American Academy of Pediatrics
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# Depression Coding Fact Sheet for Primary Care Clinicians

## Current Procedural Terminology (CPT®) Codes

Initial assessment usually involves a lot of time determining the differential diagnosis, a diagnostic plan, and potential treatment options. Therefore, most pediatricians will report either an office/outpatient evaluation and management (E/M) code using time as the key factor or a consultation code for the initial assessment:

### Physician Evaluation & Management Services

★**99202** Office or other outpatient visit, *new* patient; straightforward medical decision making (MDM), 15-29 min.
★**99203** low MDM, 30-44 min.
★**99204** moderate MDM, 45-59 min.
★**99205** high MDM, 60-74 min.

*A new patient is one who has not received any professional services face-to-face services rendered by physicians and other qualified health care professionals (QHP) who may report evaluation and management services reported by a specific CPT code(s) from the physician/QHP or another physician/QHP of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.*

★**99211** Office or other outpatient visit, *established* patient; minimal problem, 5 min.
★**99212** straightforward MDM, 10-19 min.
★**99213** low MDM, 20-29 min.
★**99214** moderate MDM, 30-39 min.
★**99215** high MDM, 40-54 min.

★+**99417** Prolonged physician services in office or other outpatient setting, with direct patient contact; first hour (*use in conjunction with codes **99205, 99215** only*)

- Used only with the highest level E/M services (99205, 99215)
- Time spent does not have to be continuous but must occur on the same day as the face-to-face encounter
- Prolonged service begins at 75 minutes for new patients (99205 and 99417) and 55 minutes for established patients (99215 and 99417)
- Prolonged time can include non-direct services on the same day as the encounter

## Reporting E/M services using "Time" vs MDM

- A physician will report their level of E/M service using time **or** MDM
- If reporting based on "time" count all time on the encounter date, including pre- and post service time spent on that patient, even if the patient is not present
- You do not have to meet "time" requirements in the code descriptor to meet a code level if billing based on MDM

**Example**: A physician sees an established patient in the office to discuss the progress being made on the anti-depressive medication and using anxiety/depression support apps. The patient's chronic medical condition is not stable and is being managed by medication (moderate level MDM). The total face-to-face time was 35 minutes, with an additional 10 minutes of documented time after the patient left. The physician would report a **99215** instead of a 99214 because the total time met the criteria for the 99215 (25 mins) which was higher than the MDM level (moderate) for the 99214.

+ Designated *add-on* codes, report them separately in addition to the appropriate primary code for the service provided

★**99241** Office or other outpatient *consultation*, new or established patient; self-limited or minor problem, 15 min.
★**99242** low severity problem, 30 min.
★**99243** moderate severity problem, 45 min.
★**99244** moderate to high severity problem, 60 min.
★**99245** moderate to high severity problem, 80 min.

NOTE: Use of these codes (**99241-99245**) requires the following:
1) Written or verbal request for consultation is documented in the patient chart.
2) Consultant's opinion as well as any services ordered or performed are documented in the patient chart.
3) Consultant's opinion and any services that are performed are prepared in a written report, which is sent to the requesting physician or other appropriate source *(Note:* Patients/parents may not initiate a consultation).
For more information on 2010 consultation code changes see www.aap.org/en-us/professional-resources/practice-support/financing-and-payment/Documents/Private/AAP_Position_Medicare_Consultation_Policy.pdf Member log-in required.

[a]Time may be used as the key or controlling factor when greater than 50% of the total physician face-to-face time is spent in counseling and/or coordination of care
[c]*A new patient is one who has not received any professional services face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services reported by a specific CPT code(s) from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.*

★+**99354** Prolonged services in office or other outpatient setting, with direct patient contact; first hour (*use in conjunction with time-based codes 99241-99245, 99324-99337, 99341-99350, 90837*)
★+**99355** each additional 30 min. (*use in conjunction with 99354*)

- Used when a physician provides prolonged services beyond the usual service (ie, beyond the typical time).
- Time spent does not have to be continuous.
- Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.
- For clinical staff prolonged services, see **99415-99416**.

