of MDM for that code level must be met or exceeded.**

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

Level of MDM	Number and Complexity of Problems Addressed at the Encounter
Straightforward	Minimal - 1 self-limited or minor problem
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
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
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

Number & Complexity of Problems

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Level of MDM	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.
Straightforward	Minimal or none

Low	**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)

Moderate	**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)

High	**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)

Amount &/or Complexity of Data Reviewed + Analyzed

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Level of MDM	Risk of Complications and/or Morbidity or Mortality of Patient Management
Straightforward	Minimal risk of morbidity from additional diagnostic testing or treatment
Low	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 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 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

Risk of Complications &/or Morbidity or Mortality

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E/M Selection Based on MDM: Risk of Complications and/or Morbidity or Mortality of Patient Management

Table of Risk		
Drug Category	**Drugs in that Category**	**Treatment Use**
Cardiac drugs	Digoxin, digitoxin, quinidine, procainamide, amiodarone	Congestive heart failure, angina, arrhythmias
Antibiotics	Aminoglycosides (gentamicin, tobramycin, amikacin) Vancomycin, Chloramphenicol	Infections with bacteria that are resistant to less toxic antibiotics
Antiepileptics	Phenobarbital, phenytoin, valproic acid, carbamazepine, ethosuximide, sometimes gabapentin, lamotrigine	Epilepsy, prevention of seizures, sometimes to stabilize moods
Bronchodilators	Theophylline, caffeine	Asthma, Chronic obstructive pulmonary disorder (COPD), neonatal apnea
Immunosuppressants	Cyclosporine, tacrolimus, sirolimus, mycophenolate mofetil, azathioprine	Prevent rejection of transplanted organs, autoimmune disorders
Anti-cancer drugs	All cytotoxic agents	Multiple malignancies
Psychiatric drugs	Lithium, valproic acid, some antidepressants (imipramine, amitriptyline, nortriptyline, doxepin, desipramine)	Bipolar disorder (manic depression), depression
Protease inhibitors	Indinavir, ritonavir, lopinavir, saquinavir, atazanavir, nelfinavir	HIV/AIDS

Examples of drugs that may need to have drug levels monitored for toxicity (this is not an all-inclusive list).

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E/M Selectin Based on MDM: Risk Associated with Patient's Condition

All diagnostic/surgical procedures have inherent risk.

For "HIGH" risk selections on the MDM table, please consider the following outside risk factors:

- Advanced age/debility
- Prior surgical difficulties
- Underlying cardiac disease
- Underlying lung disease

Please ensure your documentation reflects the severity when selecting high level services

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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

- Patient admitted due to methamphetamine overdose. Record reflects patient has history of mental illness, currently unemployed and homeless.
- Clinician orders and analyzes the results of 2 labs.
- The clinician orders IV fluids w/additives to help stabilize patient
- Decision made to transfer patient to an inpatient treatment program
- What is the E/M code?

99223 – Initial care, High MDM

ADVOCATE HEALTH

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

- Patient experiencing progression of Bipolar disorder. Admitted in severe manic state. Patient has been hospitalized now for 2 days.
- Clinician reviews and analyzes the results of 3 labs.
- Clinician adjusts the patient's current medication to higher dosage.
- What is the E/M code?

99232 – Subsequent care, Moderate MDM

ADVOCATE HEALTH

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

- New patient presents in clinic with history of anxiety disorder requesting medication refill, currently stable.
- No labs or diagnostic testing ordered.
- The clinician renews the patient's prescription for current medication
- What is the E/M code?

99203 – New patient, Low MDM

ADVOCATE HEALTH

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

- Patient presents for a follow-up encounter for schizophrenia. The patient continues to have auditory hallucinations and is experiencing moderate anxiety
- No labs or diagnostic testing ordered.
- The clinician reviews the patient's medications and makes the necessary medication adjustments
- What is the E/M code?

99214 – Established patient, Moderate MDM

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E/M Selection Based on MDM: Coding & Documentation Risk Areas

The most common risk areas of the MDM portion of the documentation includes:

- Not listing all problems addressed during the encounter
- Not clearly describing the severity of the problems addressed during the encounter including whether they are worsening or not improving as expected
- Incomplete documentation of the data reviewed especially discussions with other physicians/APPs and personal review of images, tracings, and **specific** labs reviewed.

Documentation Tips

Be sure to describe the following in your documentation:

- Gathering history from someone other than the patient, e.g., a family member or friend and why
- Independent interpretation of tests
- Discussion of management of the patient with an external clinician (one outside your practice or specialty)
- Discussion of a test interpretation with an external clinician (one outside your practice or specialty)
- The impact of social determinants of health on the care of the patient
- Decision regarding escalation of hospital-level care
- Route of administration of parenteral controlled substances you order
    - Use descriptive terms to clearly describe the severity of the patient's condition, e.g., "exacerbation of a chronic illness" versus "a severe exacerbation of a chronic illness" or a "life-threatening exacerbation".

Evaluation and Management Services

Based on Total Time

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Evaluation & Management Code Selection Based on Time

- Time alone may be used to select the level of service.
- The time included is the total time personally spent by the clinician **on the date of the visit.**
- The time includes both face-to-face and non-face-to-face time.
- A face-to-face encounter with the patient is required.
- Total time must be documented in the patient's medical record.
- Only distinct time can be calculated (e.g., in a facility setting, overlapping MD and APP time should only be counted once).
- Time spent by clinical staff on the patient visit is not counted as part of the total time.

Time does not include:

- Travel
- The performance of other services that are reported separately
- Teaching that is general and not limited to discussion of a specific patient's management

Evaluation & Management Code Selection Based on Time

- Time spent on services reported separately is not included in the total time (e.g., if an AWV is performed, the time spent on the AWV is not included in total time of the office/outpatient visit).

EPIC SmartPhrase used by Atrium Health – SE Region:

- Charlotte/Navicent/Floyd/Wake SmartPhrase: **.timeattestation**

  "On the day of the visit I spent *** minutes (SmartList inserted here)."

  - This time does not include any time spent performing procedures or assessments that are separately billable.

- The combination of resident and teaching physician's time may not be used to calculate total time. Only the teaching physician's time may be used to support the level of service selected.

Evaluation & Management Code Selection Based on Time

Physician/APP 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)

Evaluation & Management Code Selection Based on Time

Total time associated with each code is a required threshold that must be met or exceeded to report the level of service.

CPT CODE	TIME
99202	15 minutes **must be met or exceeded**
99203	30 minutes **must be met or exceeded**
99204	45 minutes **must be met or exceeded**
99205	60 minutes **must be met or exceeded**
99212	10 minutes **must be met or exceeded**
99213	20 minutes **must be met or exceeded**
99214	30 minutes **must be met or exceeded**
99215	40 minutes **must be met or exceeded**

Please reference E/M Services Matrix for other E/M categories

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Evaluation & Management Code Selection Based on Time – Cautionary Example

Clinician sees a total of 25 patients on the date of service in the clinic setting.

15 of the patients are billed on time spent:

- A total of 1080 minutes is documented in the patients' notes.
- This equates to 18 hours spent on non-face-to-face and face-to-face activities on the day of the visit for the 15 patients.

The time spent involved with the other 10 patients billed using MDM still needs to be considered during the 24-hour period.

