

# Billing for the Evaluation and Treatment of Adult Depression by the Primary Care Clinician

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Depression is a common problem encountered in primary care practice. There are many barriers that the primary care clinician faces in managing patients with depression. Financial reimbursement is one infrequently addressed barrier that influences how care is provided. This article addresses the coding, documentation, and reimbursement issues that pertain to the treatment of depression in the primary care setting. Coding options are reviewed with specific documentation guidelines. Reimbursement and fee schedule issues are also addressed, including clarification of certain limitations on payment by some payers.

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**D**epression is frequently encountered in the primary care setting,<sup>1</sup> and this disorder is associated with substantial functional impairment for patients and cost for the health care system.<sup>2,3</sup> The primary care setting remains an important site for the treatment of depression for a number of reasons including (1) patients with depression often experience physical symptomatology that leads them to the medical setting, (2) the mental health setting remains stigmatized for many patients, (3) access to mental health professionals is often limited due to undersupply, (4) some medical disorders biologically predispose patients to develop depression, and (5) the burden of physical illness often leads to the development of depression.

It is likely that the primary care clinician (PCC) will remain a core treatment resource for depression. Since reimbursement issues are important in determining how resources are allocated, both PCCs and policy makers should have a clear understanding of this area. Treatment of depression may consist of either medical management (e.g., psychopharmacology) or psychosocial intervention (e.g., psychotherapy or counseling), or some combination

of these modalities. In order to be properly reimbursed for providing these services, the PCC should understand the appropriate terms for coding and the documentation required for reimbursement of the service. To help the PCC in this process, our article reviews information on coding, documentation, and payment for the assessment and treatment of depression in the primary care setting. Because of differences among payers, this information is separated by payer type.

## MEDICARE

When providing assessment or treatment for depression, the PCC has a number of coding options. The first is the 908xx series listed in the Current Procedural Terminology (CPT) manual<sup>4</sup> under the “psychiatry” heading. Although the 908xx codes are rarely used by non-mental health professionals, there is no Medicare restriction on the type of physician able to use these codes.

### Initial Evaluation (90801)

The 90801 code can be used for an initial diagnostic or evaluative procedure of a depressed patient. The code’s intended use includes a history, a mental status examination, formulation of a treatment plan, and, possibly, medical diagnostic tests. At a minimum, the clinician’s note to support this code should include the chief complaint, a medical and psychiatric history, a complete mental status examination, a pertinent medical review of systems, a family and social history, a diagnosis, a review of laboratory tests (if any), a treatment plan, and a legible signature. There is no specification of exactly what has to be included in the history, examination, or review of systems, and some clinicians find this code easier for complying with documentation requirements than the 99204 code, which is the most common alternative choice for an initial office visit.

### Counseling (90804 to 90809)

This series of codes is used in the office setting for established patients when “insight oriented, behavior modifying, and/or supportive psychotherapy” is the treatment of choice. These codes are used when providing an intervention that is primarily psychotherapeutic, with or without some medical evaluation and management (E&M) component, such as use of antidepressants or ordering

and/or interpretation of laboratory tests related to the issue of depression (e.g., thyroid-stimulating hormone levels, complete blood counts, B<sub>12</sub> levels). Documentation for these codes is based on face-to-face time, and the clinician's note must include specific notation of this time. CPT code 90804 is used for 20 to 30 minutes, 90806 for 45 to 50 minutes, and 90808 for 75 to 80 minutes of face-to-face time spent with the patient. When psychotherapy is supplemented by some E&M service, 90805 supplants 90804 (90807 supplants 90806). Each of these "upgrades" carries a small, incrementally increased payment over the psychotherapy without E&M codes. Documentation for these psychotherapy services needs to include the following elements: the date of service, face-to-face time, nature of the problem, nature of the therapy, patient response to therapy, diagnosis, and a legible signature, as well as the E&M services provided, if any.

### Pharmacologic Management (90862)

The 90862 code is used when evaluating the effects of prescribed psychotropic drugs, with only minimal psychotherapy provided. The code is not timed but generally consists of a 10- to 15-minute visit. Guidelines require that the clinician's note contain a comment on the clinical condition of the patient (the interval history and mental status examination are focused on the response to medication and side effects), a comment on use of or change in medication, a comment on side effects, and a legible signature. In order for the 90862 code to be used, the patient must be taking some type of psychotropic medication.

