Guidance to Help Ensure You Are Coding Patient Visits Correctly

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The APA Practice Management HelpLine has been receiving a number of questions regarding coding and documentation using the recently revised outpatient E/M code requirements. The following guidance will help you select the appropriate level of an outpatient E/M service and document it correctly. The guidance includes documentation examples and the definition of time. The requirements will be applied in all sites of service beginning in January 2023.

In January 2021, as part of its efforts to reduce the burden of documentation in health care records, the Centers for Medicare and Medicaid Services (CMS) adopted CPT recommendations for changes to E/M outpatient code documentation requirements. The effect of this has been to focus documentation on the Medical Decision-Making component of an E/M note and require only clinically appropriate history and examination elements. In some cases, time can be used to determine the code level of a visit. Please see the section on "Time" at the end of this article.

Picking the appropriate CPT code for any service should be based on the following three factors: First, the CPT code selected should be the most accurate code available that describes the service. Second, the level of the code should accurately reflect the complexity of the service provided during that encounter, or under certain circumstances, time alone can be used to determine the E/M level (see below). Third, documentation should support why the service is medically necessary and note any changes in treatment that are considered or implemented.

One way to help support medical necessity for the service in your documentation is to start your note with "Chief Complaint/Reason for the Visit." This sets the stage for describing why this particular visit is medically necessary. Examples include "Follow-up visit for patient with chronic depression," "TMS service #3," "Medication management plus psychotherapy follow-up visit for patient with chronic psychosis and intermittent suicidal ideations." Each note should reflect the patient's condition and the work done during that encounter.

Let's look at some sample notes for commonly used outpatient E/M services. The format of these notes represents one example of how to document progress notes. No specific format is required so long as the note clearly identifies the required elements for the visit.

Medical Decision Making (MDM) requires that two out of three Problem(s), Amount and/or Complexity of Data, and Level of Risk be at or above the required level for the code selected. Problems and Risk are always present in every encounter. Sufficient data elements to meet requirements for higher level codes are often not present. For that reason, only Problem(s) and Risk are used in the following examples. If a complex data review is an important part of your practice, it can be used as one of the two out of three elements.

99212

CC: F/U visit for retired recently widowed patient grieving the loss of his wife 6 months ago.

Hx: Sam states that he has been improving and has taken my advice to spend more time with his grandchildren. He finds himself smiling more, but with occasional sad periods when he gets tearful thinking about his wife. He has not had any thoughts of suicide, appetite is good, and he is concentrating better.

Exam: As above.

MDM: Continued gradual improvement in mood. Not taking any more sleeping medicine (OTC). Discussed his wishes regarding follow-up visits, and we agreed, at his request, to meet on a prn basis going forward.

Dx: Bereavement.

Code	Level of MDM	Problem(s)	Risk
99212	Straightforward	Self-limited problem (bereavement)	Minimal
Code Selection Rationale: Minimal risk follow-up visit for patient with a self-limited problem—bereavement. Straightforward level of work for the provider.			

99212 + 90833

CC: F/U visit for 40-year-old executive with chronic depression and relationship problems being seen for weekly psychotherapy and medication management.

Hx: Susan states that she has been taking her fluoxetine regularly, with no complaints or side effects.

Exam: As above.

MDM: Continued gradual improvement in mood. Continue fluoxetine 20 mg.

Dx: Major depressive disorder, recurrent.

Psychotherapy Note

Time spent in psychotherapy: approx. 25 mins

Modality: Psychodynamic

Goals: Reduction in depressive symptoms and improved relationship with husband.

Focus: Relationship issues with her husband. Working on developing more awareness of alternative understanding of her husband's behavior and his openness to discussing her feelings/perceptions.

Code	Level of MDM	Problem(s)	Risk
99212	Straightforward Based on medical necessity for weekly medication management visit	Stable chronic illness	Moderate Prescription drug management
90833	16-37 minutes of psychotherapy time		

Code Selection Rationale: Even though this patient has a stable chronic illness and moderate risk (prescription drug management) and would typically meet criteria for low-level MDM (99213), the level of E/M work done on this date of service is straightforward, associated with checking on side effects or other complaints, which meets medical necessity for 99212. If the patient had been experiencing side effects that warranted further exploration but were determined not to require a medication change, for example, mild headache or nausea, and were tolerable with the thought that side effects may go away with time, a 99213 may have been appropriate. If the patient was experiencing significant side effects found to be intolerable, for example, vomiting, and the medication was changed with a discussion of risks, alternatives, and side effects, a 99214 may have been warranted. Circumstances justifying a 99215 need to be highly complex, for example, report of suicidal ideation with a possible plan and discussion/consideration of hospitalization.