Office & Other Outpatient Visits

Observation Care

Consultations

Emergency Department

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Office & Other Outpatient Visits, New 99202-99205

CPT Code	History and Exam	Complexity of MDM	Time
99202	Medically Appropriate	Minimal/Straightforward	15 min **must be met or exceeded**
99203	Medically Appropriate	Low	30 min **must be met or exceeded**
99204	Medically Appropriate	Moderate	45 min **must be met or exceeded**
99205	Medically Appropriate	High	60 min **must be met or exceeded**

Office & Other Outpatient Visits, Established 99211-99215

CPT Code	History and Exam	Complexity of MDM	Time
99211	Evaluation and management of an established patient that may not require the presence of a physician or APP		
99212	Medically Appropriate	Minimal/Straightforward	10 min **must be met or exceeded**
99213	Medically Appropriate	Low	20 min **must be met or exceeded**
99214	Medically Appropriate	Moderate	30 min **must be met or exceeded**
99215	Medically Appropriate	High	40 min **must be met or exceeded**

Initial Hospital Inpatient or Observation Care 99221-99223

CPT Code	History and Exam	Complexity of MDM	Time
99221	Medically Appropriate	Low	40 minutes **must be met or exceeded**
99222	Medically Appropriate	Moderate	55 min **must be met or exceeded**
99223	Medically Appropriate	High	75 min **must be met or exceeded**

Subsequent Hospital Inpatient or Observation Care 99231-99233

CPT Code	History and Exam	Complexity of MDM	Time
99231	Medically Appropriate	Low	25 min **must be met or exceeded**
99232	Medically Appropriate	Moderate	35 min **must be met or exceeded**
99233	Medically Appropriate	High	50 min **must be met or exceeded**

Hospital Inpatient or Observation Discharge Services 99238-99239

CPT Code	Time	Documentation Required
99238	**Up to 30 minutes**	Per Palmetto GBA guidelines: When documenting discharge services, the amount of time spent performing the service should be documented.
99239	**> 30 minutes**	

- Includes total duration of time spent by physician/APP for final hospital or observation discharge of a patient.
- Includes (as appropriate) final examination of the patient, discussion of the hospital stay, instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions, and referral forms.
- Physicians/APPs of the same specialty and group can combine their time to report 99239.

Time spent with the patient by the physician/APP **DOES NOT** need to be continuous.

Hospital Inpatient or Observation Service (Including Admission & Discharge Services) 99234-99236

Patient is placed in observation or is admitted for **at least 8 hours but less than 24 hours** on the same calendar day. These codes require two or more visits on the same date, one being an initial admission and another being a discharge.

CPT Code	History and Exam	Complexity of MDM	Time
99234	Medically Appropriate	Low	45 min **must be met or exceeded**
99235	Medically Appropriate	Moderate	70 min **must be met or exceeded**
99236	Medically Appropriate	High	85 min **must be met or exceeded**

Per Georgia Medicaid
Observation or Inpatient Hospital Care codes 99234 through 99236 must be used for outpatient observation or hospital admission that begin and end on
the same calendar date with a **minimum of twelve (12) hours**.

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Observation Care Services

- The clinician initiating the observation service must place an order for the service.
- Documentation must indicate the medical necessity for the observation status of the patient.
- The series of hospital inpatient or observation care codes used depends on the number of calendar days the patient is in observation status and may be affected by the amount of time the patient spent in observation.

Observation Care Billing Scenarios

Timing of Care	1 calendar day < 8 hours	1 calendar day 8+ hours	2 calendar days	3 or more calendar days
Report	99221 – 99223 only	99234 – 99236 only	**1st day:** 99221 – 99223 **2nd day:** 99238 – 99239	**1st day:** 99221 – 99223 **2nd + days:** 99231 – 99233 **Last day:** 99238 – 99239

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Consultations

A consultation is defined as:

- A written request for opinion or advice regarding evaluation and/or management of a specific problem

OR

- An initial encounter conducted to determine whether to accept responsibility for ongoing management of the patient's entire care or the care of a specific condition or problem

- Must be provided at the request of another physician/APP or appropriate source:
  - Documentation should specify who requested the consultation

Consultation vs. Transfer of Care

Ask yourself: "**What is the intent of the service being requested** to determine whether this is a 'Consultation' or a 'Transfer of Care' situation?"

Transfer of care is defined as:

- The transfer of complete or specific care of a patient from one physician/APP to another physician/APP

Consultation codes should *not* be reported when a physician/APP has agreed to accept responsibility for care of a patient ***before*** the initial evaluation

If a consultation is provided, a written report documenting your findings must be provided to the requesting physician/APP as a:

- Part of a common (shared) medical record,
- Separate letter, or
- Copy of consultation report via cc:

Office or Other Outpatient Consultations 99242-99245

CPT Code	EPIC I-Codes New/Est	History and Exam	Complexity of MDM	Time
99241	Code was deleted for 2023			
99242	I1702 / I1712	Medically Appropriate	Minimal / Straightforward	20 min **must be met or exceeded**
99243	I1703 / I1713	Medically Appropriate	Low	30 min **must be met or exceeded**
99244	I1704 / I1714	Medically Appropriate	Moderate	40 min **must be met or exceeded**
99245	I1705 / I1715	Medically Appropriate	High	55 min **must be met or exceeded**

Inpatient or Observation Consultations 99252-99255

CPT Code	EPIC I-Codes New/Est	History and Exam	Complexity of MDM	Time
99251	Code was deleted for 2023			
99252	I1722	Medically Appropriate	Minimal/ Straightforward	35 min **must be met or exceeded**
99253	I1723	Medically Appropriate	Low	45 min **must be met or exceeded**
99254	I1724	Medically Appropriate	Moderate	60 min **must be met or exceeded**
99255	I1725	Medically Appropriate	High	80 min **must be met or exceeded**

ADVOCATE HEALTH

Consultations

Scenario – Inpatient vs. Outpatient

- The patient is admitted by another specialty
- The admitting clinician requests a psychiatric evaluation
- Psychiatry's initial patient evaluation should be reported as a consultation service based on the patient's admission status

Patient is admitted to inpatient status	Patient is admitted to observation status
• When requested, the initial psych evaluation should be reported as an inpatient consultation	• When requested, the initial psych evaluation should be reported as an outpatient consultation

Emergency Department Services 99281-99285

CPT Code	History and Exam	Complexity of MDM
99281	**NEW DEFINITION - Evaluation and management of a patient that may not require the presence of a physician or APP**	
99282	Medically Appropriate	Straightforward
99283	Medically Appropriate	Low
99284	Medically Appropriate	Moderate
99285	Medically Appropriate	High

Total Time is not a descriptive component for ED levels of services. Emergency Department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period.

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Virtual Health Documentation and Coding

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Technology	Documentation	Code Selection	
		Ambulatory / Office Visits/ OnDemand	Hospital/Facility
Audio Only	• Audio/phone E/M services can be provided to **new and established patients (eff. 01/01/2025).** • **Use EPIC/ENCOMPASS phone visit smart phrase, which includes the following:** ○ Document visit occurred via "telephone – audio only technology" ○ Document patient consent to visit / eConsent ○ Location of the clinician (office/hospital/other) ○ Summarize clinical discussion ○ Document time spent on the call with patient	Select new or established patient phone visit E/M code based on the documented time on the call with the patient or level of MDM documented.	Audio/phone E/M codes are used to report episodes of care initiated by an established patient. There are bundling requirements with other E/M codes that would make these services not applicable in the inpatient setting.
2-Way Audio with Video	• **Use EPIC/ENCOMPASS video visit smart phrase which includes the following:** ○ Visit occurred via "2-way audio/video technology" ○ Location of the Patient ○ Location of the Clinician (office/hospital/other) ○ Document patient consent to visit / eConsent ○ Document teammates assisting with patient • Document key elements performed via video visit as if seeing the patient in person • Document the video start and stop times as prompted in the template **Note:** We are asking for the start and stop times due to some specific payer requirements. The start and stop time is not used for code selection. Please reference EPIC TIP Sheets - Ambulatory and Inpatient for applicable smartphrases	Select the E/M level of office/outpatient code that represents the video service, either based on the level of MDM documented (including medically necessary history and exam); or the total time spent by the billing clinician on the date of service in activities related to the visit. When billing on time, select EPIC or ENCOMPASS time smart phrase and complete with time detail. The time documented should not be a range. **Office consults** – select the consult code from the charge menu for a new or established patient. Append the -GT modifier (MW) or -VVI tracking code (SE) to the selection. **Post Op visits** – select the usual CPT 99024 and append the -GT modifier (MW) or -VVI tracking code (SE).	Select the E/M level of hospital/facility code that represents the video service, either based on the level of MDM documented (including medically necessary history and exam); or the total time spent by the billing clinician on the date of service in activities related to the visit, when the code category allows time-based billing. When billing on time, select EPIC or ENCOMPASS time smart phrase (.timeattestation) and complete with time detail. The time documented should not be a range. **Inpatient or ED consults** – select the usual consult code from the charge menu for a new or established patient. Append the -VVI tracking code to the internal code selection.

