ALCOHOL, DRUG & MENTAL HEALTH SERVICES
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Memorandum

Date: April 18, 2013

To: Master Contract Providers

From: Kyree Klimist, QA Associate Administrator

Re: **Documentation Standards for Evaluation and Management Services**

Following the March 15, 2013 Evaluation and Management Coding Training Update several Providers have asked for additional guidance regarding the documentation standards for Evaluation and Management Services when documenting based on the elements (rather than on time when Counseling and Coordination predominates the session).

The Quality Assurance Training page on the ACBHCS website has been updated to include such resources. See the section titled: *Training Resources: CPT Code Changes for 2013*.

Key documents that will be helpful, and are attached, include:

- E/M Coding Based on the Elements:
  - E/M Progress Note Template: Based on the Elements
  - E/M Documentation Based on the Elements: Auditing Tool
  - E/M Services Guide: Coding by Key Components: AACAP
  - E/M Progress Note Examples: Office, Established Client: AACAP
- E/M Coding Based on Time (Counseling & Coordination of Care):
  - Instructions for E/M Progress Note Template: Counseling & Coordination of Care
  - E/M Progress Note Template: Counseling & Coordination of Care

If Providers base their selection of the E/M code on the items included in the templates (and document as such), their note will well support the code claimed.

Additional online training resources are listed on the QA Training web page. An introductory webinar to begin training on the selection of the E/M code based on the elements is found on the AACAP website: E/M Coding 2 (relevant to Child and Adolescent as well as Adult Psychiatric Medical Providers). The slides for this training are also attached.

There is one additional training designed to provide Quality Assurance Staff of Master Contract Providers with an overview of the CPT Code changes for 2013 (and will include selection of E/M codes based on both The Elements as well as on Counseling & Coordination of Care).

May 13, 2013
10:00 am – Noon
2000 Embarcadero Cove, Oakland
5th Floor, Gail Steele Room

Registration can be done online at: https://www.surveymonkey.com/s/CPT2013

BACK

Evaluation and Management Progress Note—Based on the Elements

Client Name:_____ **PSP#:**_____ **Date:**_____

EM Code:_____ **Face-to-Face EM Time:**_____ **Total Time:**_____

EM Code Psychotherapy Add-on:_____ **Face-to-Face Therapy Time:**_____

EM Code Interactivity Complexity Add-on (only with Psychotherapy add-on):_____

Two of three criteria for: (I-III) History, Exam and/or Medical Decision Making must be met. ***Score the key.***

I. HISTORY:

Hx of Present Illness (HPI): Past Medical, Family & Social Hx (PFSH), and Review of Systems (ROS)

Two of three: HPI or Status of Chronic Conditions, PFSH, and/or ROS must be completed.

Chief Complaint/Reason for Encounter (Required):

A. HPI. History of Present Illness:

Elements: Location, Quality, Severity, Duration, Timing, Context, Modifying Factors, & Associated Signs and Symptoms. If unable to gather from client or others, indicate and describe condition preventing collection.

One – three elements = Brief; Four or more elements = Extended.

OR Status of Chronic Conditions:

One – two conditions = Brief; Three or more conditions = Extended.

Describe HPI and/or Status of Chronic Conditions:

B. PFSH. Past Medical History, Family History & Social History:

Elements Completed: One element = Pertinent; Two elements for Established (Three for New Client) Client = Complete .

Past Medical History: ___Check if no change and see note dated ___/___/___ for detail.

Diagnoses: Medications:

Surgeries: Allergies:

Family History: ___Check if no change and see note dated ___/___/___ for detail.

Social History: ___Check if not change and see note dated ___/___/___ for detail.