The 90833 psychotherapy code was chosen based on the time spent providing psychotherapy. Total time of the visit was considered, subtracting out the approximate time of the E/M portion, and the remaining time spent in psychotherapy was approximately 25 minutes, warranting the 90833 code. The estimated time spent in psychotherapy (25 minutes in this case) should be documented. When considering time, keep in mind that the E/M work requires time, which should be accounted for within the total time of the visit. Higher complexity E/M work requires more time. When added to the time attributed to psychotherapy, the total time of the visit should make sense. For example, say you met with a patient for a total time of 20 minutes and billed a 99214 + 90833. Because the 90833 must account for at least 16 minutes of the total time of the visit, it doesn't make sense that you completed the complex work of a 99214 in 4 minutes.

99213

CC: F/U visit for a patient with recurrent major depressive disorder, in remission.

Hx: Margaret tells me that she has been doing pretty well since our last visit 3 months ago. Her PCP has not changed her HCTZ blood pressure medicine. She has been sleeping and eating well, her return to work has been good for her, and she is functioning well in that setting. She has resumed her usual activities and has had no suicidal ideation nor periods lasting more than a few minutes of sadness throughout the day. We agreed to continue the fluoxetine at 40 mg.

Exam: As above.

MDM: Stabilizing mood in patient with recurrent episodes of depression. Will continue fluoxetine 40 mg daily. Rx given for 3 months. Return in 3 months or prn.

Dx: Major depressive disorder, recurrent.

Code	Level of MDM	Problem(s)	Risk
99213	Low	Stable chronic Illness (MDD, recurrent)	Moderate Prescription drug management
Code Selection Rationale: Although this patient has moderate risk due to being on a prescription medication, her Number and Complexity of Problems are low (one stable chronic illness), and no data were reviewed. Therefore, two out of three of the MDM elements result in a low level of MDM. Also, with regard to the medical necessity for this visit, a 99213 seems appropriate. Although she has hypertension and is taking medication for it, the psychiatrist is not managing this condition, and thus it would not count as a second chronic illness for this visit.			

99214

CC: F/U medication management visit for acutely depressed patient attending IOP.

Hx: John says that his mood has continued to improve slowly. He has been attending IOP regularly and says he's getting a lot out of it, particularly learning how to better manage his home and work relationships. He continues to sleep only about 4 hours per night, awakening early and unable to return to sleep. Appetite is still less than his usual, and his concentration is still impaired. He says he can't read a book, which he used to enjoy; he can barely make it through a newspaper article. He denies suicidal plan or intent. He still gets fleeting thoughts that his family would be better off without him, but he says these thoughts are much better than his constant preoccupation with suicide prior to his recent hospitalization and switch in his meds. He denies any side effects to the increased dose of citalopram (40 mg) and continues to take 100 mg trazadone, but he is still not sleeping through the night.

Exam: Mood is depressed but improving by self-report. Affect is somewhat flat. Thoughts are goal oriented, with some passive suicidal ideation as described above, but no plans or intent. No evidence of psychosis. Some difficulty with concentration. ST memory 2/3, LT memory good.

MDM: John has been improving, with improved mood and some improvement in his relationships at home. He has not returned to work yet but has spoken with his boss and feels good about that. Still having concentration problems, sleep disturbance, and passive suicidal ideation. Continuing to attend IOP.

Dx: Major depressive disorder, recurrent, severe.

Plan: 1. Continue citalopram 40 mg. 2. Continue trazadone 100 mg; if no improvement, consider switch or augmentation next visit. 3. Continue in IOP focusing on relationships and goal of return to work. 4. Next visit in one week.

Code	Level of MDM	Problem(s)	Risk
99214	Moderate	Chronic illness (major depressive disorder recurrent) with exacerbation	Moderate Prescription drug management
Code Selection Rationale: Moderate risk patient in IOP with chronic illness with exacerbation, requiring moderate level MDM associated with discussion/consideration of slow improvement and possible switch or augmentation strategy.			

99214

CC: F/U medication management visit for 54 yr old man with hx of bipolar disorder and alcohol use disorder last seen 3 months ago.

Hx: Tom states that he has been doing well on his current regimen of medications. He has been sticking to a stable routine, as we previously discussed. His work has been good, and his relationship with his wife is improving although it remains "bumpy." He is getting at least 6 hours of sleep at night and works hard at going to bed and getting up at the same times. He has had none of the early signs of an impending manic episode that we have discussed. He proudly tells me he is now about to celebrate 2 years of sobriety. He continues to attend regular AA meetings and stays in regular contact with his sponsor.

Exam: Appropriately dressed and groomed male with full affect and stable mood. No evidence of hypomania or depression and no suicidal ideation or intentions. Speech is normal rate and rhythm. No evidence of psychosis.

MDM: Tom remains stable on his current medication regimen. Discussed possible return to marital therapy, but he wants to think about it before restarting. Upcoming 2-year anniversary of sobriety.

Dx: Bipolar I disorder, in partial remission; alcohol use disorder.

Plan: Continue with lamotrigine 200 mg daily. Continue with AA meetings and sponsor's support. Will assist with return to marital therapy if patient and wife agree. Next appointment in 3 months or prn.