Resources for Leaders and Providers: Southeast Region Virtual Health - Home (sharepoint.com)

EPIC Tip Sheets:
Epic Virtual Visit Documentation and Billing Tools (Ambulatory)

Orders - Inpatient Virtual Visit Documentation and Billing Tools.pdf

Virtual Visit SmartPhrase: **.virtualvisit**

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Virtual Check-in (Phone) Services: I-codes

I-code	Descriptions
I4111	Virtual Check-in (Phone) New Pt; 5-10 minutes
I4112	Virtual Check-in (Phone) New Pt; 11-20 minutes
I4113	Virtual Check-in (Phone) New Pt; 21+ minutes
I4114	Virtual Check-in (Phone) Est Pt; 5-10 minutes
I4115	Virtual Check-in (Phone) Est Pt; 11-20 minutes
I4116	Virtual Check-in (Phone) Est Pt; 21+ minutes

Virtual E/M Visit (Video): I-codes

I-code	Descriptions
I4117	Virtual E&M Visit (Video) New Pt; Level 1
I4119	Virtual E&M Visit (Video) Est Pt; Level 2
I4120	Virtual E&M Visit (Video) Est Pt; Level 3
I4121	Virtual E&M Visit (Video) New Pt; Level 2
I4122	Virtual E&M Visit (Video) New Pt; Level 3
I4123	Virtual E&M Visit (Video) Est Pt; Level 4
I4124	Virtual E&M Visit (Video) Est Pt; Level 5
I4127	Virtual E&M Visit (Video) New Pt; Level 4
I4128	Virtual E&M Visit (Video) New Pt; Level 5

Advance Practice Practitioners (APPs)

ADVOCATE HEALTH

NP/PA – Billing Guidance

Medicare

- Nurse Practitioners and Physician Assistants (NPs/PAs) are recognized clinicians for Medicare and may bill directly for their services.
- The payment differential from Medicare for NPs/PAs direct billing is 85% of the Medicare Fee Schedule.

Commercial Payers

- Some commercial payers do not currently credential NP/PAs. The NP/PAs should be associated with a supervising physician. Our billing system may automatically default to the physician's name/number, as appropriate.

Medicaid

- Advanced Practice Professionals must enroll and bill for services they provide under their own NPI numbers.

NP/PA – Billing Guidance, Inpatient Setting

- Atrium Health does not allow hospital admitting privileges for Nurse Practitioners or Physician Assistants.
- All admission orders and discharge summaries for inpatient services must be countersigned by the physician.
- Nurse Practitioners and Physician Assistants can independently bill for initial hospital care and hospital discharge services.

Advanced Practice Practitioner (APP) Services

To ensure billing accuracy, when an NP/PA/CNM:

- Performs and documents a service independently, ***OR***
- Performs and documents any portion of an E/M service beyond gathering the Review of Systems and Past/Family/Social Histories such as:
  - History of present illness (HPI)
  - Physical examination
  - Medical decision making (MDM)
  - Counseling/coordination of care

1. **Enter the NP/PA/CNM name in the *Service Provider* field, *and***
2. **Enter the name of the supervising physician in the *Billing Provider* field**

ADVOCATE HEALTH

Physician Services

To ensure billing accuracy, when a Physician ***performs and documents the entire service independently*** the physician must:

- Select the service supported by the documentation based on the CPT code requirements
- Enter his/her name in both the *Service Provider* and *Billing Provider* fields

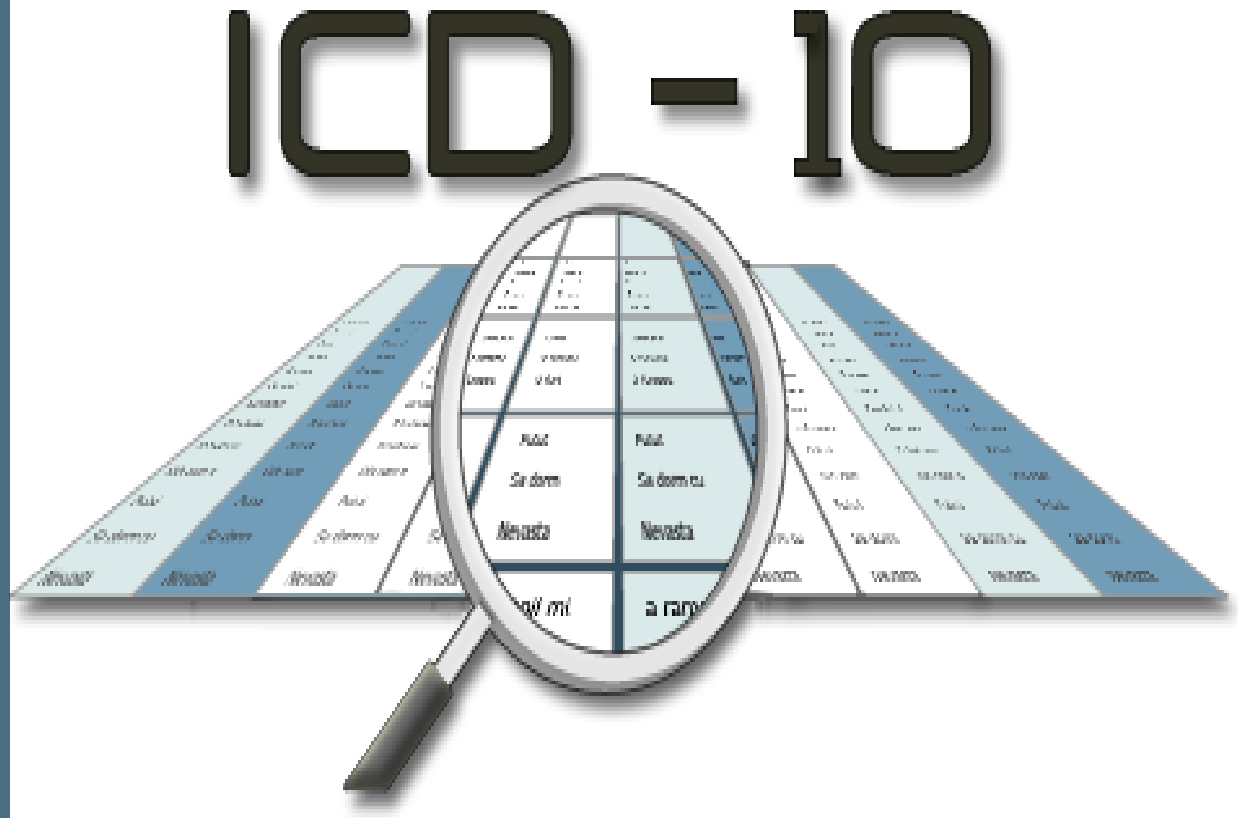
Physicians must not change the Service Provider when co-signing an NP/PA/CNM note

ADVOCATE HEALTH

Provider Charge Workflow (PCW)

- PCW allows physicians/NP/PA/CNMs to capture their hospital charges electronically.
- The NP/PA/CNM places the order for the charge and indicates the supervising physician on the order.
- The physician ***cannot*** place the order and indicate that the service was shared with an Advanced Practice Practitioner.

