

Category	Service	Min Time (Minutes)	Documentation Tips	CPT Code	HCPCS Code	APG
Assessment	Psychiatric assessment with counseling	30	Focus of session includes evaluation for medication or management of medication and some counseling is also provided. Document counseling - issues covered, behavioral recommendations, patient's response, plan for patient; document evaluation and management of medication, medical conditions, mental and substance abuse conditions. Select code based on time.	90805	N/A	315
	Psychiatric assessment with counseling	45-50	Focus of session includes evaluation for medication or management of medication and some counseling is also provided. Document counseling - issues covered, behavioral recommendations, patient's response, plan for patient; document evaluation and management of medication, medical conditions, mental and substance abuse conditions. Select code based on time.	90807	N/A	316
	Assessment - Brief	15	Face-to-face INDIVIDUAL session; determine preliminary diagnosis, treatments, level of services needed; document patient information and history; what is the likelihood of success of treatment and patient's motivation to be engaged in the process? Is this clearly documented in the assessment? Can level of care selected be clearly determined from documentation? Document plan for next steps.	N/A	T1023	323
	Assessment - Normative	30	Face-to-face INDIVIDUAL session; determine preliminary diagnosis, treatments, level of services needed; document patient information and history; what is the likelihood of success of treatment and patient's motivation to be engaged in the process? Is this clearly documented in the assessment? Can level of care selected be clearly determined from documentation? Document plan for next steps.	90801	H0001	323
	Assessment - Extended	75	Face-to-face INDIVIDUAL session; determine preliminary diagnosis, treatments, level of services needed; document patient information and history; what is the likelihood of success of treatment and patient's motivation to be engaged in the process? Is this clearly documented in the assessment? Can level of care selected be clearly determined from documentation? Document plan for next steps.	N/A	H0002	324
Screening	Screening - Brief	15	Face-to-face INDIVIDUAL session (no groups); for CD svcs only - no Mental Health screens; identify substance use problems - document screening tool used and results; Not intended if patient already meets criteria for admission (court order or assessment from another program); document patient response; document feedback to patient and recommendations.	N/A	H0049	324
Intervention	Intervention - Brief	15	<u>Pre-admission service;</u> face-to-face INDIVIDUAL session (no groups); document what information was provided; document at-risk behavior prompting intervention; document patient response such as will not accept referral to treatment even with risky behavior identified. You may bill up to 3 Brief Intervention visits prior to admission.	N/A	H0050	324
	Treatment - Brief	15	<u>Post-admission service;</u> face-to-face INDIVIDUAL session (no groups); patient must be active in treatment; document TARGET behavior; document evidence-based or clinical practice of intervention; if addressing emergent issue, document such; document patient's response to intervention provided.	N/A	H0050	324
	Individual Therapy - Brief	25	Face-to-face INDIVIDUAL session (no groups); address material relevant to the treatment plan; document progress toward goals; document patient's participation - active, passive, increasing/decreasing - in development and modification of treatment program; document interventions/evidence-based services; document patient's response - his/her feelings, emotions, perception; document action plan. Select code based on time.	90804	G0396	315