Evaluation and Management Progress Note—Based on the Elements

C. Review of Systems & Active Medical Problems

# of systems completed: One = Problem Pertinent; Two – nine = Extended; Ten or > = Complete.

Systems:			Document Notes if Positive:
1. Constitutional	pos___	neg ___	
2. Eyes	pos___	neg ___	
3. Ears/Nose/Mouth/Throat	pos___	neg___	
4. Cardiovascular	pos___	neg___	
5. Respiratory	pos___	neg___	
6. Gastrointestinal	pos___	neg___	
7. Genitourinary	pos___	neg___	
8. Muscular	pos___	neg___	
9. Integumentary	pos___	neg___	
10. Neurological	pos___	neg___	
11. Endocrine	pos___	neg___	
12. Hemotologic/Lymphatic	pos___	neg___	
13. Allergies/Immune	Pos___	neg___	

TOTAL # OF SYSTEMS:_____

II. PSYCHIATRIC SPECIALITY EXAMINATION

Number of Bullets completed: 1-5 = Prob. Focused (PF); 6-8 = Expanded Prob. Focused (EPF); 9 = Detailed, all = Comprehensive.

--Vital Signs (any 3 or more of the 7 listed):
Blood Pressure: (Sitting/Standing) _____ (Supine) _____ Height_____ Weight_____

Temp_____ Pulse (Rate/Regularity) _____ Respiration _____

--General Appearance and Manner (E.g., Development, Nutrition, Body Habitus, Deformities, Attention to Grooming, etc.):

--Musculoskeletal: __Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) (note any atrophy or abnormal movements):

(and/or) __Examination of gait and station:

-- Speech: Check if normal: ___rate __volume __articulation __coherence __spontaneity

Abnormalities; e.g., perseveration, paucity of language:

--Thought processes: Check if normal: __associations __processes __abstraction __computation
Indicate abnormalities:

--Associations (e.g., loose, tangential, circumstantial, intact):

--Abnormal or psychotic thoughts (e.g., hallucinations, delusions, preoccupation with violence (V/I), homicidal (H/I), or suicidal ideation (S/I), obsessions):

S/I: __ Present__ Absent H/I: __Present __ Absent V/I: __Present __ Absent

--Judgment and insight:

--Orientation:

Evaluation and Management Progress Note—Based on the Elements

--Memory (Recent/Remote):
--Attention/Concentration:
--Language:
-- Fund of knowledge: __intact __inadequate
--Mood and affect: **TOTAL BULLETS:_____**
Other Findings—*not a countable bullet* (e.g. cognitive screens, personality, etc.):

III. **MEDICAL DECISION MAKING**

Two of three criteria must be met: Data; Diagnosis/Problems; Risk

A. **Data Reviewed:**	Points:	Description:
___ Review and/or order of clinical lab tests	1 POINT	**DESCRIBE:**
___Review and/or order of tests in the radiology section of CPT	1 POINT	**DESCRIBE:**
___Review and/or order of tests in the medicine section of CPT	1 POINT	**DESCRIBE:**
___Discussion of test results with performing provider	1 POINT	**DESCRIBE:**
___Decision to obtain old records and/or obtain history from someone other than client	1 POINT	**DESCRIBE:**
___Review and summarization of old records and/or obtaining history from someone other than client and/or discussion of case with another health care provider	2 POINT	**DESCRIBE:**
___Independent visualization of image, tracing, or specimen itself (not simply review report)	2 POINT	**DESCRIBE:**

DATA TOTAL POINTS: _____

Evaluation and Management Progress Note—Based on the Elements

B. Diagnosis/Problem

Indicate Status and points for each:
-Self-limiting or minor (stable, improved, or worsening) (1 point: max=2 Dx/Problem)
-Established problem (to examining provider); stable or improved (1 point)
-Established problem (to examining provider); worsening (2 point)
-New problem (to examining provider); no additional workup or diagnostic procedures ordered (3 point: max=1 Dx/Problem)
-New problem (to examining provider); additional workup planned*(4 point)
*Additional workup does not include referring client to another provider for future care