Diagnosis Coding



ADVOCATE HEALTH

The Importance of Diagnosis Coding

- Diagnosis codes should support the medical necessity for the service provided
- Diagnosis codes selected for billing purposes should *always* be supported by documentation in the patient's medical record
- Code assignment is not based on clinical criteria used by the physician/APP to establish the diagnosis but by physician/APP's statement that the condition exists
  - The physician/APP's statement that the patient has a condition is sufficient
- Incorrect diagnosis coding can have a direct impact on compliance as well as revenue

General Diagnosis Coding Guidelines

Since a coder (or physician) should only code what is available in the clinician's documentation, it is important for physicians/APPs to keep the following in mind when documenting and coding a patient's encounter:

- Document and code all diagnoses that directly impact the treatment plan for the presenting problem
  - "Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s)"
  - Chronic condition(s) should be used as secondary diagnoses when not actively being treated but may impact the current treatment plan for the presenting problem

General Diagnosis Coding Guidelines

- Document and code conditions to the highest degree of specificity known during each encounter
  - When a diagnosis has not yet been confirmed/established, document what is known
    - e.g., patient's signs and symptoms, abnormal test results, etc.
  - In the ambulatory setting, only definitive diagnosis codes may be coded. Conditions that are "probable", "suspected", "rule out" should not be coded.

Example:

Patient presents with altered mental status. The clinician diagnosis "Probable schizoaffective d/o". The appropriate diagnosis code would describe "altered mental status" because probable conditions are not coded in the outpatient setting

General Diagnosis Coding Guidelines

Altered Mental Status

- Document the etiology of the altered mental status as:
  - Coma
  - Confusion/delirium (including drug-induced)
  - Drowsiness/somnolence
  - Stupor/semi-coma
  - Transient alteration of awareness
  - Encephalopathy
    - Alcoholic, Anoxic/hypoxic, Drug-induced/toxic (specify drug), Hepatic, Hypertensive, Hypoglycemic, Metabolic/septic, Traumatic/post-concussion, Wernicke
    - Other (specify)
- Document any associated diagnoses/conditions

General Diagnosis Coding Guidelines

Major depressive disorder

- **Episode**
  - Single episode
  - Recurrent episode
- **Severity**
  - Mild
  - Moderate
  - Severe
    - Without psychotic features
    - With psychotic features
  - In partial or Full remission
  - Document any associated diagnoses/conditions

General Diagnosis Coding Guidelines

Bipolar disorder

- **Severity** – document the severity of the depression as either
  - Mild
  - Moderate
  - Severe without psychotic features
  - Severe with psychotic features
  - In partial
  - Full remission
- **Type** – documentation should specify the presentation of the current episode
  - Manic
  - Depressed
  - Mixed

Diagnosis Coding Example

Example 1

A psych clinician is consulted by the hospitalist group to evaluate a patient for depression (F32.9) who jumped off a bridge in a suicide attempt. The patient has fractures of the right femur (S72.351A), left ulna (S52.041A) and right ulna (S52.041A), bilateral rib fractures (S22.413A) and a traumatic pneumothorax (S27.000A). The psych clinician diagnosed major depressive disorder, single episode severe w/o psychotic features (F32.2)

What diagnosis code(s) should be assigned by the psych clinician?

F32.2 – Single episode of major depressive d/o severe

General Diagnosis Coding Guidelines

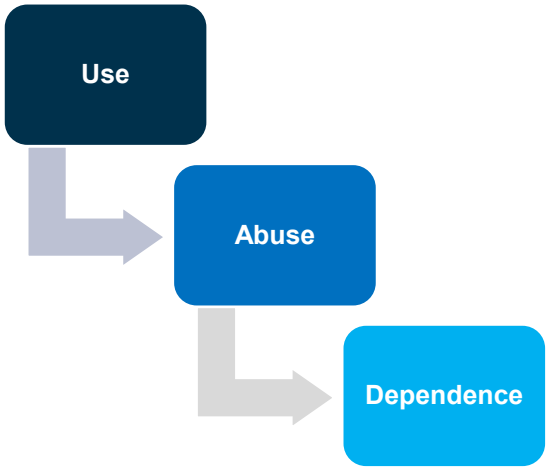
Psychoactive Substance Use

- **Identify the type of drug or substance**
- **Describe the frequency of usage** (i.e., Use, Abuse, Dependence, In remission)
- **Severity**
  - Mild
  - Moderate
  - Severe
- **Cause-effect relationship** – between the mental disorder and the use or abuse of a substance
  - Specify whether the substance caused a psychoactive induced-disorder
  - Specify the type of induced disorder
    - (e.g. delusions, hallucinations, anxiety, sleep disorders, sexual dysfunctions, or other related conditions)
- **Intoxication** – Documentation should specify intoxication/withdrawal as "Uncomplicated" or "With delirium"

General Diagnosis Coding Guidelines
Diagnosis Code Sequencing

Substance use, abuse and dependence

When the documentation refers to use, abuse and dependence of the same substance, only one code should be assigned to identify the pattern of use based on the following hierarchy:



- If both use and abuse are documented, assign only the code for abuse
- If both use and dependence are documented, assign only the code for dependence
- If both abuse and dependence are documented, assign only the code for dependence
- If use, abuse and dependence are all documented, assign only the code for dependence

Diagnosis Coding Example

Documentation states the patient has a history of cocaine abuse (F14.10) but is currently in cocaine dependence in remission (F14.21). Patient also has a history of alcohol abuse related hallucinations (F10.151) but is currently in alcohol dependence with hallucinations (F10.251).

Which diagnosis codes should be reported?

A. F14.10 and F14.21
B. F14.10 and F10.151
C. F14.10 and F10.251
D. F14.21 and F10.151
E. F14.21 and F10.251

Questions????

APPENDIX

Appendix

- **EMR Cautionary Examples**
  - Cloning
  - Prepopulated templates
- **NC Medicaid Documentation Requirements for Psychiatry Services**
- **Psychiatry Services**
- **Definitions**
  - Definitions related to the MDM table

Cloning Example

DOS: 11/19/2022

Interval History:

Last seen 6 months ago when we discussed a switch from Cymbalta to Celexa. She notes she has mood swings.

ROS: Denies having a plan for suicide Denies homicidal ideation

Objective:

Orientation: Oriented x4

Language: Normal

Fund of knowledge: Average

Recent and remote memory: No impairment in recent or remote _

Speech: Normal in rate, tone, and volume _

Thought process: Logical Goal directed

Associations: Intact

Mood: Depressed

Affect: Appropriate to stated mood/ thought content

Thought content related to harm to self or others: Intermittent intrusive thoughts (none in several weeks), +Passive Suicidal Ideations, Insight: Fair

Judgment: Good

A/P: Bipolar disorder, currently depressed, moderate.

Switch from Cymbalta to Celexa 20mg for now. Discussed a trial of Risperdal. Risks including sedation and weight gain reviewed. Dosage 0.5mg qAM and 1mg qHS.

DOS: 11/22/2022

Interval History:

Last seen 6 months ago when we discussed a switch from Cymbalta to Celexa. She notes she has mood swings.

ROS: Denies having a plan for suicide Denies homicidal ideation

Objective:

Orientation: Oriented x4

Language: Normal

Fund of knowledge: Average

Recent and remote memory: No impairment in recent or remote _

Speech: Normal in rate, tone, and volume _

Thought process: Logical Goal directed

Associations: Intact

Mood: Depressed

Affect: Appropriate to stated mood/ thought content

Thought content related to harm to self or others: Intermittent intrusive thoughts (none in several weeks),

+Passive Suicidal Ideations, Insight: Fair

Judgment: Good

A/P: Bipolar disorder, currently depressed, moderate.

Switch from Cymbalta to Celexa 20mg for now. Discussed a trial of Risperdal. Risks including sedation and weight gain reviewed. Dosage 0.5mg qAM and 1mg qHS.

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Cloning Example

DOS: 08/04/2022

HPI: Doing fairly well. She has days where she wakes up more depressed, but she will pray and focus on the positive. No change in auditory hallucinations, "it is better controlled with the medication". Now also with amenorrhea.

Mental Status Exam:

- Behavior/ Appearance: Easy to engage, good eye contact, pleasant and easy to engage in conversation
- Level of consciousness/Orientation: Alert and oriented x 4
- Affect/Mood: neutral, depressed at times
- Speech and volume: Regular rate and rhythm, normal volume
- Language: intact
- Thought Process: Linear and goal directed
- Thought Content: Non-bizarre, No suicidal ideation, No homicidal ideation
- Memory: Recent intact to today's events and remote intact to medical history
- Attention/Concentration: fair
- Fund of Knowledge: Intact to current events
- Perceptual disturbances: chronic AH
- Judgment/ Insight: intact

Assessment/Plan: Schizoaffective disorder. Patient continues to have significant benefit from medication and no changes will be made today. Continue Celexa (40mg) and Abilify (10mg).

