**HOW TO USE THE TEMPLATES FOR INITIAL OFFICE/OUTPATIENT VISIT WITH A NEW PATIENT USING E/M CODES 99204 OR 99205 COUNSELING AND/OR COORDINATION OF CARE MORE THAN 50% OF THE FACE-TO-FACE TIME**

The template for an Initial Visit Office/Outpatient E/M service (99204 and 99205) includes the essential documentation required to be included in a 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. Code 99204 requires a minimum of 45 minutes of face-to-face time with the patient and Code 99205 requires a minimum of 60 minutes face-to-face time with the patient. For both services, at least 50% of the face-to-face time must be spent providing counseling and/or coordination of care. Code 99204 or 99205 may be used as an alternative to 90791/90792.

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 office/outpatient visits, only face-to-face time with the patient providing counseling and/or coordination of care constitutes the service time.

- In addition, a statement must be included in the progress note that: "Greater than 50% of patient face 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:

**Chief Complaint**: Patient's reason for consulting with the psychiatrist.

**History of Present Illness:** Document at least four of the following seven elements of History: update mental status of patient and psychiatric assessment.

**Past/Family/Social History:** Document in full all three elements.

**Review of Systems:** Document for each system positives, pertinent negatives or no complaint.

**Current Medication(s)/Medication History**: Note all current medications and medication history. A box is included to permit a check off to indicate that no side effects or adverse reactions were noted by the psychiatrist or reported by the patient. If there are side effects or adverse reactions noted or reported, include documentation.

**Psychiatric Medical Examination:** Document all elements.

**Lab Tests History:** Document prior lab test history, lab test results reviewed during session or request to patient to provide prior lab test results.

**Assessment/Discussion:** Document your assessment of the patient's condition.

**Diagnoses:** Document patient's diagnoses/preliminary diagnoses.

**Initial Treatment Plan:** Check off whether the patient will receive psychotherapy or counseling and any medication recommended and/or prescribed. Document any lab tests ordered.

**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. Since this is an initial visit, it is presumed that the focus of the counseling will involve discussion of your assessment of the patient, treatment plan, risks/benefits of treatment recommended and prognosis/goals of treatment.

**Coordination of Care Provided**: If you consulted with any of the individuals identified while the patient was face-to-face, you should then indicate with whom and the nature of the discussion.

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 office/outpatient services, only face-to-face time with the patient may be counted for the total session time. Also, document session start and stop time.

**CPT Code**: Check off CPT code. Code 90875 is included if patient required a sign interpreter or play therapy for a child.

**Greater than 50%**: Check off when counseling and/or coordination of care exceeded 50% of total session time: patient face-to-face time for office/outpatient services.

General Counsel