Axis I-V: Status: Points___ Plan (RX, Lab, etc.):	Axis I-V: Status: Points___ Plan (RX, Lab, etc.):
Axis I-V: Status: Points___ Plan (RX, Lab, etc.):	Axis I-V: Status: Points___ Plan (RX, Lab, etc.):
Axis I-V: Status: Points___ Plan (RX, Lab, etc.):	Axis I-V: Status: Points___ Plan (RX, Lab, etc.):

DIAG/PROBLEMS TOTAL POINTS: _____

C. Risk

Minimal -One self-limited or minor problem.
Low - Two or more self-limited or minor problems; One stable chronic illness; Acute uncomplicated.
Moderate -One or > chronic illnesses with mild exacerbation, progression, or side effects; Two or more stable chronic illnesses or Undiagnosed new problem with uncertain prognosis; Acute illness with systemic symptoms
High - One or more chronic illnesses with severe exacerbation, progression, or side effects; Acute or chronic illnesses that pose a threat to life or bodily function

Indicate Highest Risk Level and Describe:

Psychotherapy Add-on: ___ Supportive, ___ CBT, ___Behavior-modifying, ___Psychoeducational
Describe:

_____ _____
Medical Provider's Name (Print) Signature Date

USE ALTERNATE FORM IF COUNSELING/COORDINATION IS > 50% OF TIME.

BACK

Evaluation and Management Progress Note—Based on the Elements

SCORING KEY

(Circle all results from Progress Notes)

I. History: (Choose two highest circled to determine History Type)

CC	HPI	PFSH	ROS	HISTORY TYPE
YES	BRIEF	N/A	N/A	PF
YES	BRIEF	N/A	PROBLEM PERTINENT	EPF
YES	EXTENDED	PERTINENT	EXTENDED	DET
YES	EXTENDED	COMPLETE	COMPLETE	COMPREHENSIVE

II. Psychiatric Exam: (Select one)

PF	EPF	COMPLETE

III. Medical Decision Making (Select two highest circled to determine MDM Complexity)

Data Points	Dx/Prob Points	Risk	Complexity
0 - 1	0 - 1	Minimal	Straightforward
2	2	Low	Low
3	3	Moderate	Moderate
4	4	High	High

RESULTS: CPT CODES

(Select two highest circled to determine CPT Code)

New Client Office (requires 3 of 3)				Established Client Office (requires 2 of 3)			
CPT Code	History	Exam	MDM	CPT Code	History	Exam	MDM
99201	PF	PF	Straightforward	99211	N/A	N/A	N/A
99202	EPF	EPF	Straightforward	99212	PF	PF	Straightforward
99203	DET	DET	Low	99213	EPF	EPF	Low
99204	COMP	COMP	Moderate	99214	DET	DET	Moderate
99205	COMP	COMP	High	99215	COMP	COMP	High
Initial Hospital/PHP (requires 3 of 3)				**Subsequent Hospital/PHP (requires 2 of 3)**			
CPT Code	History	Exam	MDM	CPT Code	History	Exam	MDM
99221	DET	DET	Straightforward	99231	PF	PF	Straightforward
99222	COMP	COMP	Moderate	99232	EPF	EPF	Moderate

BACK

E/M Documentation Auditor's Instructions

Client: E/M Code: Time: Date of Service:

1. History

Refer to data section (table below) in order to quantify. After referring to data, circle the entry farthest to the *RIGHT* in the table, which best describes the HPI, ROS and PFSH. If one column contains three circles, draw a line down that column to the bottom row to identify the type of history. If no column contains three circles, the column containing a circle farthest to the *LEFT*, identifies the type of history.

After completing this table which classifies the history, circle the type of history within the appropriate grid in Section 5.