### Evaluation and Management (992xx series)

The 992xx series is more familiar to PCCs, as it is the basic E&M office visit series of codes for a new or established patient. Although generally not thought of as applying to psychiatric management, this series can be used for providing a depression assessment, as well as antidepressant management and/or counseling. The 9920x code is used for an initial visit, and the 9921x series is used for follow-up visits. Appendix C of the CPT manual<sup>4</sup> indicates that 99204 would be an appropriate code for an initial evaluation of a depressed patient. Potential coding options for providing follow-up for a depressed patient would include 99212, 99213, 99214, and 99215 for medical management (the level determined by the complexity of the diagnoses and medical decision making [MDM]) or for counseling (the level determined by the time of the encounter). The 3 key components of documentation for medical management are history, examination, and MDM. For initial visits, all 3 components must be documented according to the specific requirements of the code; for follow-up medical management visits, 2 of the 3 components must meet the necessary level of complexity to support the chosen code level. For follow-up visits,

**Table 1. American Medical Association CPT Codes and Medicare Fee Schedule for Depression-Relevant Diagnosis and Management<sup>a,b</sup>**

Code	Description	Time (min)	Allowable Fee	Medicare Payment
Psychiatry codes				
90801	Initial evaluation	N/A	\$144.31	\$115.45
90804	Counseling	20–30	\$66.22	\$33.11
90805	Counseling and medical evaluation and management	20–30	\$72.60	\$36.30
90806	Counseling	40–50	\$99.09	\$49.55
90807	Counseling and medical evaluation and management	40–50	\$105.40	\$52.70
90862	Pharmacologic management	N/A	\$52.25	\$26.13
General office evaluation and management codes <sup>c</sup>				
99204	Initial evaluation: comprehensive	45	\$136.44	\$109.15
99212	Straightforward follow-up	10	\$37.86	\$18.93
99213	Low complexity follow-up	15	\$53.07	\$26.53
99214	Moderate complexity follow-up	25	\$82.80	\$41.40
99215	Complex follow-up	40	\$120.99	\$60.49

<sup>a</sup>Data from the American Medical Association.<sup>4</sup>

<sup>b</sup>Medicare fees are regional. Listed fees in this table are for Rhode Island; other states will vary.

<sup>c</sup>Time is the controlling factor when counseling comprises > 50% of the visit.

Abbreviations: CPT = Current Procedural Terminology, N/A = not applicable.

time is the controlling factor when counseling dominates > 50% of the visit.

### Payment

Table 1 summarizes the relevant CPT codes and the current fee schedule. Medicare generally pays a physician provider 80% of the participating provider allowable fee. For code 90801, Medicare pays 80% of the allowable charge, whether there is a psychiatric or medical diagnosis. The remaining 20% can be billed to the patient and/or be covered by some "medigap" type of insurance plan. However, for follow-up visits coded as either 90862 or the 9080x series, when the diagnosis is listed as a psychiatric disorder such as depression, Medicare applies a mental health limitation, paying 65.2% of the 80% fee, resulting in a net payment of 50% of the fee. The remaining 50% of the fee can be billed to the patient or be covered by some "medigap" type of insurance plan. For patients who have Medicaid as a secondary insurance, however, the "balance" of the 50% cannot be billed.

In order to give the provider some sense of how to determine the level of service for depression follow-up visits, the following examples are offered (however, they have not been formally reviewed or endorsed by Medicare). Keep in mind that the documentation for follow-up visits requires 2 out of the 3 key components (history, examination, and MDM). For the provision of counseling, time becomes the determining factor for level of service.

Documentation of E&M codes for history and examination requires that a certain number of elements be present in the clinician's note as summarized in Table 2.

