
Initial assessment usually involves a lot of time determining the differential diagnosis, a diagnostic plan, and potential treatment options. Therefore, most pediatricians will report either an office/outpatient evaluation and management (E/M) code using time as the key factor or a consultation code for the initial assessment:

Physician Evaluation & Management Services

★ 99202  Office or other outpatient visit, new patient; straightforward medical decision making (MDM), 15-29 min.
★ 99203  low MDM, 30-44 min.
★ 99204  moderate MDM, 45-59 min.
★ 99205  high MDM, 60-74 min.

A new patient is one who has not received any professional services face-to-face services rendered by physicians and other qualified health care professionals (QHP) who may report evaluation and management services reported by a specific CPT code(s) from the physician/QHP or another physician/QHP of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

★ 99211  Office or other outpatient visit, established patient; minimal problem, 5 min.
★ 99212  straightforward MDM, 10-19 min.
★ 99213  low MDM, 20-29 min.
★ 99214  moderate MDM, 30-39 min.
★ 99215  high MDM, 40-54 min.

★+ 99417 Prolonged physician services in office or other outpatient setting, with direct patient contact; first hour (use in conjunction with codes 99205, 99215 only)
- Used only with the highest level E/M services (99205, 99215)
- Time spent does not have to be continuous but must occur on the same day as the face-to-face encounter
- Prolonged service begins at 75 minutes for new patients (99205 and 99417) and 55 minutes for established patients (99215 and 99417)
- Prolonged time can include non-direct services on the same day as the encounter

Reporting E/M services using “Time” vs MDM

- A physician will report their level of E/M service using time or MDM
- If reporting based on “time” count all time on the encounter date, including pre- and post service time spent on that patient, even if the patient is not present
- You do not have to meet “time” requirements in the code descriptor to meet a code level if billing based on MDM

Example: A physician sees an established patient in the office to discuss the progress being made on the anti-anxiety medication and using anxiety support apps. The patient’s chronic medical condition is not stable and is being managed by medication (moderate level MDM). The total face-to-face time was 35 minutes, with an additional 10 minutes of documented time after the patient left. The physician would report a 99215 instead of a 99214 because the total time met the criteria for the 99215 (25 mins) which was higher than the MDM level (moderate) for the 99214.

+ Codes are add-on codes, meaning they are reported separately in addition to the appropriate code for the service provided
★ Indicates CPT allows as a telemedicine service

Office or other outpatient consultation, new or established patient; self-limited or minor problem, 15 min.
- 99241

Low severity problem, 30 min.
- 99242

Moderate severity problem, 45 min.
- 99243

Moderate to high severity problem, 60 min.
- 99244

Moderate to high severity problem, 80 min.
- 99245

NOTE: Use of these codes (99241-99245) requires the following:

a) Written or verbal request for consultation is documented in the patient chart;
b) Consultant's opinion as well as any services ordered or performed are documented in the patient chart; and
c) Consultant's opinion and any services that are performed are prepared in a written report, which is sent to the requesting physician or other appropriate source (Note: Patients/Parents may not initiate a consultation)

Prolonged services in office or other outpatient setting, with direct patient contact; first hour (use in conjunction with time-based codes 99241-99245, 99324-99337, 99341-99350, 90837)
- +99354

Each additional 30 min. (use in conjunction with 99354)
- +99355

- Used when a physician or other QHP provides prolonged services beyond the usual service (ie, beyond the typical time).
- Time spent does not have to be continuous.
- Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

If reporting your E/M service based on time and not key factors (hx, exam, medical decision making), the physician must reach the typical time in the highest code in the code set being reported (eg, 99245) before face-to-face prolonged services can be reported.

Physician Non-Face-to-Face Services
*For more information on reporting these and other non-face-to-face services see the Care Management fact sheet.

Principal Care Management
1. A single (1) chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death
2. A condition that requires development, monitoring, or revision of disease-specific care plan,
3. A condition that requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities
4. Ongoing communication and care coordination between relevant practitioners furnishing care may be reported by different physicians or QHPs in the same calendar month for the same patient
5. Documentation in the patient’s medical record should reflect coordination among relevant managing clinicians
6. Principal care management services are disease-specific management services. Even if a patient may have multiple chronic conditions they may receive principal care management if the reporting physician or other QHP is providing single disease rather than comprehensive care management

Principal care management services, for a single high-risk disease, with the following required elements:
- 99424

- One complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death,
- The condition requires development, monitoring, or revision of disease-specific care plan,
- The condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities,
- Ongoing communication and care coordination between relevant practitioners furnishing care;

+ Codes are add-on codes, meaning they are reported separately in addition to the appropriate code for the service provided
★ Indicates CPT allows as a telemedicine service

Codes are add-on codes, meaning they are reported separately in addition to the appropriate code for the service provided.