Code	Level of MDM	Problem(s)	Risk
99214	Moderate	Two stable chronic illnesses (bipolar I disorder and alcohol use disorder)	Moderate Prescription drug management
Code Selection Rationale: Moderate risk patient with two stable chronic illnesses requiring moderate level MDM associated with ongoing prescription treatment and chronic illness monitoring and support.			

99215

CC: F/U visit for 45 yr old female patient with recent exacerbation of chronic depression with intermittent suicidal thoughts.

Hx: Sarah tells me that she has been spending a lot of time in bed still, with periods of crying and low appetite. She has lost about 5 lbs in the past 2 weeks. She awakens about 3 am every night and can't get back to sleep. She has been having thoughts that her family would be better off without her and has considered what it would be like to be dead and continues to feel the presence of those she has loved who are now dead. She says it brings her a sense of peace to consider being with her dead parents. She is taking her bupropion and aripiprazole as prescribed.

Exam: As above, with passive suicidal thoughts, some vague hallucinatory experiences, and more movement toward acting on her wish to be with her dead parents.

MDM: Worsening depression and suicidal thoughts with movement toward action in patient with history of prior suicide attempts when in an acute depressive episode like this. Discussed with her and her husband my recommendation for hospitalization at this time. She is reluctant but trusts my judgment. Her husband is very supportive. Will make arrangements for hospitalization, and I will speak to her inpatient psychiatrist. F/U post hospitalization and possible PHP.

Dx: Major depressive disorder, recurrent severe, with psychotic features.

Code	Level of MDM	Problem(s)	Risk
99215	High	Chronic illness (major depressive disorder, recurrent) with severe exacerbation	High Decision regarding hospitalization
Code Selection Rationale: High-risk patient with severe exacerbation of chronic illness, requiring high level MDM associated with discussion/consideration of hospitalization due to suicide risk.			

Psychotherapy Codes

There are several scenarios in which psychotherapy codes are used with an E/M service. Sometimes during an E/M visit an issue comes up for which the psychiatrist needs to take time to teach the patient a technique to help with a symptom or circumstance. An example might be teaching breathing techniques to help deal with anxiety or cognitive-behavioral approaches to help deal with certain feelings that come up repeatedly. If the time involved exceeds the 16-minute minimum for add-on psychotherapy, it is appropriate to use the psychotherapy code for that visit. Some psychiatrists see patients for combined E/M and psychotherapy visits as a prescribed treatment (see above example) such as a patient with chronic severe depression with intermittent suicidal ideation seen on a weekly basis for combined E/M plus psychotherapy services. Documentation for each visit should include distinct documentation for each component (E/M and psychotherapy), listed separately in the note (see above example). In determining the psychotherapy time, first think of the entire time of the visit, then consider how much time was spent performing the E/M work, subtract that from the total time of the visit, and if the remaining time was spent in psychotherapy, calculate that time as the psychotherapy time and bill accordingly. Time is not used in selecting the level of the E/M service when billing in conjunction with a psychotherapy visit.

Time

The alternative to using Medical Decision Making (MDM), which can be used only when no psychotherapy is involved, is to base the level of the visit only on total time. You must still establish medical necessity and describe your medical decision-making, assessment, plan, and so on, but you don't need to meet the above criteria.

Established Patient	Time (Total Time on Day of Visit)
99212	10-19 minutes
99213	20-29 minutes
99214	30-39 minutes
99215	40-54 minutes

Time is defined as **total time on the date of the encounter** of the physician (both face-to-face and non-face-to-face time) and does not include time spent by clinical staff or residents/fellows. Here are some examples of work that can count toward the total time of the visit when using time as the determinant of the level of the code:

- Preparing to see the patient (for example, review of tests, records).
- Obtaining and/or reviewing separately obtained history.
- Performing a medically necessary appropriate exam 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 reported separately).
- Documenting clinical information in the electronic or other health record.
- Independently interpreting results and communicating results to the family.
- Care coordination (when not reported separately).

Additional Resources

For information on billing and documentation for psychiatric care, please go to CPT Coding and Reimbursement on APA's website at https://www.psychiatry.org/psychiatrists/practice/practice-management/coding-reimbursement-medicare-and-medicaid/coding-and-reimbursement. Also helpful is a table on medical decision-making posted at https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Practice-Management/Coding-Reimbursement-Medicare-Medicaid/Coding-Reimbursement/Private/Quick-Guide-to-2021-Office-Outpatient-EM-Services-Coding-Changes.pdf.

E/M Reality Check

The Practice Management HelpLine has been seeing an uptick in commercial payer audits, which seem to be largely based on the level of E/M being billed with add-on psychotherapy on a weekly basis. A primary care physician is unlikely to see a patient weekly unless the patient is having an acute problem. Payers apparently do not expect a 99214 level of E/M to be billed with a psychotherapy code on a weekly basis even though the patient may have the necessary number of chronic disorders that would permit that level of E/M billing unless the patient is experiencing significant problems requiring active management. Payers seem generally willing to pay for lower levels of E/M provided with this frequency but are auditing psychiatrists who routinely use 99214 (or even 99215).

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