Table 2. Documentation Elements for Evaluation and Management Codes<sup>a</sup>

Code	History			Examination Type	Medical Decision Making			Time (min) <sup>f</sup>
	HPI <sup>b</sup>	ROS <sup>c</sup>	PFSH <sup>d</sup>		Number of Diagnoses	Elements of Clinical Data	Risk	
99204	4	10	3	Comprehensive (complete MSE <sup>e</sup> )	3	3	Moderate	N/A
99212	1	N/A	N/A	Problem-focused	1	0	Minimal	10
99213	1	1	N/A	Expanded problem-focused	2	2	Low	15
99214	4	2	1	Detailed	3	3	Moderate	25
99215	4	10	2	Comprehensive (complete MSE)	4	4	High	40

<sup>a</sup>Data from the Centers for Medicare and Medicaid Services.<sup>5</sup>

<sup>b</sup>HPI (history of present illness) elements = number required from the following: time, duration, context, quality, severity, location, modifying factors, and associated signs and symptoms.

<sup>c</sup>ROS (review of systems) = number required from the following: constitutional, eyes, cardiovascular, respiratory, gastrointestinal, genitourinary, musculoskeletal, skin/breast, neurologic, psychological, endocrine, hematic/lymphatic, allergy, and ears, nose, and throat.

<sup>d</sup>PFSH (past, family, social history) = number required from the following: surgeries, injuries, chronic conditions, habits, occupation, marital, housing, etc.

<sup>e</sup>See Appendix 1 for Medicare definition and required elements of the MSE.

<sup>f</sup>Face-to-face time in minutes.

Abbreviations: MSE = mental status examination, N/A = not applicable.

### Problem-Focused History and Examination

A problem-focused history and examination (H&E) initial evaluation or follow-up requires a chief complaint and a brief update on symptoms. An example would be, "Chief complaint—depression. Patient reports some improvement, sleeping better."

### Expanded Problem-Focused H&E

An expanded problem-focused H&E initial evaluation requires a chief complaint, a brief update on symptoms, and a problem-pertinent system review. An example would be, "Chief complaint—depression. Patient is not as sad, sleeping better, while appetite and energy remain diminished. No headache, dizziness, or other medication side effects."

### Detailed H&E

A detailed H&E initial evaluation or follow-up requires a chief complaint, an extended history and physical examination, and some pertinent past, family, and social history that is directly related to the problem. An example would be, "Chief complaint—depression. The patient is not as sad, is sleeping better, while concentration and energy are 'OK.' No suicidal ideation or psychotic symptoms are reported." A checklist of DSM-IV depression symptoms could be used, with comments made on any item checked as positive. An example of documenting relevant past history could include 1 or more of the following: "The patient is experiencing less stress with the spouse, doing better at work, but finding it more difficult to manage the children."

### Comprehensive H&E

A comprehensive H&E initial evaluation or follow-up includes all of the criteria for a detailed examination, as well as a complete past, family, and social history and a complete review of all body systems or a complete examination of a single organ system (e.g., a complete mental

status examination). This level of service requires more comprehensive documentation, including the content listed for the "detailed" history, as well as a complete mental status examination (Appendix 1). Documentation of a complete mental status examination could be facilitated by use of a form.

Documentation of the level of MDM can appear somewhat complex, as the level is determined by the number of diagnoses, amount of data reviewed, and level of risk, as noted in Table 2.

### Straightforward MDM

The straightforward level of MDM might apply to a patient with some very mild depressive symptoms, who has no other medical problems and no medical evaluation component. It is probably too low a level to apply to most situations, except, perhaps, when a "watchful waiting" decision for minor depression seems appropriate.

### Low MDM

The low MDM level might apply to a patient with some mild depressive symptoms and 1 or 2 medical issues or medications, with low risks involved with the depressive symptoms. Patients presenting with an episode of major depressive disorder would most likely require a higher level of MDM, especially if there are medical comorbidities and/or use of medications.

### Moderate MDM

The moderate MDM level seems appropriate for a patient with a DSM-IV Axis I psychiatric diagnosis (such as major depressive disorder, substance induced mood disorder, or adjustment disorders). The presence of medical comorbidities complicating the psychiatric diagnosis (such as comorbid arthritis, cancer, bowel disease, etc.), as well as the use of psychotropic medication and issues involved in the use of multiple medications, would justify this level of MDM.

### High MDM

A high level of MDM would be justified with a depressed patient in the presence of hallucinations, drug withdrawal panic attacks, suicidality, or severe depression requiring an urgent visit. It is likely that a patient of this severity would be referred to the mental health care sector.