HISTORY					
	HPI: Status of chronic conditions: ☐ 1 condition ☐ 2 conditions ☐ 3 conditions **OR**		Status of 1-2 chronic conditions		Status of 3 chronic conditions
	HPI (history of present illness) elements: ☐ Location (WHERE) ☐ Severity (1-10) ☐ Timing WHEN//OFTEN ☐ Modifying factors (WHAT WORSENS/LESSENS) ☐ Quality (DESCRIBE) ☐ Duration (ONSET TO) ☐ Context WJATWJEM ☐ Associated signs and symptoms (ELSE)		Brief (1-3)		*Complete Extended (4 or more)
	ROS (review of systems): ☐ Constitutional (wt loss, etc) ☐ Eyes ☐ Ears, nose, mouth, throat ☐ Card/vasc ☐ Resp ☐ GI ☐ GU ☐ Musculo ☐ Integumentary (skin, breast) ☐ Neuro ☐ Psych ☐ Endo ☐ Hem/lymph ☐ Alrgy/immuno ☐ All others negative	None	Pertinent to problem (1 system)	Extended (2-9 systems)	**Complete
	PFSH (past medical, family, social history) areas: ☐ Past history (the patient's past experiences with illnesses, operation, injuries and treatments) ☐ Family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk) ☐ Social history (an age appropriate review of past and current activities)		None	Pertinent 1 history area)	***Complete (2 or 3 history areas)
		PROBLEM FOCUSED	**EXP.PROB. FOCUSED**	**DETAILED**	**COMPRE-HENSIVE**

***Complete Hx** Allow if unable to obtain & describe condition preventing.

****Complete ROS** 10 or more, or some systems with statement "all others neg."

*****Complete PFSH** 2 history areas: a) Established patients - office (outpatient) care; b) Emergency department.

3 history areas: a) New patients - office (outpatient) care, domiciliary care, home care; b) Consultations; c) Initial hospital care; d) Hospital observation; e) Initial Nursing Facility Care.

NOTE: Subsequent Hospital & Subsequent Nursing Facility Care E/M services require only an interval history, it is not necessary to record information about the PFSH. Refer to procedure code descriptions.

2. Examination

Refer to data section (table below) in order to quantify. After referring to data, identify the type of examination.
Circle the type of examination within the appropriate grid in Section 5.

EXAM	SYSTEM/BODY AREA
• 3/7 vital signs: sitting or standing BP, supine BP, pulse rate and regularity, respiration, temperature, height, weight • General appearance	**Constitutional**
• Muscle strength and tone • Gait and Station	**Musculoskeletal**
• Speech • Thought process • Associations • Abnormal/psychotic thoughts • Judgment and insight • Orientation • Recent and remote memory • Attention and concentration • Language • Fund of knowledge • Mood and affect	**Psychiatric**
1 – 5 bullets	*PROBLEM FOCUSED EXAM*
At least 6 bullets	*EXPAND PROB FOCS'D EXAM*
At least 9 bullets	*DETAILED EXAM*
All bullets in Constitutional and Psychiatric boxes and 1 bullet in Musculoskeletal box.	*COMPREHENSIVE EXAM*

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3. Medical Decision Making

MEDICAL DECISION MAKI

Number of Diagnoses or Treatment Options

Identify each problem or treatment option mentioned in the record. Enter the number in each of the categories in Column B in the table below. (There are maximum number in two categories.) Do not categorize the problem(s) if the encounter is dominated by counseling/coordinating of care, and duration of time is not specified. In that case, enter 3 in the total box.

Number of Diagnoses or Treatment Options

A	B	X C	= D
Problem(s) Status	**Number**	**Points**	**Result**
Self-limited or minor (stable, improved or worsening)	*Max = 2*	1	
Est. problem (to examiner); stable, improved		1	
Est. problem (to examiner); worsening		2	
New problem (to examiner); no additional workup planned	*Max = 1*	3	
New prob. (to examiner); add. workup planned		4	
		TOTAL	

Multiply the number in columns B & C and put the product in column D. Enter a total for column D.