## [B] Physician Non-Face-to-Face Services

### Principal Care Management

1. A single (1) chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death
2. A condition that requires development, monitoring, or revision of disease-specific care plan,
3. A condition that requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities
4. Ongoing communication and care coordination between relevant practitioners furnishing care may be reported by different physicians or QHPs in the same calendar month for the same patient
5. Documentation in the patient's medical record should reflect coordination among relevant managing clinicians
6. Principal care management services are disease-specific management services. Even if a patient may have multiple chronic conditions they may receive principal care management if the reporting physician or other QHP is providing single disease rather than comprehensive care management

**99424** Principal care management services, for a single high-risk disease, with the following required elements:
- one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death,
- the condition requires development, monitoring, or revision of disease-specific care plan,
- the condition requires frequent adjustments in the medication regimen and/or the management of

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+ Designated *add-on* codes, report them separately in addition to the appropriate primary code for the service provided

the condition is unusually complex due to comorbidities,

- ongoing communication and care coordination between relevant practitioners furnishing care;

first 30 minutes provided personally by a physician or other QHP, per calendar month.

+ **99425** each additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month (List separately in addition to 99424)

### Chronic Care Management

Codes are selected based on the amount of time spent by the physician or qualified health care professional providing care coordination activities. CPT clearly defines what is defined as care coordination activities. In order to report chronic care or complex chronic care management codes, you must

1. provide 24/7 access to physicians or other qualified health care professionals or clinical staff
2. use a standardized methodology to identify patients who require chronic complex care coordination services
3. have an internal care coordination process/function whereby a patient identified as meeting the requirements for these services starts receiving them in a timely manner
4. use a form and format in the medical record that is standardized within the practice
5. be able to engage and educate patients and caregivers as well as coordinate care among all service professionals, as appropriate for each patient.

**99491** Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements:

- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
- Chronic conditions place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline;
- Comprehensive care plan established, implemented, revised, or monitored.

(For time spent by the physician directing clinical staff, refer to codes **99490, 99487, 99489** below)

## Online Digital Evaluation and Management Service

These are patient-initiated services with physicians or other qualified health care professionals (QHPs) who are allowed to report E/M services. Online digital E/M services require physician or other QHP's evaluation, assessment, and management of the patient and are not for the nonevaluative electronic communication of test results, scheduling of appointments, or other communication that does not include E/M. These are more appropriate when dealing with a more minor issue or during a month when you are not coding or providing more robust care thus this time would be reported under another service like care management.

- Patient must be established (problem can be new)
- Services must be initiated through Health Insurance Portability and Accountability Act (HIPAA)-compliant secure platforms
- Reported once for the physician's or other QHP's (including all in the same group practice) cumulative time during a seven-day period
- The seven-day period begins with the physician's or other QHP's initial, personal review of the patient-generated inquiry.
- Online digital E/M services require permanent documentation storage (electronic or hard copy) of the encounter.

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+ Designated *add-on* codes, report them separately in addition to the appropriate primary code for the service provided

- Do not report these codes separately if the patient is seen within 7 days of the service for an issue related to the encounter.
- Your *date of service* will be the date the initiation of the e-visit began or the range of dates it took place because this service is cumulative time over 7 days.

**99421** Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
**99422** 11-20 minutes
**99423** 21 or more minutes

### Telephone Care Services

Telephone care must be initiated by the parent, patient or the guardian. The telephone call cannot be related to an E/M service within the previous 7 days nor can they lead to an appointment within the next 24 hours or soonest available. This is not telehealth or telemedicine. Your *date of service* will be date the phone call takes place.

**99441** Telephone evaluation and management to patient, parent or guardian not originating from a related E/M service within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
**99442** 11-20 minutes of medical discussion
**99443** 21-30 minutes of medical discussion

### Medical Team Conference

**99367** Medical team conference by physician with interdisciplinary team of healthcare professionals, patient and/or family not present, 30 minutes or more

### Prolonged Services

**99358** Prolonged services without direct patient contact; first hour

**+99359** each additional 30 min. (+ designated add-on code, use in conjunction with 99358)

### Care Plan Oversight

**99339** Care Plan Oversight - Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (e.g., assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (e.g., legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes
**99340** 30 minutes or more

## [B]Physician-Directed Non–Face-to-Face Services

Behavioral health integration care management, chronic care management, psychiatric collaborative care management services and transition care management are reported under the directing physician or other qualified health care professional, however, the time requirement can be met by clinical staff working under the direction of the reporting physician or other qualified health care professional. See each code set for details.