+ **99425** each additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month (List separately in addition to 99424)

### Chronic Care Management

Codes are selected based on the amount of time spent by the physician or qualified health care professional providing care coordination activities. CPT clearly defines what is defined as care coordination activities. In order to report chronic care or complex chronic care management codes, you must

1. provide 24/7 access to physicians or other qualified health care professionals or clinical staff;
2. use a standardized methodology to identify patients who require chronic complex care coordination services;
3. have an internal care coordination process/function whereby a patient identified as meeting the requirements for these services starts receiving them in a timely manner;
4. use a form and format in the medical record that is standardized within the practice;
5. be able to engage and educate patients and caregivers as well as coordinate care among all service professionals, as appropriate for each patient.

**99491** Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements:

- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
- Chronic conditions place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline;
- Comprehensive care plan established, implemented, revised, or monitored.

(For time spent by the physician directing clinical staff, refer to codes **99490, 99487, 99489** below)

### Online Digital Evaluation and Management Service

These are patient-initiated services with physicians or other qualified health care professionals (QHPs) who are allowed to report E/M services. Online digital E/M services require physician or other QHP’s evaluation, assessment, and management of the patient and are not for the nonevaluative electronic communication of test results, scheduling of appointments, or other communication that does not include E/M. These are more appropriate when dealing with a more minor issue or during a month when you are not coding or providing more robust care thus this time would be reported under another service like care management.

- Patient must be established (problem can be new)
- Services must be initiated through Health Insurance Portability and Accountability Act (HIPAA)-compliant secure platforms
- Reported once for the physician’s or other QHP’s (including all in the same group practice) cumulative time during a seven-day period
- The seven-day period begins with the physician’s or other QHP’s initial, personal review of the patient-generated inquiry.
- Online digital E/M services require permanent documentation storage (electronic or hard copy) of the encounter.
- Do not report these codes separately if the patient is seen within 7 days of the service for an issue related to the encounter.
• Your date of service will be the date the initiation of the e-visit began or the range of dates it took place because this service is cumulative time over 7 days.

99421 Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
99422 11-20 minutes
99423 21 or more minutes

Telephone Care Services
Telephone care must be initiated by the parent, patient or the guardian. The telephone call cannot be related to an E/M service within the previous 7 days nor can they lead to an appointment within the next 24 hours or soonest available. This is not telehealth or telemedicine. Your date of service will be date the phone call takes place.

99441 Telephone evaluation and management to patient, parent or guardian not originating from a related E/M service within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
99442 11-20 minutes of medical discussion
99443 21-30 minutes of medical discussion

Medical Team Conference

99367 Medical team conference by physician with interdisciplinary team of healthcare professionals, patient and/or family not present, 30 minutes or more

Care Plan Oversight

99339 Care Plan Oversight - Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (e.g., assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (e.g., legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes
99340 30 minutes or more

Prolonged Services

99358 Prolonged services without direct patient contact; first hour

+99359 each additional 30 min. (+ designated add-on code, use in conjunction with 99358)

[B]Physician-Directed Non–Face-to-Face Services
Behavioral health integration care management, chronic care management, psychiatric collaborative care management services and transition care management are reported under the directing physician or other qualified health care professional, however, the time requirement can be met by clinical staff working under the direction of the reporting physician or other qualified health care professional. See each code set for details.
Behavioral Health Integration Care Management

99484 Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements:

- initial assessment or follow-up monitoring, including the use of applicable validated rating scales;
- behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
- facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and
- continuity of care with a designated member of the care team.

Tips:
- Reported by the supervising physician or other qualified health care professional.
- The assessment and treatment plan is not required to be comprehensive and the office/practice is not required to have all the functions of chronic care management (99487, 99489, 99490).
- May be used in any outpatient setting, as long as the reporting professional has an ongoing relationship with the patient and clinical staff and as long as the clinical staff is available for face-to-face services with the patient.
- Behavioral integration care management (99484) and chronic care management services may be reported by the same professional in the same month, as long as distinct care management services are performed.

