Headway

Billing & coding desktop reference
Psychiatrists and nurse practitioners

Evaluation and Management (E/M) codes are CPT codes used to document and bill for patient encounters, such as office visits and consultations. These codes reflect the complexity of the patient's condition and the care provided based on the history, examination, and medical decision-making involved.

E/M codes

MDM level	New patients	Existing patients
Low	99203: 30-44 mins	99213: 20-29 mins
Moderate	99204: 45-59 mins	99214: 30-39 mins
High	99205: 60-74 mins	99215: 40-54 mins

Time or MDM?

E/M codes can be based on either time or medical decision making (MDM). If using an add-on psychotherapy code, you must use and document MDM.

How to select your code based on Time or MDM

E/M only →	Time OR Medical Decision Making
E/M and add-on Psychotherapy →	Medical Decision Making ONLY

Elements of medical decision making

For a session to be classified at a particular MDM level, it must fulfill at least 2 out of the 3 required elements.

CPT code & MDM level	ELEMENT 1 **Number and complexity of problems addressed at the encounter**	ELEMENT 2 **Amount and/or complexity of data to be reviewed and analyzed**	ELEMENT 3 **Risk of complications and/or morbidity/mortality of patient management**
Low 99203 99213	• 2 or more self-limited or minor problems, or • 1 stable chronic illness, or • 1 acute, uncomplicated illness or injury	**Limited:** Must meet 1 of 2 categories • Category 1: Tests and Documents • Category 2: Assessment requiring an independent historian(s)	**Low risk** Example: • New patient seen for adjustment disorder and referred to therapist
Moderate 99204 99214	• 1 or more chronic illnesses with exacerbation, progression or side effects of treatment, or • 2 or more stable chronic illnesses, or • 1 undiagnosed new problem with uncertain prognosis, or • 1 acute illness with systemic symptoms or • 1 acute complicated injury	**Moderate:** Must meet 1 of 3 categories • Category 1: Tests, documents, or independent historian: • Category 2: Independent interpretation of tests performed by another physician • Category 3: Discussion of management or test interpretation with external physician	**Moderate risk** Examples: • Management of psychiatric medications • Patient whose adherence to treatment is impacted by homelessness
High 99205 99215	• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or • 1 acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive:** Must meet 2 of 3 categories of "Moderate amount and/or complexity of data to be reviewed and analyzed	**High risk** Examples: • Drug therapy requiring intensive monitoring for toxicity • Decision regarding hospitalization

For the full MDM matrix, please visit our resource hub for psychiatrists and nurse practitioners

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Choosing a MDM level

Session must meet the requirements of 2 out of 3 elements of MDM. Based on your assessment, identify the corresponding values in the tool below.

Number and complexity of problems addressed at the encounter	Amount and/or complexity of data to be reviewed and analyzed	Risk of complications and/or morbidity/mortality of patient management	MDM Level
Low	None	Low	99213 / Low
Low	None	Moderate	99213 / Low
Moderate	None	Low	99213 / Low
Moderate	None	Moderate	99214 / Moderate
Moderate	None	High	99214 / Moderate
Moderate	Limited	Moderate	99214 / Moderate
Moderate	Moderate	Moderate	99214 / Moderate
High	None	Moderate	99214 / Moderate
High	None	Low	99214 / Moderate
High	None	High	99215 / High
High	Limited	Moderate	99214 / Moderate
High	Extensive	High	99215 / High
High	Extensive	Moderate	99215 / High

Add-on psychotherapy codes

Add-on psychotherapy codes are specific codes used when a psychotherapy session is performed in conjunction with an Evaluation and Management (E/M) service by the same provider on the same day. These codes ensure that both the medical and psychotherapeutic components of the visit are separately identified and billed appropriately. The add-on codes are used to document the time spent on psychotherapy services only, excluding any time devoted to the E/M service. These codes can only be used with E/M codes (99202-99215).

CPT code and description	Time range for billing
90833: Individual psychotherapy	16-37 minutes face to face with the client
90836: Individual psychotherapy	38-52 minutes face to face with the client
90838: Individual psychotherapy	53 minutes or more face to face with the client

How to document add-ons

Clearly separate add-ons from the E/M section of the progress note.

Be sure to include:

- Identified issues addressed during psychotherapy
- Precise duration of time conducting psychotherapy
- Description of intervention / modalities utilized
- Treatment plan outlining goals for psychotherapy
- Assessment of progress towards goals
- Psychotherapy plan, care needs, and cadence