### Behavioral Health Integration Care Management

**99484** Care management services for behavioral health conditions, at least 20 minutes of clinical staff time,

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+ Designated *add-on* codes, report them separately in addition to the appropriate primary code for the service provided

directed by a physician or other qualified health care professional, per calendar month, with the following required elements:

- initial assessment or follow-up monitoring, including the use of applicable validated rating scales;
- behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
- facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and
- continuity of care with a designated member of the care team.

Tips:

- Reported by the supervising physician or other qualified health care professional.
- The assessment and treatment plan is not required to be comprehensive and the office/practice is not required to have all the functions of chronic care management (99487, 99489, 99490).
- May be used in any outpatient setting, as long as the reporting professional has an ongoing relationship with the patient and clinical staff and as long as the clinical staff is available for face-to-face services with the patient.
- Behavioral integration care management (99484) and chronic care management services may be reported by the same professional in the same month, as long as distinct care management services are performed.

### Principal Care Management

**99426** Principal care management services, for a single high-risk disease, with the following required elements:

- one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death,
- the condition requires development, monitoring, or revision of disease-specific care plan,
- the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities,
- ongoing communication and care coordination between relevant practitioners furnishing care;

first 30 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month.

+ **99427** each additional 30 minutes of clinical staff time directed by a physician or other QHP, per calendar month

(List separately in addition to code **99426**)

### Psychiatric Collaborative Care Management Services

**99492** Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements:

- outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional;
- initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan;
- review by the psychiatric consultant with modifications of the plan if recommended;
- entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and
- provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.

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+ Designated *add-on* codes, report them separately in addition to the appropriate primary code for the service provided

**99493** Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements:

- tracking patient follow-up and progress using the registry, with appropriate documentation;
- participation in weekly caseload consultation with the psychiatric consultant;
- ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers;
- additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant;
- provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies;
- monitoring of patient outcomes using validated rating scales; and
- relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.

**+ 99494** Initial or subsequent psychiatric collaborative care management**,** each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (List separately in addition to code for primary procedure)

## Care Management Services:

Codes are selected based on the amount of time spent by clinical staff providing care coordination activities. CPT clearly defines what is defined as care coordination activities. In order to report chronic care or complex chronic care management codes, you must

1. provide 24/7 access to physicians or other qualified health care professionals or clinical staff;
2. use a standardized methodology to identify patients who require chronic complex care coordination services
3. have an internal care coordination process/function whereby a patient identified as meeting the requirements for these services starts receiving them in a timely manner
4. use a form and format in the medical record that is standardized within the practice
5. be able to engage and educate patients and caregivers as well as coordinate care among all service professionals, as appropriate for each patient.

**99490** Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:

- multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
- chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
- comprehensive care plan established, implemented, revised, or monitored.

Do not report 99490 for chronic care management services that do not take a minimum of 20 minutes in a calendar month.

**99487** Complex chronic care management services;

- multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
- chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
- establishment or substantial revision of a comprehensive care plan;
- moderate or high complexity medical decision making;

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+ Designated *add-on* codes, report them separately in addition to the appropriate primary code for the service provided

- 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.

Do not report 99487 for chronic care management services that do not take a minimum of 60 minutes in a calendar month.

**+99489** each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

Complex chronic care management is reported by the physician or qualified health care professional who provides or oversees the management and coordination of all of the medical, psychosocial, and daily living needs of a patient with a chronic medical condition. Typical pediatric patients

1. receive three or more therapeutic interventions (eg, medications, nutritional support, respiratory therapy)

2. have two or more chronic continuous or episodic health conditions expected to last at least 12 months (or until death of the patient) and places the patient at significant risk of death, acute exacerbation or decompensation, or functional decline

3. commonly require the coordination of a number of specialties and services.

## Transition Care Management

★**99495** Transitional care management (TCM) services with the following required elements:
- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Medical decision-making of at least moderate complexity during the service period
- Face-to-face visit, within 14 calendar days of discharge

★**99496** Transitional care management services with the following required elements:
- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Medical decision-making of high complexity during the service period
- Face-to-face visit, within 7 calendar days of discharge

These services are for a patient whose medical and/or psychosocial problems require moderate or high complexity medical decision-making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility to the patient's community setting (home, domiciliary, rest home, or assisted living). TCM commences on the date of discharge and continues for the next 29 days and requires a face-to-face visit, initial patient contact, and medication reconciliation within specified timeframes. Any additional E/M services provided after the initial may be reported separately.
Refer to the *CPT* manual for complete details on reporting care management and TCM services.

