Evaluation and Management (E/M) Codes and Psychotherapy: Documenting Your Work

Overview: Patients with psychiatric diagnoses may receive a medical E/M service on the same day as a psychotherapy service by the same physician or other qualified health care professional (QHP). You may report these services with an appropriate E/M code and an add-on code specifically for psychotherapy when performed with an E/M service (90833, 90836, 90838). Standalone psychotherapy codes (90832, 90834, 90837) should not be used in conjunction with an E/M service.

Per CPT guidelines, "To report both E/M and psychotherapy, the two services must be significant and separately identifiable." The medical and psychotherapeutic components of the service should be separately identified within the progress note (within the same progress note is acceptable) and should include the following information.

ONE EXAMPLE - NEW PATIENT
E/M PLUS PSYCHOTHERAPY PROGRESS NOTE

Patient Identifier: _____
Date: _____
Diagnosis: _____

E/M:
History: _____
Examination: _____
Medical decision making: _____

Psychotherapy:
Time spent on psychotherapy services only: _____
[Include description of type & content of psychotherapy provided]
List additional attendees, if any: _____
Legible Signature of Practitioner, Degree, Licensure:
_____

Documentation of E/M services:

Effective Jan. 1, 2023, hospital observation care codes (99217–99220, 99224–99226) are deleted, and code descriptors for hospital inpatient care codes (99221–99223, 99231–99233, 99238–99239) are revised to include inpatient or observation E/M services. Guidelines for hospital and other E/M services are now aligned with office or other outpatient E/M services (99202–99205, 99212–99215) to allow these codes to be selected based on the *total time* for E/M services on the date of the encounter or on the *level of medical decision making (MDM)* defined for each service. A medically appropriate history and physical examination, as determined by the treating provider, is included in the code descriptors, however, the level of history and exam are no longer used to determine the level of E/M service.

Note: Per CPT guidelines, E/M services that are billed with a psychotherapy add-on code (90833, 90836, 90838) cannot be billed by time and must be based on MDM components.

- **Total time** includes *face-to-face and non-face-to-face time* personally spent by the physician or other QHP on the date of the encounter. Code descriptors specify the time that must be met or exceeded. **Effective Jan. 1, 2024,** office or other outpatient E/M code descriptors specify a single time to meet/exceed instead of a time range for the encounter.
  - Includes time for activities such as preparing to see the patient, obtaining a history, performing an exam, providing counseling or education, preparing orders, independently interpreting tests or coordinating care (if not separately reported) and documenting the health record
  - Excludes time for activities performed by clinical staff, time spent performing separately reportable procedures, travel time or general teaching time

- **MDM elements:** The four levels of MDM include straightforward, low, moderate, or high complexity. To qualify for a given level of decision-making, two of three MDM elements must be met or exceeded.

1. Number and complexity of problem(s) that are addressed during the encounter
- A problem is considered to be addressed or managed when it is evaluated or treated at the encounter by the physician reporting the service

2. Amount and/or complexity of data to be reviewed and analyzed
- Data include medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter (excluding interpretations that are separately reported)

3. Risk of complications and/or morbidity or mortality of patient management
- Risk is described as the probability and/or consequences of an event. For the purposes of MDM, the level of risk is based on 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.

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Prior to Jan.1, 2021 for office E/M services and Jan. 1, 2023 for hospital/other E/M services, the level of service is based on three key components (history, exam and MDM) with time *only* used for selection if counseling and/or coordination of care dominate the visit. For more details on time or MDM, including definitions and examples, refer to the CPT® E/M Services Guidelines appropriate for your date of service.

Documentation of psychotherapy services:

Per CPT®, the appropriate psychotherapy add-on code is selected based on the **face-to-face time** of the psychotherapeutic intervention. The code closest to the actual time of the service provided should be reported. Do *not* include any of the time devoted to the E/M service (i.e., time spent on history, examination, or MDM). The chart below shows the time listed in the code descriptors and the ranges included in the guidelines. Note: Less than 16 minutes of psychotherapy is not reported. The individual patient must be present for all or a majority of the service, but informants may be included.

Time-based Add-on Codes for Psychotherapy Performed with an E/M Service		
90833 - 30 minutes with patient (16-37 minutes)	**90836** - 45 minutes with patient (38-52 minutes)	**90838** - 60 minutes with patient (53 or more minutes)

Documentation must support that the add-on psychotherapy service is provided in *addition* to the E/M service (significant and separately identifiable). A separate diagnosis is *not* required to report the E/M and psychotherapy service on the same date. Document the **time** spent providing face-to-face psychotherapy, a description of the type and content of the psychotherapy provided, and any additional attendees.

The Optum Behavioral Health Services Documentation Requirements Reimbursement Policy specifies the following documentation guidelines for individual psychotherapy:

1. The medical record should be complete and legible
2. The documentation of each patient encounter should include:
   - First and last name of the member
   - Date of service
   - Legible identity of the provider with credentials
   - Start and stop times or total time of session for time-based codes
   - Therapy intervention techniques indicated
   - Patients progress, response to treatment indicated
3. Changes in treatment and revision of diagnosis, if applicable (clinical consideration only)
4. A treatment plan is required, with measurable goals and objectives, that is updated as clinically indicated

See the policy for more details, including documentation guidelines for group/family therapy and psychiatric diagnostic evaluations.

Resources:

This overview and reminder of E/M coding guidelines is provided to help support continued improvements. Please review these additional resources for more details:

- **Optum Reimbursement Policies:** Behavioral Health Services Documentation Req. Reimbursement Policy
- **American Psychiatric Association (APA):** CPT® Coding and Reimbursement
- **American Medical Association (AMA):** CPT® Evaluation and Management and CPT® Manual > Evaluation and Management (E/M) Guidelines
- **Centers for Medicare & Medicaid Services (CMS):** Internet-Only Manual (IOM) 100-04, Ch. 12, Sect. 30.6, Evaluation and Management Services Guide, 1995 Documentation Guidelines and 1997 Documentation Guidelines

For a brief overview of coding for office or hospital E/M services, please see our additional Training and Education Materials located at: Fraud, Waste, Abuse, Error and Payment Integrity.