BCA Recipe Card - Must meet TWO of THREE categories:

Final E/M Code	Problems: Number/Complexity	Data: Amount/Complexity	Risk of Complication
Straightforward **99202 (15-29 mins)** **99212 (10-19)**	**1** self-limited or minor problem	**None**	**None** Rest, Employ Coping Skills
Low **99203 (30-44 mins)** **99213 (20-29 mins)**	•**2+** Self-limited or minor illness •**1** Stable chronic •**1** Acute uncomplicated illness	**Limited: 1 of 2 data categories required** •**2** Unique tests or documents **OR** •1 Independent historian assessment	**Low** OTC Meds Psychotherapy
Moderate **99204 (45-59 mins)** **99214 (30-39 mins)**	•**1+** Progressing chronic, exacerbation or treatment SE •**2+** Stable chronic •**1** Undiagnosed new problem • **1** Acute illness w/systemic symptoms	**Moderate: 1 of 3 data categories required** •**3** Unique tests,external notes from unique source or ind historian assessment •Test interp not separately reported by clinician •Mgmt discussion or test interp w/external clinician/appropriate source	**Moderate** •Rx drug mgmt •SDoH significantly limiting dx or mgmt
High **99205 (60-74 mins)** **99215 (40-54 mins)**	•**1+** Chronic illness w/severe exacerbation or treatment SE •**1** Acute or chronic illness posing a threat to life/ bodily function	**Extensive: 2 of 3 data categories required** •**3** Unique tests,external notes from unique source or ind historian assessment •Test interp not separately reported by clincian •Mgmt discussion or test interp w/external clinician/appropriate source	**High** •Intensive monitoring for drug therapy for toxicity •Decision regarding hospitalization •DNR or de-escalation of care d/t poor prognosis

This coding tool is based off of AMA guidelines as published in CPT© 2024 Professional Edition. This card is intended to be used as a quick reference tool. Please see AMA guidelines for full details. Training on the use of this tool is available from BCA, Inc. Please visit us at www.bcarev.com

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Psychiatric Services with Medical Consideration *Use when provided by MDs, DOs, NPs & PAs*	PDE with medical consideration
C Psychiatric Diagnostic Evaluation (PDE with *medical consideration)*	**90792**
PDE Documentation Tips: Document who referred and why; CC, HPI, history, [psych, social & family hx] and, appropriate medical hx. Include also, strengths, coping skills, resources, support systems. Include also MSE, formulation; Include all Dx that require or affect care. Include treatment plan. Include goals with timeframes, your expectations and patient instructions.	
D Psychotherapy w/medical management (choose for time > 16 mi.)	***Document therapy time***
These psychotherapy codes must be coded with a qualifying E/M code. Documentation: Reason for visit and changes since last visit: Identify psychotherapy modalities/techniques used today; note MSE/observations. Assessment include dx for med. mgt., all diagnoses evaluated, treated, and that affect your care today; Include today's status of problem(s). Include also progress toward goals, changes in treatment plan, and follow-up.	✚ 90833 16-37 minutes ✚ 90836 38-52 minutes ✚ 90838 53 or > minutes
E Interactive complexity (add with appropriate documentation)	✚ 90785
May use with codes above for increased work intensity today, if documentation supports: 1 Manage maladaptive behavior which complicates delivery of care today ***- or*** 2 Caregiver emotions/behavior interfere w/implementation of treatment plan ***- or*** 3 Need to initiate sentinel event discussion...mandated report to 3rd party ***- or*** 4 Use of play equipment, devices, interpreter to overcome barriers to interaction	

Allowable Activities for Time-Based Coding		
Must be on date of service, may be face-to-face or other		
Review of lab/test result, consult note, discharge summary		
Obtaining history, reviewing separately obtained history		
Time spent on medically necessary exam and/or evaluation		
Education or counseling of patient/family/caregiver		
Order labs, xrays, other diagnostic tests or procedures, meds		
Referral/Communicaton with other health care professionals		
Clinical information documentation in the EMR/health record		
Independent Results Interp: results/communication to patient/family/caregiver		
Coordination of care not separately reported		
Reminder: Don't count time by ancillary staff, resident or student, time on another DOS or procedure time		
Note: Time spent performing separately reported services, e.g., procedures, EKGs, chronic care management activities, etc. cannot be counted towards total visit time.		
F. Psychotherapy for crisis	**90839** *(if 31-60 min)*	
Typically life threatening	✚ **90840** addl 31 min	
Requires urgent assessment, pt in crisis, must work to restore safety, must devote full attention to patient, cannot provide any other services during counted time frame. Document presentation, need for urgent eval, MSE and other components. Include your time mobilizing resources to diffuse crisis. Report only once per day, even if time is not continuous (cumulative total of all time on DOS).		