### [B]Psychiatric Diagnostic or Evaluative Interview Procedures

★**90791** Psychiatric diagnostic interview examination evaluation

★**90792** Psychiatric diagnostic evaluation with medical services

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+ Designated *add-on* codes, report them separately in addition to the appropriate primary code for the service provided

**[B]Psychotherapy**

★**90832** Psychotherapy, 30 min with patient and/or family;

★**+90833** with medical evaluation and management (Use in conjunction with **99201–99255, 99304–99337, 99341–99350)**

★**90834** Psychotherapy, 45 min with patient and/or family;

★**+90836** with medical evaluation and management services (Use in conjunction with **99201–99255, 99304–99337, 99341–99350)**

★**90837** Psychotherapy, 60 min with patient and/or family;

★**+90838** with medical evaluation and management services (Use in conjunction with **99201–99255, 99304–99337, 99341–99350)**

**+90785** Interactive complexity (Use in conjunction with codes for diagnostic psychiatric evaluation **[90791, 90792],** psychotherapy **[90832, 90834, 90837],** psychotherapy when performed with an evaluation and management service **[90833, 90836, 90838, 99201–99255, 99304–99337, 99341–99350],** and group psychotherapy **[90853])**

- Refers to specific communication factors that complicate the delivery of a psychiatric procedure. Common factors include more difficult communication with discordant or emotional family members and engagement of young and verbally undeveloped or impaired patients. Typical encounters include
    - Patients who have other individuals legally responsible for their care
    - Patients who request others to be present or involved in their care such as translators, interpreters, or additional family members
    - Patients who require the involvement of other third parties such as child welfare agencies, schools, or probation officers

★**90846** Family psychotherapy (without patient present)

★**90847** Family psychotherapy (conjoint psychotherapy) (with patient present)

**90849** Multiple-family group psychotherapy

**90853** Group psychotherapy (other than of a multiple family group)

- For interactive group psychotherapy, use code **90785** in conjunction with code **90853.**

## [B]Other Psychiatric Services/Procedures

★**+90863** Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (Use in conjunction with **90832, 90834, 90837)**

- For pharmacologic management with psychotherapy services performed by a physician or other qualified health care professional who may report E/M codes, use the appropriate E/M codes **(99201–99255, 99281–99285, 99304–99337, 99341–99350)** and the appropriate psychotherapy with E/M service **(90833, 90836,90838).**
- Note that code **90862** was deleted.

**90885** Psychiatric evaluation of hospital records, other psychiatric reports, and psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes

**90887** Interpretation or explanation of results of psychiatric, other medical exams, or other accumulated data to family or other responsible persons, or advising them how to assist patient

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+ Designated *add-on* codes, report them separately in addition to the appropriate primary code for the service provided

**90889** Preparation of reports on patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other individuals, agencies, or insurance carriers

## [B]Screening and Testing

### Psychological Testing

**96130** Psychological testing evaluation services by physician or other qualified health care professional, including 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; first hour

+ **96131** each additional hour (List separately in addition to code **96130**)

**96136** Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes

+ **96137** each additional 30 minutes (List separately in addition to **96136**)

**96146** Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only

### Assessment of Aphasia

**96105** Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g., Boston Diagnostic Aphasia Examination) with interpretation and report, per hour

### Emotional/Behavioral Assessment

**96127** Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument

## [B] Other Qualified Nonphysician Healthcare Professional Services

CPT defines a *qualified nonphysician health care professional* is a professional who may independently report services but may not report the physician or other qualified health care professional E/M services. These include but not limited to speech-language pathologists, physical therapists, occupational therapists, social workers, or dietitians.

### Medical Team Conference

**99366** Medical team conference with interdisciplinary team of healthcare professionals, face-to-face with patient and/or family, 30 minutes or more, participation by a nonphysician qualified healthcare professional

**99368** Medical team conference with interdisciplinary team of healthcare professionals, patient and/or family not present, 30 minutes or more, participation by a nonphysician qualified healthcare professional

### Telephone Assessment: Nonphysician Healthcare Professional

**98966** Telephone assessment and management service provided by a qualified nonphysician healthcare professional to an established patient, parent or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

**98967** 11-20 minutes of medical discussion

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+ Designated *add-on* codes, report them separately in addition to the appropriate primary code for the service provided

**98968** 21-30 minutes of medical discussion

## Online Digital Evaluation and Management Service

Refer to codes 99421-99423 for more details.

