HOW TO USE THE TEMPLATES FOR PROGRESS NOTES FOR E/M CODES + PSYCHOTHERAPY

This template includes the essential documentation required to be included when psychotherapy is provided together an E/M service (99212 or 99213 plus either a 90833 (30 minutes) or 90836 (45 minutes). Remember that the primary service is the E/M service and the psychotherapy code (90833 for 30 minutes and 90836 for 45 minutes) is an "add-on" procedure to the E/M code. Codes 90833 and 90836 are never billed on their own.

There are two options when completing the template. You can print the template version of the form and complete your note by hand or, if you prefer to enter your information directly into the form, you can download the fill-in version of the form. After entering the information into the designated spaces on the form, you can print the form to be included in the patient's chart and/or save the completed form directly to your computer.

Please note that when E/M codes are billed with a psychotherapy code, the E/M codes must be documented based on "elements" and never based on provision of counseling or coordination of care.

When providing a service combining and E/M service and an individual psychotherapy procedure, both services must be documented.

E/M Documentation: There are two components of documentation for 99212 and 99213: history and examination. History includes Chief Complaint, History of Present Illness (HPI) and Review of Systems (ROS). HPI must include one to three elements of the patient's history since last visit. ROS should include patient's positive responses and pertinent negatives to treatment in terms of symptoms and functioning.

The Psychiatric Medical Examination for 99212 requires documentation of one to five elements of the psychiatric exam and for 99213 requires at least six elements to be documented.

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.

I-STOP Review: If I-STOP review was required and performed, check off the box and enter any other pertinent information.

Psychotherapy: Include documentation of psychotherapeutic interventions related to goals of psychotherapy whether insight oriented, behavior management or supportive.

Treatment Plan Update: Indicate any changes in the treatment plan, e.g., frequency of visits, contact with family or healthcare provider or no change.

Medical Necessity: Insert the frequency of treatment (e.g., 1 X per week, 2 X per week, 1 X per 2 weeks, etc.) and check off any appropriate boxes to describe reason for continued care.

Duration: Insert total session time in minutes and start and stop time. For the psychotherapy component, count only face to face time with patient or family member.

CPT Code: Insert both the CPT code for the E/M code (99212 or 99213) and for the add-on psychotherapy code (90833 for a 30 minute session and 90836 (for a 45 minute session).

Total Face to Face Time: Enter the total face to face time spent with the patient.

Approximate Psychotherapy Time: Enter the approximate amount of psychotherapy time spent with the patient (excluding time spent providing the E/M service). Minimum times for the add-on psychotherapy codes are as follows: 16 minutes for 90833, 38 minutes for 90836, and 53 minutes for 90838. The Approximate Psychotherapy Time should always be less than the Total Face to Face Time since both an E/M service and the psychotherapy add-on service were provided during the treatment session.

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