Will order lab for prolactin level today.

DOS: 11/27/2022

HPI: Doing fairly well. No change in auditory hallucinations. Most recent bloodwork is not available.

Mental Status Exam:

- Behavior/ Appearance: Easy to engage, good eye contact, pleasant and easy to engage in conversation
- Level of consciousness/Orientation: Alert and oriented x 4
- Affect/Mood: neutral, depressed at times
- Speech and volume: Regular rate and rhythm, normal volume
- Language: intact
- Thought Process: Linear and goal directed
- Thought Content: Non-bizarre, No suicidal ideation, No homicidal ideation
- Memory: Recent intact to today's events and remote intact to medical history
- Attention/Concentration: fair
- Fund of Knowledge: Intact to current events
- Perceptual disturbances: chronic AH
- Judgment/ Insight: intact

Prolactin level within normal limits (26.7) in August 2022.

Assessment/Plan: Schizoaffective disorder. Patient feels like the benefits of medication still outweigh the concerns of weight gain. Continue Celexa (40mg) and Abilify (10mg).

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Prepopulated Template Inconsistencies Example

Past Medical History
Seasonal allergies
Hypertension
Memory disturbance
Major depressive disorder, recurrent, severe

Family History
Mother – hypertension
Sister – breast cancer

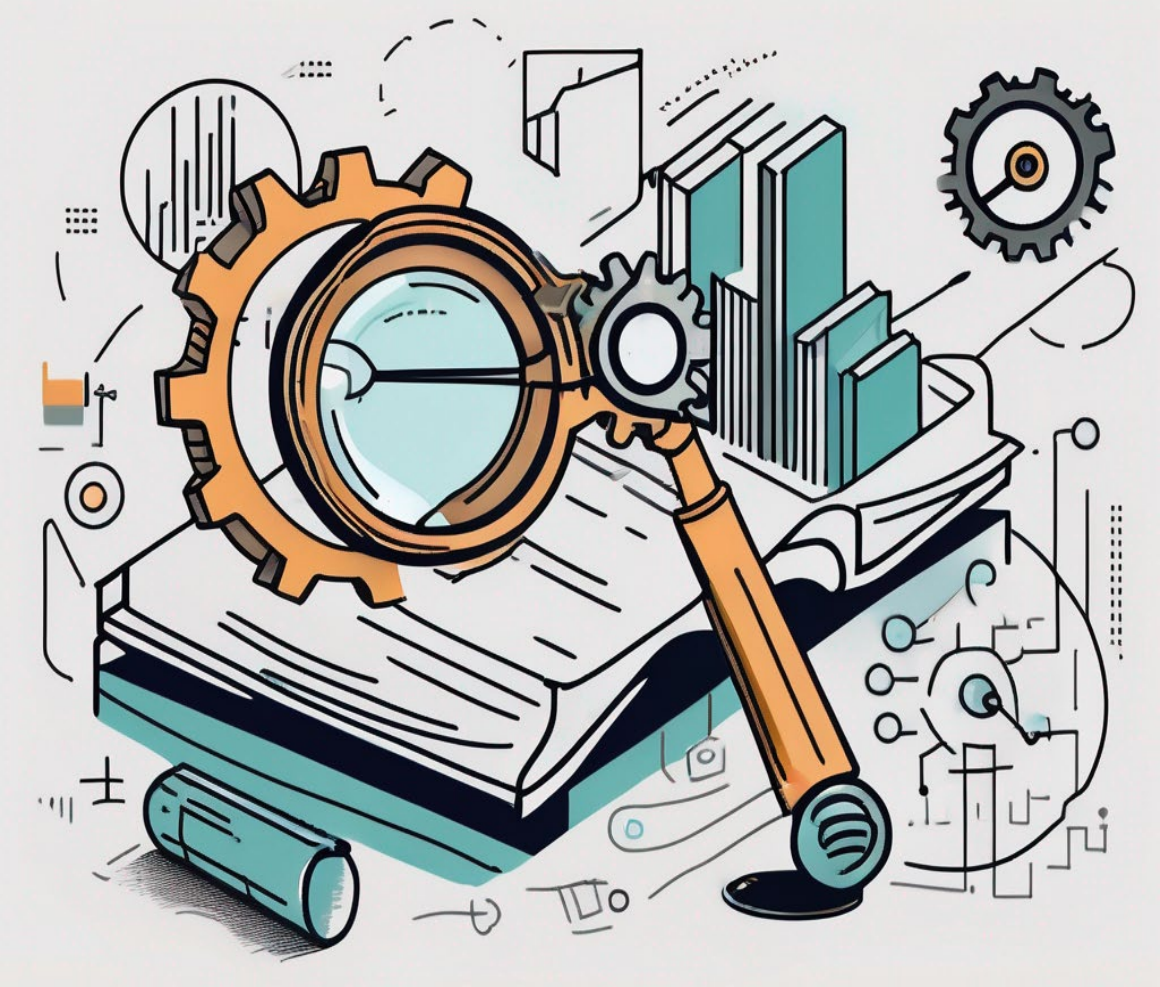
Social History
Alcohol – Denies

Mental Status Exam:
General appearance – Well groomed, Fair eye contact
Speech – Normal
Fund of knowledge – Average
Gait and Station – Normal
Recent and remote memory – Intact
Mood/Affect – Normal

When using a prepopulated note template or macro (i.e., charting by exception), the physician/APP must remember to:

- Update any item when the response differs from the pre-loaded response (e.g., from negative to positive, or normal to abnormal);
- Remove any item(s) not performed.
- Failure to remove a negative response when the question was never asked, creates an erroneous record entry and can potentially lead to improper patient care or payment.

NC Medicaid Documentation Requirements for Psychiatry Services



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Psychiatric Services
Comprehensive Clinical Assessment

A Comprehensive Clinical Assessment (CCA) is an intensive clinical and functional evaluation of patient's presenting mental health, developmental disability, and substance use disorder.

- The clinician may complete the CCA upon admission or update a recent CCA from another clinician if available and it reflects the current level of functioning. Information from that assessment may be utilized as a part of the current comprehensive clinical assessment
- The CCA must be completed by a licensed professional **prior to** provision of outpatient therapy services, including individual, family and group therapy.

Psychiatric Services
Comprehensive Clinical Assessment

The assessment should include the following elements:

- Presenting problems, source of distress, precipitating events
- Chronological general health and behavioral health history, patient's symptoms, treatment and treatment response
- Current medications (both physical and psychiatric)
- Review of biological, psychological, familial, social, developmental and environmental dimensions to identify strengths, needs, and risks in each area
- Evidence of patient and legally responsible person participation in assessment
- Analysis and interpretation of the assessment information with an appropriate case formulation, consisting of a determination of ASAM level of care when a substance use disorder is present;
- DSM-5 diagnosis including mental health, substance use disorders or intellectual/developmental disabilities
- Recommendations for additional assessments, services, support or treatment based on the CCA results

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Psychiatric Services Individualized Plan

An individualized plan of care (i.e., service plan, treatment plan) is based on the assessment and is developed in partnership with the patient or legally responsible person, or

both.

- The treatment plan is required within 15 business days of the first face-to-face patient contact
- It must be updated as required, but a new plan is required at least annually
- All updated or new plans require the patient or legally responsible person's signature, and the licensed professional's signature
  - Patients receiving medication management only would be exempt from the requirement of having to sign the treatment plan
- The treatment plan for patients receiving medication management only would not need to be a separate document and could be integrated into service notes

Psychiatric Services Individualized Plan

The **Individualized Plan must contain at a minimum:**

- Patient outcomes that are anticipated to be achieved by provision of the service and a projected dated of achievement
- Strategies
- Staff responsible
- A schedule for review of the plan (in consultation with the patient or legally responsible person or both) as needed but at least annually to review goals and strategies to promote effective treatment
- Basis for evaluation or assessment of outcome achievement
- Written consent or agreement by the patient or legally responsible person or a written statement by the clinician stating why such consent could not be obtained

Psychotherapy

Psychotherapy is the treatment of mental illness and behavioral disturbances in which the physician or other qualified health care professional, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

- Psychotherapy services include ongoing assessment and adjustment of psychotherapeutic interventions and may include involvement of informants in the treatment process.