The following codes are reported by nonphysician providers who may independently bill such as physical therapists and psychologists, but are not reported for clinical staff (eg, RN) unless noted in writing by your payer.

**98970** Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes

**98971** 11-20 minutes

**98972** 21 or more minutes

## Health Behavior Assessment and Intervention

**96156** Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)

**96158** Health behavior intervention (HBI), individual, face-to-face; initial 30 minutes
**96159** each additional 15 minutes (Report with 96158)
**96164** HBI, group (2 or more patients), face-to-face; initial 30 minutes
**96165** each additional 15 minutes (Report with 96164)
**96167** HBI, family (with the patient present), face-to-face; initial 30 minutes
**96168** each additional 15 minutes (Report with 96167)
**96170** HBI, family (without the patient present), face-to-face; initial 30 minutes
**96171** each additional 15 minutes (Report with 96170)

*Report the family HBI codes only when the intervention is centered around the family. Do not report if the parent is present because of the age of the patient, but they not involved in the intervention. Refer to the individual or group codes instead.

### [B] Prolonged Clinical Staff Services with Physician or Other Qualified Health Care Professional Supervision

Codes **99415, 99416** are used when a prolonged E/M service is provided in the office or outpatient setting that involves prolonged clinical staff face-to-face time beyond the typical face-to-face time of the E/M service, as stated in the code description.

+ **99415** Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour
+ **99416** each additional 30 minutes

Codes **99415-99416**

- Must always be reported in addition to an appropriate office/outpatient E/M service (ie, **99201-99215**)
- Require that the physician or qualified health care professional is present to provide direct supervision of the clinical staff.
- Are used to report the total duration of face-to-face time spent by clinical staff on a given date providing prolonged services, even if the time spent by the clinical staff on that date is not continuous.
- Are not reported for time spent performing separately reported services other than the E/M service is not counted toward

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+ Designated *add-on* codes, report them separately in addition to the appropriate primary code for the service provided

the prolonged services time.

- Requires a minimum of 45 minutes spent beyond the typical time of the E/M service code being reported. May require that the clinical staff spend more time if the physician does not meet the time criteria of the E/M service being reported
- May not be reported in addition to **99354** or **99355**.

**[B]Miscellaneous Services**

**99071** Educational supplies, such as books, tapes or pamphlets, provided by the physician for the patient's education at cost to the physician

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**[A]*International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)* Codes**

- Use as many diagnosis codes that apply to document the patient's complexity and report the patient's symptoms and/or adverse environmental circumstances.
- Once a definitive diagnosis is established, report the appropriate definitive diagnosis code(s) as the primary code, plus any other symptoms that the patient is exhibiting as secondary diagnoses that are not part of the usual disease course or are considered incidental.

**[B]Depression/Depressive Disorders**

**F32.A** Depression, unspecified
**F32.0** Major depressive disorder, single episode, mild
**F32.1** Major depressive disorder, single episode, moderate
**F32.2** Major depressive disorder, single episode, severe without psychotic features
**F32.3** Major depressive disorder, single episode, severe with psychotic features
**F32.4** Major depressive disorder, single episode, in partial remission
**F32.5** Major depressive disorder, single episode, in full remission
**F32.89** Other specified depressive episodes (eg, atypical depression, post-schizophrenic depression)
**F32.9** Major depressive disorder, single episode, unspecified
**F33.0** Major depressive disorder, recurrent, mild
**F33.1** Major depressive disorder, recurrent, moderate
**F33.2** Major depressive disorder, recurrent severe without psychotic features
**F33.3** Major depressive disorder, recurrent, severe with psychotic symptoms
**F33.40** Major depressive disorder, recurrent, in remission, unspecified
**F33.41** Major depressive disorder, recurrent, in partial remission
**F33.42** Major depressive disorder, recurrent, in full remission
**F33.8** Other recurrent depressive disorders
**F33.9** Major depressive disorder, recurrent, unspecified
**F34.0** Cyclothymic disorder
**F34.1** Dysthymic disorder (depressive personality disorder, dysthymia neurotic depression)
**F34.81** Disruptive mood dysregulation disorder
**F34.89** Other specified persistent mood disorders
**F39** Mood (affective) disorder, unspecified