Appendix C of the 2003 CPT manual<sup>4</sup> provides some pertinent examples. The application of these criteria to psychotherapy or counseling visits is not intuitively obvious. Even though examples listed in the CPT manual have particular specialties identified, applicability is not limited to any particular specialty. Example 1 is for code 99204, an initial office visit for a 17-year-old adolescent girl with depression. Example 2 is for code 99214, an office visit for a 52-year-old, established male patient, with a 12-year history of bipolar disorder responding to lithium carbonate and brief psychotherapy. Both psychotherapy and a prescription are provided. The third example given is for code 99215, an office visit for a 27-year-old, established female patient with bipolar disorder who was stable on treatment with lithium carbonate and monthly supportive psychotherapy but who has developed symptoms of hypomania. (Other examples of 99215 indicate that high complexity MDM would be justified by the presence of hallucinations, severe depressive symptoms requiring an urgent visit, or comorbid panic attacks related to drug abstinence). No examples are provided for psychiatry services for codes 99212–13.

### Medicare Payment Summary

While all third-party payers use CPT codes, documentation requirements and fee schedules are specific to each insurer's policies. Table 1 allows a direct comparison of the billing options under the Medicare fee schedule. A quick analysis will show that for a 20- to 30-minute depression counseling visit, including the prescribing of an antidepressant as well as medical comorbidity sustaining a level 3 (99213) service, the choice for the provider would be to receive \$36.30 for a 90805 code or \$26.53 for a 99213 code. Clearly, the so-called "psychiatry" codes reimburse at a higher rate (despite the clear lack of parity with other medical diagnoses that pay 80% of costs). If the patient complexity justifies a level 4 E&M service (99214), however, the reimbursement would be \$41.40. Appendix 2 supplies templates for the various levels of coding to help the clinician document the required information to support the code that is most relevant for an individual patient.

### COMMERCIAL PAYERS

There appears to be significant variability in the policies and requirements for coding and documentation for PCCs treating depression. The following 3 generalizations, however, seem accurate. First, commercial payers

generally do not recognize the use of the 908xx series for PCCs. The reason for this nonrecognition may be that commercial payers often "carve out" psychiatric benefits to be managed by a third party. The third party can perform various functions including administration of services, authorization and review of services, and bearing financial risk. By limiting the use of the 908xx codes to mental health providers, psychiatric services provided in the mental health sector can be tracked. Although they comprise a significant component of mental health care, the mental health services in the primary care sector (the so-called de facto mental health system) are generally not managed or tracked. Second, documentation rules to support coding are generally not as rigorous as Medicare standards. Many commercial payers are increasingly adopting Medicare standards in order to allow for less potential abuse or incorrect categorization of the level of service. When the office visit is primarily for psychotherapy, the level of service would be determined mostly by face-to-face time rather than by level of history, examination, and MDM as is done for Medicare. The CPT manual<sup>4</sup> documents typical face-to-face times for each office code: 99212 is 10 minutes, 99213 is 15 minutes, 99214 is 25 minutes, and 99215 is 40 minutes. Third, commercial payers currently may or may not pay less for a service code when the diagnosis is depression compared with a medical diagnosis.

### MEDICAID

The payment by Medicaid to PCCs for the diagnosis and treatment of depression in adults (when coded as depression and not as some other medical diagnosis) varies by state. Some states pay the same for depression as for a medical diagnosis, some apply a reduction because depression is a psychiatric diagnosis, and some do not accept PCC use of psychiatric diagnostic codes for an office visit, implying that they do not want PCCs to provide psychiatric services. States that do provide payment have variability in their limits of coverage either in terms of total amount per year or number of visits.

### DISCUSSION

Many PCCs think that use of depression as the primary diagnosis code results in lower payment. It may be that the Medicare mental health reduction is being generalized to all payers, when that generalization is not necessarily accurate. One result of depression-coding avoidance is that the prevalence of depression in the primary care setting ascertained from claims would likely be underestimated. In addition, some PCCs may not code for depression due to concerns about confidentiality and stigmatizing the patient.