Bring total to **line A** in Final Result for Complexity (table below)

Amount and/or Complexity of Data Reviewed

For each category of reviewed data identified, circle the number in the points column. Total the points.

Amount and/or Complexity of Data Reviewed

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

Bring total to **line C** in Final Result for Complexity (table below)

Risk of Complications and/or Morbidity or Mortality

Use the risk table below as a guide to assign risk factors. It is understood that the table below does not contain all specific instances of medical care; the table is intended to be used as a guide. Circle the most appropriate factor(s) in each category. The overall measure of risk is the highest level circled. Enter the level of risk identified in Final Result for Complexity (table below).

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	• One self-limited or minor problem	• Laboratory tests requiring venipuncture • EKG/EEG • Urinalysis	• Rest
Low	• Two or more self-limited or minor problems • One stable chronic illness • Acute uncomplicated illness		• Over-the-counter drugs
Moderate	• One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis, • Acute illness with systemic symptoms		• Prescription drug management
High	• One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment • Acute or chronic illnesses or injuries that may pose a threat to life or bodily function (self//other)		• Drug therapy requiring intensive monitoring for toxicity

Final Result for Complexity

Draw a line down any column with 2 or 3 circles to identify the type of decision making in that column. Otherwise, draw a line down the column with the 2nd circle from the left. After completing this table, which classifies complexity, circle the type of decision making within the appropriate grid in Section 5.

Final Result for Complexity

A	Number diagnoses or treatment options	≤ 1 Minimal	2 Limited	3 Multiple	≥ 4 Extensive
B	Highest Risk	Minimal	Low	Moderate	High
C	Amount and complexity of data	≤ 1 Minimal or low	2 Limited	3 Multiple	≥ 4 Extensive
Type of decision making		**STRAIGHT-FORWARD**	**LOW COMPLEX.**	**MODERATE COMPLEX.**	**HIGH COMPLEX.**

4. Time

If the physician documents total time *and* suggests that counseling or coordinating care dominates (more than 50%) the encounter, time may determine level of service. Documentation may refer to: prognosis, differential diagnosis, risks, benefits of treatment, instructions, compliance, risk reduction or discussion with another health care provider.

Does documentation reveal total time? Time: Face-to-face in outpatient setting / Unit/floor in inpatient setting	☐ Yes ☐ No
Does documentation describe the content of counseling or coordinating care?	☐ Yes ☐ No
Does documentation reveal that more than half of the time was counseling or coordinating care?	☐ Yes ☐ No

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

5. LEVEL OF SERVICE

	New Office (Requires 3 components within shaded area)					Established Office (Requires 2 components within shaded area)				
History	P	EPF	D	C	C	*Minimal problem*	**PF**	**EPF**	**D**	**C**
Examination	P	EPF	D	C	C	*that may not require*	**PF**	**EPF**	**D**	**C**
Complexity	S	SF	L	M	H	*physician*	**SF**	**L**	**M**	**H**
Time Code	**10” 99201**	**20” 99202**	**30” 99203**	**45” 99204**	**60” 99205**	**5” 99211**	**10” 99212**	**15” 99213**	**25” 99214**	**40” 99215**

BACK

Evaluation and Management Services Guide

Coding by Key Components

American Academy of Child & Adolescent Psychiatry
www.aacap.org

History

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

CC	HPI	PFSH	ROS	History Type
Yes	*Brief* (1-3 elements or 1-2 chronic conditions)	N/A	N/A	*Problem focused* (PF)
			Problem pertinent (1 system)	*Expanded problem focused* (EPF)
	Extended (4 elements or 3 chronic conditions)	*Pertinent* (1 element)	*Extended* (2-9 systems)	*Detailed* (DET)
		Complete (2 elements (est) or 3 elements (new/initial))	*Complete* (10-14 systems)	*Comprehensive* (COMP)