**[B]Anxiety Disorders**

**F40.8** Phobic anxiety disorders, other (phobic anxiety disorder of childhood)
**F40.9** Phobic anxiety disorder, unspecified

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+ Designated *add-on* codes, report them separately in addition to the appropriate primary code for the service provided

**F41.1** Generalized anxiety disorder
**F41.8** Anxiety depression (mild or not persistent)
**F41.9** Anxiety disorder, unspecified
**F93.0** Separation anxiety disorder of childhood

**[B]Somatic Symptoms and Related Disorders**
**F44.4** Conversion disorder with motor symptom or deficit
**F44.5** Conversion disorder with seizures or convulsions
**F44.6** Conversion disorder with sensory symptom or deficit
**F44.7** Conversion disorder with mixed symptom presentation

**[B]Feeding and Eating Disorders/Elimination Disorders**
**F50.89** Eating disorders, other
**F50.9** Eating disorder, unspecified
**F98.0** Enuresis not due to a substance or known physiological condition
**F98.1** Encopresis not due to a substance or known physiological condition
**F98.3** Pica (infancy or childhood)

**[B]Obsessive-Compulsive and Related Disorders**
**F42.9** Obsessive-compulsive disorder
**F63.3** Trichotillomania/hair plucking
**F63.9** Impulse disorder, unspecified
**F98.8** Other specified behavioral and emotional disorders with onset usually occurring in childhood and adolescence (nail-biting, nose-picking, thumb-sucking)

**[B]Trauma- and Stressor-Related Disorders**
**F43.20** Adjustment disorder, unspecified
**F43.21** Adjustment disorder with depressed mood
**F43.22** Adjustment disorder with anxiety
**F43.23** Adjustment disorder with mixed anxiety and depressed mood
**F43.25** Adjustment disorder with mixed disturbance of emotions and conduct
**F43.29** Adjustment disorder with other symptoms
**F43.0** Acute stress reaction
**F43.8** Other reactions to severe stress
**F43.9** Reaction to severe stress, unspecified

**[B]Neurodevelopmental Disorders**
**F70** Mild intellectual disabilities
**F71** Moderate intellectual disabilities
**F72** Severe intellectual disabilities
**F73** Profound intellectual disabilities
**F79** Unspecified intellectual disabilities
**F80.89** Other developmental disorders of speech and language
**F80.9** Developmental disorder of speech and language, unspecified
**F90.0** Attention-deficit hyperactivity disorder, predominantly inattentive type
**F90.1** Attention-deficit hyperactivity disorder, predominantly hyperactive type
**F95.0** Transient tic disorder
**F95.1** Chronic motor or vocal tic disorder

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**F95.2** Tourette's disorder
**F95.9** Tic disorder, unspecified

**[B]Other**
**F07.81** Postconcussional syndrome
**F07.89** Personality and behavioral disorders due to known physiological condition, other
**F07.9** Personality and behavioral disorder due to known physiological condition, unspecified
**F45.41** Pain disorder exclusively related to psychological factors
**F45.42** Pain disorder with related psychological factors (Code also associated acute or chronic pain **G89.-)**
**F48.8** Nonpsychotic mental disorders, other (neurasthenia)
**F48.9** Nonpsychotic mental disorders, unspecified
**F45.41** Pain disorder exclusively related to psychological factors
**F51.01** Primary insomnia
**F51.02** Adjustment insomnia
**F51.03** Paradoxical insomnia
**F51.04** Psychophysiologic insomnia
**F51.05** Insomnia due to other mental disorder (Code also associated mental disorder)
**F51.09** Insomnia, other (not due to a substance or known physiological condition)
**F93.8** Childhood emotional disorders, other

**[B]Substance-Related and Addictive Disorders:**
If a provider documents multiple patterns of use, only one should be reported. Use the following hierarchy: use–abuse–dependence (eg, if use and dependence are documented, only code for dependence).