The diagnosis and treatment of depression by PCCs do not generally follow current guidelines.<sup>6,7</sup> There is often poor patient compliance with medication and inadequate

provision of psychotherapy.<sup>8</sup> An examination of depression treatment in 1801 depressed older primary care patients noted that the mean number of counseling sessions during 3 months of treatment was 2.47, and only 1% of patients reported 4 or more sessions.<sup>9</sup> Lack of adequate counseling regarding the need for antidepressants can lead to suboptimal medication compliance.<sup>10</sup> Two studies have demonstrated that brief medication counseling (albeit provided by nonphysicians) to discuss medication could enhance adherence and improve clinical response.<sup>11,12</sup> Even though forms of collaborative care involving mental health providers within a primary care model have appeared to lead to superior outcomes compared with usual primary care treatment of depression,<sup>13</sup> it is likely that many PCCs will continue to be in a position of providing depression care by themselves and that the financial incentives to do so may play an important role in the time and nature of care they choose to provide. Perception and/or reality of financial disincentives through lower payment may be a factor contributing to data that indicate a significantly lower percentage of patients treated for depression in the primary care sector receive adequate care than that in the specialty mental health sector.<sup>14</sup>

While current evidence<sup>15</sup> generally indicates that educational initiatives alone (without other more comprehensive system interventions) do not lead to improved care, the actual implementation of depression management guidelines may be limited by a number of constraints including (1) inadequate depth of training for PCCs that would allow them to feel comfortable treating depression, (2) visit time requirements that may disrupt the office routine, and (3) financial disincentives. With improved education at the residency level and increased familiarity of PCCs with depression, fiscal constraints may become the most important factor limiting the translation of educational gains into treatment practice, and without attention to restructuring the financial incentives, depression treatment may never be fully actualized in the primary care setting. The lack (and perceived lack) of parity between depression treatment and treatment of medical disorders has clear implications for the type of treatment system that has emerged.

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## Appendix 1. Mental Status Examination<sup>a</sup>

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For a problem-focused examination:	1 to 5 elements
For an expanded problem-focused examination:	at least 6 elements
For a detailed examination:	at least 9 elements
For a comprehensive examination:	all 11 elements

### Elements

1. Speech:
  - Rate
  - Volume
  - Articulation
  - Coherence
  - Spontaneity with notation of abnormalities (e.g., perseveration, paucity)
2. Thought processes:
  - Rate
  - Content (e.g., logical vs. illogical, tangential)
  - Abstract reasoning
  - Computation
3. Associations: (e.g., loose, tangential, circumstantial, intact)
4. Abnormal or psychotic thoughts:
  - Hallucinations
  - Delusions
  - Preoccupation with violence
  - Homicidal or suicidal ideation
  - Obsessions
5. Judgment: (e.g., concerning everyday activities and social situations)
  - Insight (e.g., concerning psychiatric condition)
6. Orientation:
  - Person
  - Place
  - Time
7. Recent and remote memory
8. Attention span and concentration
9. Language: (e.g., naming, repeating)
10. Fund of knowledge (e.g., awareness of current events, past history, vocabulary)
11. Mood and affect: (e.g., depression, anxiety, hypomania, lability)

<sup>a</sup>Based on Centers for Medicare and Medicaid Services.<sup>5</sup>

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Appendix 2 appears on page 26.

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**Appendix 2. Templates for Chart Notes to Cover Medicare Documentation<sup>a</sup>**