- Psychotherapy time may include face-to-face time with family members as long as the patient is present for part of the service.
    - A medical evaluation may occur on the same day as a psychotherapy service by the same physician or other qualified health care professional

Approved Clinicians of Service - Medicare

Clinicians Eligible to Bill These Services:		
Physicians (MD/DO)**	Nurse Practitioners**	Marriage and Family Therapists
Clinical Psychologists**	Clinical Social Workers	Mental Health Counselors
Clinical Nurse Specialists**	Physician Assistants*	Independently Practicing Psychologists**
Certified Nurse Midwives**	Certified RN Anesthetists*	

May perform diagnostic psychological and neuropsychological testing:

(*) These clinicians must perform testing under general physician or clinical psychologist supervision

(**) These clinicians are excluded from having to perform these tests under the general supervision of a physician or clinical psychologist

Note: Physical/Occupational Therapists and Speech Language Pathologists are authorized to bill these test codes as “sometimes therapy” codes – 96105, 96110 and 96112 – 96113

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Psychiatry Services

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Psychiatric Diagnostic Evaluation

Psychiatric Diagnostic Evaluation (Integrated biopsychosocial assessment) includes the following:

- Complete medical and psychiatric history (including past medical, family and social)
- Mental status Examination
- Establishment of an initial diagnosis
- Evaluation of the patient's ability and capacity to respond to treatment
- Initial plan of treatment/Treatment recommendations
  - The evaluation may include communication with family or other sources and review and ordering of diagnostic studies.
  - The psychiatric diagnostic evaluation may include interactive complexity services when factors exist that complicate the delivery of the psychiatric procedure.

CPT Code	CPT Description
90791	Psychiatric diagnostic evaluation

Psychiatric Diagnostic Evaluation with Medical Services

Psychiatric Diagnostic Evaluation with Medical Services (Integrated biopsychosocial and medical assessment) includes the following :

- A psychiatric diagnostic evaluation (complete medical & psych. history, assessment of current mental status)
- Mental status examination
- Physical Examination elements
- Evaluation of the patient's ability and capacity to respond to treatment
- Initial plan of treatment/Treatment recommendations
  - The evaluation may include communication with family or other sources, prescription of medications, and review and ordering of laboratory or other diagnostic studies.
  - The psychiatric diagnostic evaluation may include interactive complexity services when factors exist that complicate the delivery of the psychiatric procedure.

CPT Code	CPT Description
90792	Psychiatric diagnostic evaluation with medical service

Psychiatric Diagnostic Evaluations 90791-90792

The following applies to both psychiatric diagnostic evaluation and psychiatric diagnostic evaluation with medical services:

- Cannot be reported with an E/M code on the same day by the same clinician
- Cannot be reported with a psychotherapy service code on the same day
- May only be reported once per day
- May be reported more than once for a patient when separate evaluations are conducted with the patient and other informants (i.e., family members, guardians, significant others) on different days
    - This service is considered medically necessary once every 6 months per episode of illness. If reported more than once per episode of illness, documentation will be required for the establishment of medical necessity (i.e., acute and/or marked mental status change, second opinion or need for diagnostic clarification)
- In certain circumstances, family members, guardians, or significant others may be seen in lieu of the patient. When this happens, report the service as being provided to the patient and not the informant

Interactive Complexity

Interactive complexity (+90785) refers to the communication factors that complicate the delivery of a psychiatric procedure

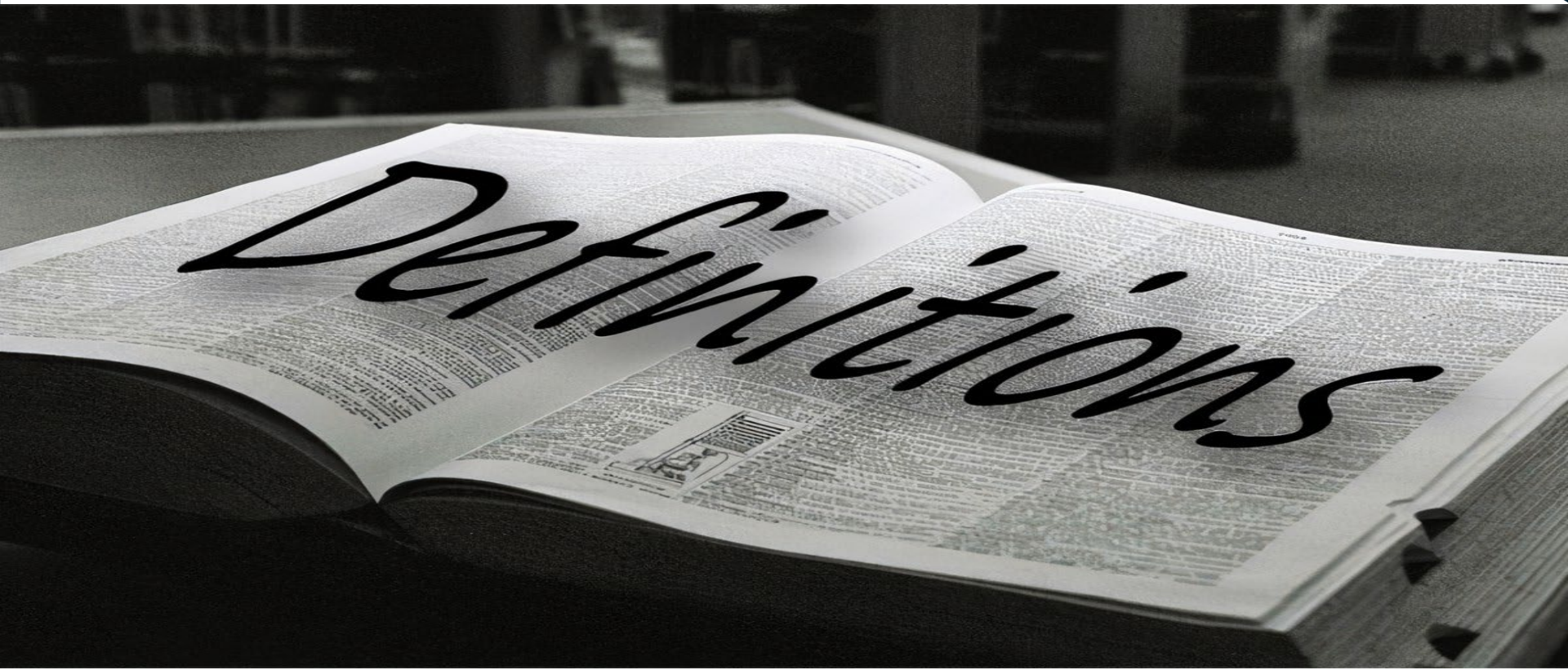
This service may be reported as an add-on code when at least one of the following factors is present:

- When there is a need to manage maladaptive communication among participants that complicates delivery of care
- Caregiver emotions or behavior that interferes with the caregiver's understanding and ability to assist in the implementation of the treatment plan
- Evidence or disclosure of sentinel event and mandated report to third party with initiation of discussion of the sentinel event and/or report with patient and other visit participants
- Use of play equipment other physical devices, interpreter or translator to communicate with the patient to overcome barriers to therapeutic or diagnostic interaction between the clinician and patient

Interactive Complexity

CPT Code	Code Description
+90785	Interactive complexity (List separately in addition to the code for primary procedure)

- When performed in conjunction with psychotherapy services, the interactive complexity component relates only to the increased work intensity of the psychotherapy service. It does not change the time for the psychotherapy service.
- Report in conjunction with codes for diagnostic psychiatric evaluation (90791-90792), Psychotherapy (90832-90838), and Group psychotherapy (90853)
- Do not report the Interactive Complexity code in conjunction with Psychotherapy for Crisis codes (90839, +90840) or in conjunction with E/M services when provided without psychotherapy.