When a minus symbol (-) is included in codes **F10–F17,** a last digit is required. Be sure to include the last digit from the following list:
**0** anxiety disorder
**2** sleep disorder
**8** other disorder
**9** unspecified disorder

**[C]**Alcohol
**F10.10** Alcohol abuse, uncomplicated
**F10.14** Alcohol abuse with alcohol-induced mood disorder
**F10.159** Alcohol abuse with alcohol-induced psychotic disorder, unspecified
**F10.18-** Alcohol abuse with alcohol-induced
**F10.19** Alcohol abuse with unspecified alcohol-induced disorder
**F10.20** Alcohol dependence, uncomplicated
**F10.21** Alcohol dependence, in remission
**F10.24** Alcohol dependence with alcohol-induced mood disorder
**F10.259** Alcohol dependence with alcohol-induced psychotic disorder, unspecified
**F10.28-** Alcohol dependence with alcohol-induced
**F10.29** Alcohol dependence with unspecified alcohol-induced disorder
**F10.94** Alcohol use, unspecified with alcohol-induced mood disorder
**F10.959** Alcohol use, unspecified with alcohol-induced psychotic disorder, unspecified
**F10.98-** Alcohol use, unspecified with alcohol-induced

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**[C]** Opioid

**F11.10** Opioid abuse, uncomplicated (mild)
**F11.11** Opioid abuse, in remission
**F11.120** Opioid abuse with intoxication, uncomplicated
**F11.20** Opioid dependence, uncomplicated (mild)
**F11.21** Opioid dependence, in remission
**F11.220** Opioid dependence with intoxication, uncomplicated
**F11.24** Opioid dependence with opioid-induced mood disorder
**F11.90** Opioid use, unspecified, uncomplicated
**F11.94** Opioid use, unspecified with opioid-induced mood disorder

**[C]**Cannabis

**F12.10** Cannabis abuse, uncomplicated
**F12.180** Cannabis abuse with cannabis-induced anxiety disorder
**F12.19** Cannabis abuse with unspecified cannabis-induced disorder
**F12.20** Cannabis dependence, uncomplicated
**F12.280** Cannabis dependence with cannabis-induced anxiety disorder
**F12.29** Cannabis dependence with unspecified cannabis-induced disorder
**F12.90** Cannabis use, unspecified, uncomplicated
**F12.980** Cannabis use, unspecified with anxiety disorder

**[C]**Sedatives

**F13.10** Sedative, hypnotic or anxiolytic abuse, uncomplicated
**F13.129** Sedative, hypnotic or anxiolytic abuse with intoxication, unspecified
**F13.14** Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced mood disorder
**F13.18-** Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced
**F13.21** Sedative, hypnotic or anxiolytic dependence, in remission
**F13.90** Sedative, hypnotic, or anxiolytic use, unspecified, uncomplicated
**F13.94** Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced mood disorder
**F13.98-** Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced

**[C]**Stimulants (eg, Caffeine, Amphetamines)

**F15.10** Other stimulant (amphetamine-related disorders or caffeine) abuse, uncomplicated
**F15.14** Other stimulant (amphetamine-related disorders or caffeine) abuse with stimulant-induced mood disorder
**F15.18-** Other stimulant (amphetamine-related disorders or caffeine) abuse with stimulant-induced
**F15.19** Other stimulant (amphetamine-related disorders or caffeine) abuse with unspecified stimulant-induced disorder
**F15.20** Other stimulant (amphetamine-related disorders or caffeine) dependence, uncomplicated
**F15.24** Other stimulant (amphetamine-related disorders or caffeine) dependence with stimulant-induced mood disorder
**F15.28-** Other stimulant (amphetamine-related disorders or caffeine) dependence with stimulant-induced
**F15.29** Other stimulant (amphetamine-related disorders or caffeine) dependence with unspecified stimulant-induced disorder
**F15.90** Other stimulant (amphetamine-related disorders or caffeine) use, unspecified, uncomplicated
**F15.94** Other stimulant (amphetamine-related disorders or caffeine) use, unspecified with stimulant-induced mood disorder
**F15.98-** Other stimulant (amphetamine-related disorders or caffeine) use, unspecified with stimulant-induced

**[C]**Nicotine (eg, Cigarettes)

**F17.200** Nicotine dependence, unspecified, uncomplicated
**F17.201** Nicotine dependence, unspecified, in remission
**F17.203** Nicotine dependence unspecified, with withdrawal
**F17.210** Nicotine dependence, cigarettes, uncomplicated
**F17.211** Nicotine dependence, cigarettes, in remission
**F17.213** Nicotine dependence, cigarettes, with withdrawal
**F17.218** Nicotine dependence, cigarettes, with
**F17.290** Nicotine dependence, other tobacco products, uncomplicated (This includes Electronic nicotine delivery systems (ENDS), e-cigarettes, vaping)
**Z72.0** Tobacco use

**[B]Symptoms, Signs, and Ill-Defined Conditions**

- Use these codes in absence of a definitive mental diagnosis or when the sign or symptom is not part of the disease course or considered incidental.