<p><b>Note for 90801 Depression Evaluation</b></p> <p>Patient name: Date of visit: Chief complaint: Medical history: Psychiatric history: Mental status examination: Review of systems: Diagnosis: Lab studies: Plan: Signature:</p>	<p><b>Progress Note for 99213</b></p> <p>Patient name: Date: Psychiatric diagnosis: CC:</p> <p><b>When used for evaluation and management visit</b></p> <p>List of core depression symptoms with update (unchanged, improved, worse):</p> <table border="0"> <tr> <td>Depressed mood</td> <td>Fatigue</td> </tr> <tr> <td>Anhedonia</td> <td>Worthless/guilty feelings</td> </tr> <tr> <td>Appetite/weight change</td> <td>Trouble concentrating</td> </tr> <tr> <td>Sleep problem</td> <td>Suicidal thoughts</td> </tr> <tr> <td>Psychomotor agitation/retardation</td> <td>Other</td> </tr> </table>	Depressed mood	Fatigue	Anhedonia	Worthless/guilty feelings	Appetite/weight change	Trouble concentrating	Sleep problem	Suicidal thoughts	Psychomotor agitation/retardation	Other
Depressed mood	Fatigue										
Anhedonia	Worthless/guilty feelings										
Appetite/weight change	Trouble concentrating										
Sleep problem	Suicidal thoughts										
Psychomotor agitation/retardation	Other										
<p><b>Note for 90862 Medication Visit</b></p> <p>Patient name: Date of visit: Symptoms being treated and response to medication: Dose of medication and comment on reason for change: Side effects: Signature:</p>	<p>Other symptoms: (e.g., somatic, panic attacks, obsessive thinking, social anxiety)</p> <p>At least 6 elements from the mental status examination (Appendix 1), OR 2 diagnoses, 2 data elements reviewed, low-risk situation</p> <p>Dose of medication and comment on reason for change: Side effects:</p>										
<p><b>Progress Note for 9080x Series When Used for a Counseling Session</b></p> <p>Patient name: Date: Face-to-face time: Problems/symptoms: (e.g., depressed mood, loss of appetite, loss of energy, poor concentration, crying, etc.) What is being done in counseling: (give examples, such as allowing venting of frustration, exploring alternative behaviors, examining distorted perceptions, etc.) Patient response to therapy: (e.g., patient still unable to accept reality, patient beginning to explore different view of the problem, patient feeling better from support) Diagnosis: Signature:</p>	<p><b>When used primarily for counseling</b></p> <p>Face-to-face counseling time: 15 minutes</p> <p>Nature of therapy: (e.g., supportive, problem exploration, cognitive/behavioral)</p> <p>Patient response to therapy: (e.g., patient still unable to accept reality, patient beginning to explore different view of the problem, patient feeling better from support)</p> <p>Signature:</p>										
<p><b>Note for 99204 Initial Evaluation of Depression</b> (requires comprehensive history, comprehensive examination, moderate medical decision making)</p> <p>Patient name: Date of visit: Chief complaint: HPI (health physical information) of depression: Related symptoms: (e.g., anxiety, substance abuse, somatic symptoms) Past psychiatric history: Family psychiatric history: Social history: (work, school, relationship status) Review of systems: (complete organ system review or complete mental status examination) Lab studies: Diagnosis: (include entire list) Plan: Signature:</p>	<p><b>Progress Note for 99214</b></p> <p><b>When used for evaluation and management visit, use progress note for 99213</b></p> <p><i>PLUS:</i></p> <ol style="list-style-type: none"> <li>1 element from PFSH (past, family, social history): pertinent comment regarding family situation, work/school/social situation</li> <li>9 elements from mental status examination (Appendix 1), OR 3 diagnoses, 3 data elements reviewed, and moderate risk</li> </ol> <p><b>When used primarily for counseling</b></p> <p>Face-to-face counseling time: 25 minutes</p> <p>Nature of therapy: (e.g., supportive, problem exploration, cognitive/behavioral)</p> <p>Patient response to therapy: (e.g., patient still unable to accept reality, patient beginning to explore different view of the problem, patient feeling better from support)</p>										
	<p><b>Progress Note for 99215</b></p> <p><b>When used for evaluation and management visit, use progress note for 99214</b></p> <p><i>PLUS:</i></p> <ol style="list-style-type: none"> <li>2 elements from PFSH: pertinent comment regarding family situation, work/school/social</li> <li>All elements from the mental status examination (Appendix 1), OR 4 diagnoses, 4 data elements reviewed, and high clinical risk</li> </ol> <p><b>When used primarily for counseling</b></p> <p>Face-to-face counseling time: 40 minutes</p> <p>Nature of therapy: (e.g., supportive, problem exploration, cognitive/behavioral)</p> <p>Patient response to therapy: (e.g., patient still unable to accept reality, patient beginning to explore different view of the problem, patient feeling better from support)</p>										

<sup>a</sup>Based on American Medical Association<sup>4</sup> and Centers for Medicare and Medicaid Services.<sup>5</sup>