ADVOCATE HEALTH

Definitions

Number and complexity of problems addressed at the encounter:

- A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or APP reporting the service.
- Referral without evaluation (by history, exam, or diagnostic study) or consideration of treatment does not qualify as being addressed.

The following definitions are related to Number and Complexity of Problems Addressed at the Encounter:

Problem: A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter.

Problem addressed: A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service. **This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice. Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being 'addressed' or managed by the physician or other qualified health care professional reporting the service**. Referral without evaluation (by history, exam, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service.

Definitions

Minimal problem: A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician's or other qualified health care professional's supervision. **[Straightforward]**

Self-limited or minor problem: A problem that runs a definite and prescribed course, is transient in nature and is not likely to permanently alter health status. **[Straightforward/Low]**

Acute, uncomplicated illness or injury: **A recent or new short-term problem with low risk of morbidity for which treatment is considered.** There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course is an acute uncomplicated illness. **[Low]**

Acute, uncomplicated illness or injury requiring hospital inpatient or observation level care: A recent or new short-term problem with low risk of morbidity for which treatment is required. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. **The treatment required is delivered in a hospital inpatient or observation level setting.** **[Low]**

Definitions

Stable, acute illness: A problem that is new or recent for which treatment has been initiated. The patient is improved and, while resolution may not be complete, is stable with respect to this condition. **[Low]**

Stable, chronic illness: A problem with **an expected duration of at least a year or until the death of the patient**. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (e.g., uncontrolled diabetes and controlled diabetes are a single chronic condition). **'Stable'** for the purposes of categorizing medical decision making is defined by the specific treatment goals for an individual patient. A patient that is not at his or her treatment goal is not stable, even if the condition has not changed and there is no short- term threat to life or function (e.g., a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic). The risk of morbidity **without** treatment is significant. **[Low/Moderate]**

Definitions

Chronic illness with exacerbation, progression, or side effects of treatment: A chronic illness that is acutely worsening, poorly controlled, or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects. **[Moderate]**

Undiagnosed new problem with uncertain prognosis: A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment. **[Moderate]**

Acute illness with systemic symptoms: An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms, such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms, see the definitions for self-limited or minor problem or acute, uncomplicated illness or injury. Systemic symptoms may not be general but may be single system. **[Moderate]**

Definitions

Chronic illness with severe exacerbation, progression, or side effects of treatment: The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and **may require escalation in level of care**. **[High]**

Acute or chronic illness or injury that poses a threat to life or bodily function: An acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, **that poses a threat to life or bodily function in the near term without treatment.** Some symptoms may represent a condition that is significantly probable and poses a potential threat to life or bodily function. These may be included in this category when the evaluation and treatment are consistent with this degree of potential severity. **[High]**

Definitions

Amount and/or complexity of data to be reviewed and analyzed

- Tests, documents, orders, or independent historian(s) – each unique test (as identified by a CPT code), order, or document is counted to meet a threshold number
- Independent interpretation of tests
- Discussion of management or test interpretation with external physician/APP/or appropriate source

The following definitions are related to Amount and/or Complexity of Data to be Reviewed and Analyzed:

***Analyzed*:** The process of using the data as part of the MDM. The data element itself may not be subject to analysis (e.g., glucose), but it is instead included in the thought processes for diagnosis, evaluation, or treatment.

- **Tests ordered are presumed to be analyzed when the results are reported. Therefore, when they are ordered during an encounter, they are counted in that encounter.**
- **Tests that are ordered outside of an encounter may be counted in the encounter in which they are analyzed.** In the case of a recurring order, each new result may be counted in the encounter in which it is analyzed. For example, an encounter that includes an order for monthly prothrombin times would count for one prothrombin time ordered and reviewed. Additional future results, if analyzed in a subsequent encounter, may be counted as a single test in that subsequent encounter.
- **Any service for which the professional component is separately reported by the physician or other qualified health care professional reporting the E/M services is not counted as a data element ordered, reviewed, analyzed, or independently interpreted for the purposes of determining the level of MDM.**

Definitions

Test: Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (e.g., basic metabolic panel [80047]) is a single test. **The differentiation between single or multiple tests is defined in accordance with the CPT code set. For the purposes of data reviewed and analyzed, pulse oximetry is not a test.**

- Tests that do not require a separate interpretation (e.g., test that are results only) and are analyzed as part of the MDM may be counted as ordered or reviewed for selecting an MDM level.
- The ordering and actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the MDM level when the service is reported separately by the physician/APP (e.g., EKG, x-ray).

***Unique*: A unique test is defined by the CPT code set.** When multiple results of the same unique test (e.g., serial blood glucose values) are compared during an E/M service, count it as one unique test. Tests that have overlapping elements are not unique, even if they are identified with distinct CPT codes. For example, a CBC with differential would incorporate the set of hemoglobin, CBC without differential, and platelet count. **A unique source is defined as a physician or qualified heath care professional in a distinct group or different specialty or subspecialty, or a unique entity.** Review of all materials from any unique source counts as one element toward MDM.

Definitions

Combination of Data Elements: A combination of different data elements, for example, a combination of notes reviewed, tests ordered, tests reviewed, or independent historian, allows these elements to be summed. It does not require each item type or category to be represented. A unique test ordered, plus a note reviewed and an independent historian would be a combination of three elements.

External: External records, communications and/or test results are from an external physician, other qualified health care professional, facility or healthcare organization.

External physician or other qualified healthcare professional: An external physician or other qualified health care professional is an individual **who is not in the same group practice or is a different specialty** or subspecialty. This includes licensed professionals who are practicing independently. The individual may also be a facility or organizational clinician such as from a hospital, nursing facility, or home health care agency.

Definitions

Discussion: Discussion requires an interactive exchange. The exchange must be direct and not through intermediaries (e.g., clinical staff or trainees). **Sending chart notes or written exchanges that are within progress notes does not qualify as an interactive exchange**. The discussion does not need to be on the date of the encounter, but it is counted only once and only when it is used in the decision making of the encounter. It may be asynchronous (i.e., does not need to be in person), but it **must be initiated and completed within a short time period (e.g., within a day or two)**.

Independent historian(s): An individual (e.g., parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient **who is unable to provide a complete or reliable history (e.g., due to developmental stage, dementia, or psychosis)** or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian is needed, the independent historian requirement is met. It does not include translation services. The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information.

Definitions

Independent Interpretation: The interpretation of a test for which there is a CPT code, and an interpretation or report is customary. **This does not apply when the physician or other qualified health care professional who reports the E/M service is reporting or has previously reported the test.** A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.

Appropriate source: For the purpose of the **Discussion of Management** data element, an appropriate source includes professionals who are not health care professionals but may be involved in the management of the patient **(e.g., lawyer, parole officer, case manager, teacher)**. It does not include discussion with family or informal caregivers.

Definitions

Risk of complications and/or morbidity or mortality of patient management

- Includes possible management options selected and those considered, but not selected, after shared medical decision making with the patient and/or family

The following definitions are related to Risk of Complications and/or Morbidity or Mortality of Patient Management:

Risk: The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk. Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty. Trained clinicians apply common language usage meanings to terms such as high, medium, low, or minimal risk and do not require quantification for these definitions (though quantification may be provided when evidence-based medicine has established probabilities).

For the purpose of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization. The risk of patient management criteria applies to the patient management decisions made by the reporting physician or other qualified health care professional as part of the reported encounter.

Definitions

***Social Determinants of Health*:** Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.

Social determinants of health are the environmental conditions where people are born, live, earn, work, play, worship and age that affect a wide range of health, functioning, and quality-of-life risks and outcomes. There are 5 domains of social determinants of health:

- Economic stability
- Access to and quality of education
- Access and quality to healthcare
- Neighborhood and built environment
- Social/community context

Documentation should specify the social determinant(s) that is complicating the medical decision making for the patient's plan of care.