Examination

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

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

Med Dec Making

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

Problem Points

Category of Problems/Major New symptoms	Points per problem
Self-limiting or minor (stable, improved, or worsening) (max=2)	1
Established problem (to examining physician); stable or improved	1
Established problem (to examining physician); worsening	2
New problem (to examining physician); no additional workup or diagnostic procedures ordered (max=1)	3
New problem (to examining physician); additional workup planned*	4

*Additional workup does not include referring patient to another physician for future care

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Evaluation and Management Services Guide

Coding by Key Components

American Academy of Child & Adolescent Psychiatry
www.aacap.org

Medical Decision Making

Data Points

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

Table of Risk

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

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

CPT Codes

New Patient Office
(requires 3 of 3)

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

Established Patient Office
(requires 2 of 3)

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

Initial Hospital/PHP
(requires 3 of 3)

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

Subsequent Hospital/PHP
(requires 2 of 3)

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

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Evaluation and Management (E/M) Patient Examples
Office, Established Patient

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

IMPORTANT

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

SERVICES SHOULD ALWAYS BE MEDICALLY NECESSARY.

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

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Evaluation and Management (E/M) Patient Examples

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

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Evaluation and Management (E/M) Patient Examples

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

HOW TO USE THE TEMPLATES FOR PROGRESS NOTES FOR E/M CODES FOR COUNSELING AND/OR COORDINATION OF CARE

Each template includes the essential documentation required to be included in an inpatient and outpatient progress note when providing an E/M service when the primary service (more than 50% of the service time as defined below) involves counseling and/or coordination of care.

Please note that E/M codes and these templates should never be used when psychotherapy is provided. When psychotherapy is provided, the 908xx psychotherapy codes must be used.

When billing for an E/M service based upon counseling and/or coordination of care, it is imperative that the counseling and/or coordination of care be documented as follows:

- The actual duration of the service time must be included in the progress note. The templates include a specific section to enter the total time.
- For outpatient visits, only face to face time with the patient providing counseling and/or coordination of care constitutes the service time.
- For inpatient visits, the service time includes both face to face patient time and floor time providing counseling and/or coordination of care.
- In addition, a statement must be included in the progress note that: "Greater than 50% of patient face to time spent providing counseling and/or coordination of care" (for outpatient services) or "Greater than 50% of patient time and floor time spent providing counseling and/or coordination of care" (for inpatient services).
- The templates include a statement to be checked off confirming compliance with this requirement.
- The templates also include a place to insert the CPT code selected for the service provided.

The elements of the templates include:

Interval History: Include documentation of new history since last visit.

Interval Psychiatric Assessment/Mental Status Examination: Update mental status of patient and psychiatric assessment

Current Diagnosis: Note the current diagnoses.

Diagnosis Update: Note any changes in diagnosis after visit.

Current Medication(s)/Medication Update: Update medication and note any changes. A box is included to permit a check off to indicate that no side affects or adverse reactions were noted by the psychiatrist or reported by the patient. If there are side affects or adverse reactions noted or reported, include documentation.

Counseling Provided: Circle whether counseling was provided to patient, family and/or caregivers. Check off one or more focuses of counseling and include specific documentation of counseling topics that were checked off.

Coordination of Care Provided: Check off one or more individuals with whom coordination of care was provided and then include documentation of specific coordination of care activities checked off.

Duration: Insert total session time in minutes. Remember that for outpatient services, only face to face time with the patient may be counted for the total session time, but for inpatient services, the session time include both face to face time with the patient and floor time providing counseling and/or coordination of care.

CPT Code: Insert CPT code selected for service provided.

Greater than 50%: Check off when counseling and/or coordination of care exceeded 50% of total session time: patient face to face time for outpatient services and floor time plus patient face to face time for inpatient services) involves counseling and/or coordination of care.