**G44.209** Tension-type headache, unspecified, not intractable
**G47.9** Sleep disorder, unspecified
**R10.84** Generalized abdominal pain
**R45.81** Low self-esteem
**R45.82** Worries
**R45.83** Excessive crying of child, adolescent or adult
**R45.84** Anhedonia
**R45.851** Suicidal ideations
**R45.86** Emotional lability
**R45.87** Impulsiveness
**R45.89** Other symptoms and signs involving emotional state
**R53.81** Other malaise
**R53.82** Chronic fatigue, unspecified
**R53.83** Other fatigue

**[B]Z Codes**

Z codes represent reasons for encounters. Categories **Z00–Z99** are provided for occasions when circumstances other than a disease, injury, or external cause classifiable to categories **A00–Y89** are recorded as 'diagnoses' or 'problems'. This can arise in 2 main ways.
(a) When a person who may or may not be sick encounters the health services for some specific purpose, such as to receive limited care or service for a current condition, to donate an organ or tissue, to receive prophylactic vaccination (immunization), or to discuss a problem is in itself not a disease or injury.
(b) When some circumstance or problem is present which influences the person's health status but is not in itself a current illness or injury.
(c) When a social determinant of health is identified during an encounter and it is either addressed or shown to complicate the encounter, it should be coded.

**Z13.31** Encounter for screening for depression
**Z59.00** Homelessness unspecified
**Z60.3** Acculturation difficulty
**Z59.5** Extreme poverty
**Z59.6** Low income

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| | |
|---|---|
| **Z59.7** | Insufficient social insurance and welfare support |
| **Z59.8** | Other problems related to housing and economic circumstances |
| **Z60.4** | Social exclusion and rejection |
| **Z60.5** | Target of (perceived) adverse discrimination and persecution |
| **Z60.9** | Problem related to social environment, unspecified |
| **Z62.21** | Foster care status (child welfare) |
| **Z62.6** | Inappropriate (excessive) parental pressure |
| **Z62.810** | Personal history of physical and sexual abuse in childhood |
| **Z62.811** | Personal history of psychological abuse in childhood |
| **Z62.812** | Personal history of neglect in childhood |
| **Z62.819** | Personal history of unspecified abuse in childhood |
| **Z62.820** | Parent-biological child conflict |
| **Z62.821** | Parent-adopted child conflict |
| **Z62.822** | Parent-foster child conflict |
| **Z63.31** | Absence of family member due to military deployment |
| **Z63.32** | Other absence of family member |
| **Z63.4** | Disappearance and death of family member |
| **Z63.5** | Disruption of family by separation and divorce |
| **Z63.8** | Other specified problems related to primary support group |
| **Z65.3** | Problems related to other legal circumstances |
| **Z72.0** | Tobacco use |
| **Z81.0** | Family history of intellectual disabilities (conditions classifiable to **F70–F79)** |
| **Z81.1** | Family history of alcohol abuse and dependence (conditions classifiable to **F10.-)** |
| **Z81.2** | Family history of tobacco abuse and dependence (conditions classifiable to **F17.-)** |
| **Z81.3** | Family history of other psychoactive substance abuse and dependence (conditions classifiable to **F11–F16, F18–F19)** |
| **Z81.8** | Family history of other mental and behavioral disorders |
| **Z86.2** | Personal history of diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism |
| **Z86.39** | Personal history of other endocrine, nutritional and metabolic disease |
| **Z86.59** | Personal history of other mental and behavioral disorders |
| **Z86.69** | Personal history of other diseases of the nervous system and sense organs |
| **Z86.79** | Personal history of other diseases of the circulatory system |
| **Z87.09** | Personal history of other diseases of the respiratory system |
| **Z87.19** | Personal history of other diseases of the digestive system |
| **Z87.798** | Personal history of other (corrected) congenital malformations |
| **Z91.5** | Personal history of self-harm |

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