Definitions

Drug therapy requiring intensive monitoring for toxicity: A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. The **monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy.** The monitoring should be that which is generally accepted practice for the agent but may be patient-specific in some cases. **Intensive monitoring may be long-term or short-term. Long-term intensive monitoring is not performed less than quarterly.** The monitoring may be performed with a laboratory test, a physiologic test, or imaging. Monitoring by history or examination does not qualify. The monitoring affects the level of MDM in an encounter in which it is considered in the management of the patient.

An example may be monitoring for cytopenia in the use of an antineoplastic agent between dose cycles.

Examples of monitoring that do not qualify include monitoring glucose levels during insulin therapy, as the primary reason is the therapeutic effect (unless severe hypoglycemia is a current, significant concern); or annual electrolytes and renal function for a patient on a diuretic, as the frequency does not meet the threshold.

Palmetto GBA, Jurisdiction M (NC, SC, VA, WV): https://www.palmettogba.com/palmetto/jmb.nsf/DID/8EELEJ7715

Palmetto GBA, Jurisdiction J (AL, GA, TN): https://palmettogba.com/palmetto/jjb.nsf/DIDC/8EELEJ7715~Specialties~Drugs%20and%20Biologicals

Definitions

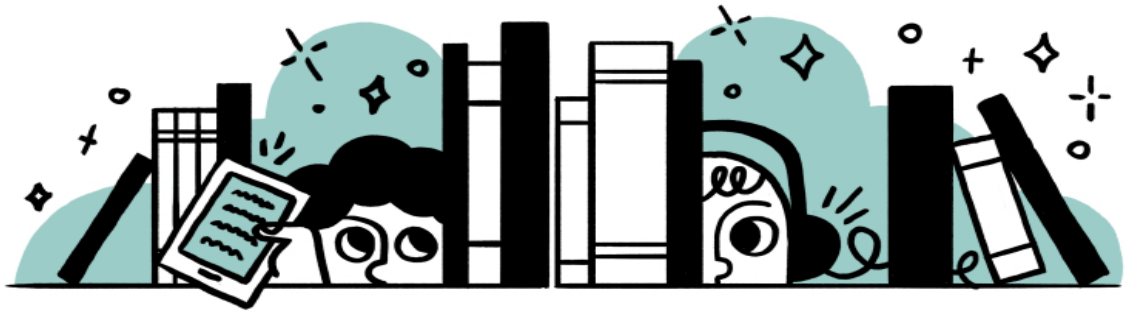
Surgery (minor or major, elective, emergency, procedure or patient risk):

- **Surgery–Minor or Major:** The classification of surgery into minor or major is based on the common meaning of such terms when used by trained clinicians, similar to the use of the term “risk.” These terms are not defined by a surgical package classification.
- **Surgery–Elective or Emergency:** Elective procedures and emergent or urgent procedures describe the timing of a procedure when the timing is related to the patient’s condition. An elective procedure is typically planned (e.g., scheduled for weeks later), while an emergent procedure is typically performed immediately or with minimal delay to allow for patient stabilization. Both elective and emergent procedures may be minor or major procedures.
- **Surgery–Risk Factors, Patient or Procedure:** Risk factors are those that are relevant to the patient and procedure. Evidence-based risk calculators may be used, but are not required, in assessing patient and procedure risk.

Definitions

Parenteral Controlled Substances: The level of risk is based on the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty and subspecialty and not simply based on the presence of an order for parenteral controlled substances.

Resources



ADVOCATE HEALTH

Accessing Billing & Documentation Resources via Physician Connect

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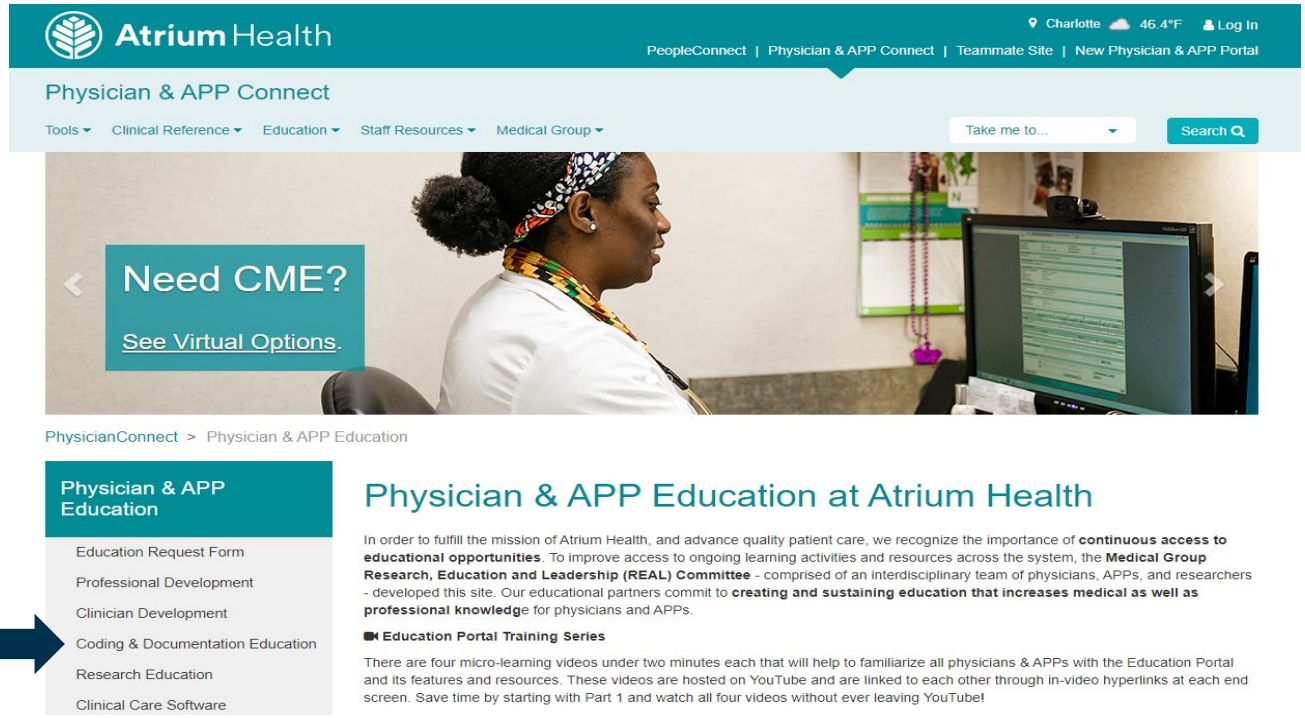

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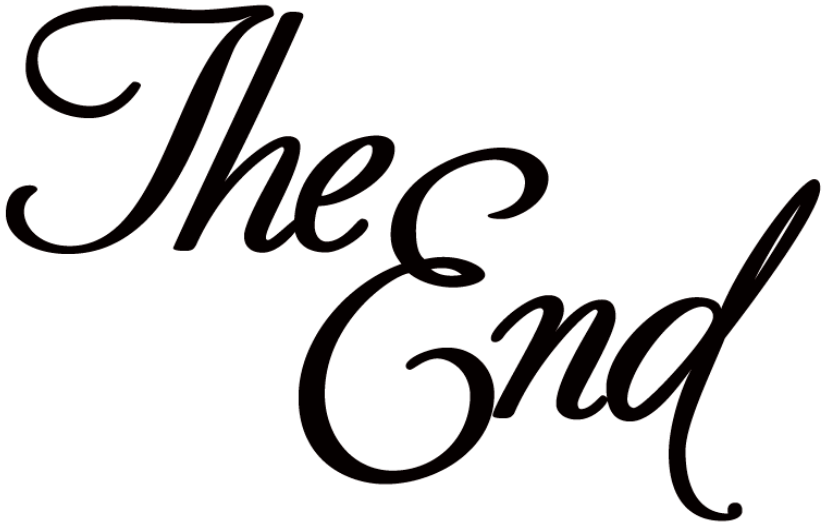

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