Justification for Continued Stay: This section is only included in the inpatient note and is intended to comply with the requirements of the NYS Medicaid Program to document medical necessity for continued inpatient psychiatric hospitalization. Check off the appropriate justification/s for the continued stay and include specific documentation in the progress note (use the **Additional Documentation** section) for the justification/s selected. (NYSPA extends appreciation to Barry Perlman, M.D., St. Joseph's Hospital, Yonkers, New York, for this element of the inpatient progress note template.)

Prepared by: Seth P. Stein, Esq., NYSPA Executive Director and General Counsel

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OUTPATIENT/OFFICE PSYCHIATRIC PROGRESS NOTE
COUNSELING AND/OR COORDINATION OF CARE

Patient's Name: _____ **Date of Visit:** _____

Interval History: _____

Interval Psychiatric Assessment/ Mental Status Examination:

Current Diagnosis: _____

Diagnosis Update: _____

Current Medication(s)/Medication Change(s) – No side effects or adverse reactions noted or reported ☐

Lab Tests: Ordered ☐ Reviewed ☐ : _____

Counseling Provided with Patient / Family / Caregiver (circle as appropriate and check off each counseling topic discussed and describe below:

☐ Diagnostic results/impressions and/or recommended studies

☐ Risks and benefits of treatment options

☐ Instruction for management/treatment and/or follow-up options

☐ Importance of compliance with chosen treatment

☐ Risk Factor Reduction

☐ Patient/Family/Caregiver Education

☐ Prognosis

Coordination of care provided (with patient present) with (check off as appropriate and describe below):

Coordination with: ☐ Nursing ☐ Residential Staff ☐ Social Work ☐ Physician/s ☐ Family ☐ Caregiver

Additional Documentation (if needed): _____

Duration of face to face visit w/patient : _____ min. **Start Time** _____ **Stop Time** _____ **CPT** _____

Greater than 50% of face to face time spent providing counseling and/or coordination of care: ☐

Psychiatrist's Signature: _____ **Date:** _____

QA TRAINING PAGE exert:

CPT and Procedure Code: http://www.acbhcs.org/providers/QA/Training.htm

Training Resources: CPT Code Changes for 2013
In response to the InSyst Procedure Code changes, that accommodate the federal CPT code changes, the Quality Assurance Office is hosting trainings for all Master Contract Providers (CBOs). For more information please see the training announcement and/or to register go to or click https://www.surveymonkey.com/s/CPT2013. For questions, please contact QAOffice@acbhcs.org.

Overview:

1. Major Changes to CPT Codes for Psychiatry and Psychotherapy in 2013: National Council
2. CPT Code Changes for 2013 FAQ: National Council
3. Interactive Complexity: AACAP

ACBHCS:
1. Power Point: CPT Code Training: From the Old to the New, ACBHCS
2. CPT Code 1/1/13 Changes FAQ
3. Master InSyst Procedure Code Table-Effective 1/1/13
4. InSyst and CPT Code Crosswalk for CPT Code Changes
5. Clinician's Gateway: CPT Codes 2013: Add-on Codes and Time
6. ACBHCS Guidelines for Scope of Practice Credentialing to Provide Specialty MH Services
7. ACBHCS Procedure Code Time Periods: Non-Medical Provider
8. ACBHCS Procedure Code Time Periods: Medical Provider

Evaluation and Management Codes:
Templates:
1. E/M Progress Note Template: Based on the Elements
   a. E/M Documentation Based on the Elements: Auditing Tool
2. Instructions for E/M Progress Note Template: Counseling & Coordination of Care
   a. E/M Progress Note Template: Counseling & Coordination of Care

Other:
1. E/M Services Guide: Coding by Key Components: AACAP
2. E/M Progress Note Examples: Office, Established Client: AACAP
3. E/M and Psychotherapy Coding Algorithm: AACAP

Online Training Resources:
The National Council Resource Page
AACAP CPT & Reimbursement Page
1997 Documentation Guidelines for Evaluation and Management Service
The American Psychiatric Association CPT Resource Page
The AMA CPT Resource Page