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Counseling	Individual Therapy - Normative	45	Face-to-face INDIVIDUAL session (no groups); address material relevant to the treatment plan ; document progress toward goals ; document patient's participation - active, passive, increasing/decreasing - in development and modification of treatment program; document interventions/evidence-based services; document patient's response - his/her feelings, emotions, perception ; document action plan. Select code based on time. <i>Documentation should reflect the increased time spent in the session versus a Brief session.</i>	90806	G0397	316
	Peer Counseling	30	Face-to-Face service; MUST LINK peer/self-help group to treatment plan ; document content of session; document patient's response and participation in session; document any recommendations or action plans. Code is based on 15 minute increments, must code 2 units to meet minimum time requirements	N/A	H0038	490
Group	Group Therapy - Patient	60	Face-to-face GROUP (max 15 people); document purpose of group ; document process of inter-group communications ; document content - universally from group plus individual responses - to participation in the session; document knowledge, skills or attitude examples expressed during the session . Select code based on attendee status.	90853	H0005	318
	Group Therapy - Family or Collateral w/o patient	30	Face-to-face GROUP (collateral and/or couples); document purpose of session - does this correspond to treatment plan? Is this session for assessment or post-admission purpose? Document content - universally from group plus individual responses - to participation in the session; document specific and practice skills identified and discussed during the session ; document the role of the collateral and link the goal of the session to the goals in the treatment plan for managing the patient's chemical dependency . Select code based on attendee status.	90846	T1006	317
	Group Therapy - Multi-Family	60	Face-to-face GROUP (max 15 people); document purpose of group ; document process of inter-group communications ; document content - universally from group plus individual responses - to participation in the session; document support, guidance and education examples expressed during the session . Select code based on attendee status. <i>Can bill for 90849 and H0005 on same DOS.</i>	90849	N/A	318
Medication Administration	Med Administration & Observation	No minimum	Face-to-face INDIVIDUAL session; clinical administration - NOT self administration; document pre- and post-administration observations of patient's condition; document medication administered; document symptoms, side effects or other medical concerns noted; document if any actions were taken or planned as a result of the observations noted. Electronic log-in and record of dose meets documentation requirements if there are NO OBSERVED symptoms, side effects or medical concerns noted.	N/A	H0033	322
	Med Administration & Observation - Methadone Administration	No minimum	Same as Med Admin & Observation - however, if patient brings own Suboxone for induction visit, this does not qualify for administration & observation. See Induction code.	N/A	H0020	322
Medication Management	Medication Management & Monitoring - Routine	10	Face-to-face INDIVIDUAL session; should be established medication regimen; document patient compliance with medication directives, patient response to medication, adverse effects, other/new medications ordered, and addiction history (use, abstinence, etc) ; document plans for changes in treatment, if any. This service is EXEMPT from the cumulative 2 service claim per day rule.	N/A	M0064	426
	Medication Management & Monitoring - Complex	15	Face-to-face INDIVIDUAL session; non-routine management for new patients or patients on established medication regimen; this is an in-depth service; not simply a status review for prescription renewal; if provided on same day as E&M or E&M with psychotherapy, 90862 is subsumed by the E&M (992xx) or Therapy w/E&M codes (9080x).	90862	N/A	426

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	Medication Management & Monitoring - Addiction Management Induction	30	Face-to-face INDIVIDUAL session; for NEW MEDICATION requiring period of observation; document comprehensive history , assessment of physical problems, course of action for using addiction medication, link to behavioral treatment, patient education , possible medication contract, possible lab orders. <u>Follow up Induction</u> should include expanded problem focused history and WHAT OCCURRED between initial and current encounter , expanded problem focused exam if necessary; document COWS if necessary; document results of direct observation and plan for treatment.	N/A	H0014	426
Smoking Cessation	Smoking Cessation	3 to 10 minutes	Face-to-face INDIVIDUAL intervention (no groups); use in conjunction with NRTs; document strategies presented to quit; document patient response and progress; Select code based on time. No more than 3 smoking cessation services should be billed in an episode of care.	N/A	99406	451
	Smoking Cessation	> 10 minutes	Face-to-face INDIVIDUAL intervention (no groups); use in conjunction with NRTs; document strategies presented to quit; document patient response and progress; Select code based on time. No more than 3 smoking cessation services should be billed in an episode of care.	N/A	99407	451
Coordination	Complex Care Coordination	45	Ancillary service; time does not have to be contiguous ; does NOT have to be face-to-face with service provider; must be within 5 WORKING days of another treatment service; document critical event or patient condition requiring coordination; document the place to resolve crisis or improve patient functioning; this is more than ROUTINE services and documentation should reflect nature of immediate coordination required.	90882	N/A	490
Physical Health	Evaluation & Management Codes	Varied	<i>Additional information on these codes will be presented at a future webinar on physician coding and documentation. A separate CODING AND DOCUMENTATION TOOL for these codes will be provided at that time.</i>	Varied	Varied	Varied
	Physical Exam/Preventive Medicine Codes	Varied		Varied	Varied	Varied