Principal Care Management

99426 Principal care management services, for a single high-risk disease, with the following required elements:

- one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death,
- the condition requires development, monitoring, or revision of disease-specific care plan,
- the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities,
- ongoing communication and care coordination between relevant practitioners furnishing care; first 30 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month.

+ 99427 each additional 30 minutes of clinical staff time directed by a physician or other QHP, per calendar month
(List separately in addition to code 99426)

Psychiatric Collaborative Care Management Services

99492 Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements:

- outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional;
- initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan;
- review by the psychiatric consultant with modifications of the plan if recommended;

+ Codes are add-on codes, meaning they are reported separately in addition to the appropriate code for the service provided
★ Indicates CPT allows as a telemedicine service

• entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and
• provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.

99493 Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements:
• tracking patient follow-up and progress using the registry, with appropriate documentation;
• participation in weekly caseload consultation with the psychiatric consultant;
• ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers;
• additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant;
• provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies;
• monitoring of patient outcomes using validated rating scales; and
• relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.

+ 99494 Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (List separately in addition to code for primary procedure)

Care Management Services
Codes are selected based on the amount of time spent by clinical staff providing care coordination activities. CPT clearly defines what is defined as care coordination activities. In order to report chronic care or complex chronic care management codes, you must

1. provide 24/7 access to physicians or other qualified health care professionals or clinical staff;
2. use a standardized methodology to identify patients who require chronic complex care coordination services
3. have an internal care coordination process/function whereby a patient identified as meeting the requirements for these services starts receiving them in a timely manner
4. use a form and format in the medical record that is standardized within the practice
5. be able to engage and educate patients and caregivers as well as coordinate care among all service professionals, as appropriate for each patient.

99490 Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:
• multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
• chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
• comprehensive care plan established, implemented, revised, or monitored.
Do not report 99490 for chronic care management services that do not take a minimum of 20 minutes in a calendar month.

99487 Complex chronic care management services;
• multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
• chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
• establishment or substantial revision of a comprehensive care plan;
• moderate or high complexity medical decision making;
• 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.

Do not report 99487 for chronic care management services that do not take a minimum of 60 minutes in a calendar month.

+99489 each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

Complex chronic care management is reported by the physician or qualified health care professional who provides or oversees the management and coordination of all of the medical, psychosocial, and daily living needs of a patient with a chronic medical condition. Typical pediatric patients

1. receive three or more therapeutic interventions (eg, medications, nutritional support, respiratory therapy)
2. have two or more chronic continuous or episodic health conditions expected to last at least 12 months (or until death of the patient) and places the patient at significant risk of death, acute exacerbation or decompensation, or functional decline
3. commonly require the coordination of a number of specialties and services.

Transition Care Management

★99495 Transitional care management (TCM) services with the following required elements:
• Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
• Medical decision-making of at least moderate complexity during the service period
• Face-to-face visit, within 14 calendar days of discharge

★99496 Transitional care management services with the following required elements:
• Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
• Medical decision-making of high complexity during the service period
• Face-to-face visit, within 7 calendar days of discharge

These services are for a patient whose medical and/or psychosocial problems require moderate or high complexity medical decision-making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility to the patient's community setting (home, domiciliary, rest home, or assisted living). TCM commences on the date of discharge and continues for the next 29 days and requires a face-to-face visit, initial patient contact, and medication reconciliation within specified timeframes. Any additional E/M services provided after the initial may be reported separately.

Refer to the CPT manual for complete details on reporting care management and TCM services.
Psychiatric Diagnostic or Evaluative Interview Procedures

★ 90791  Psychiatric diagnostic interview examination evaluation

★ 90792  Psychiatric diagnostic evaluation with medical services

Psychotherapy

★ 90832  Psychotherapy, 30 min with patient and/or family;
★ +90833  with medical evaluation and management (Use in conjunction with 99201–99255, 99304–99337, 99341–99350)

★ 90834  Psychotherapy, 45 min with patient and/or family;
★ +90836  with medical evaluation and management services (Use in conjunction with 99201–99255, 99304–99337, 99341–99350)

★ 90837  Psychotherapy, 60 min with patient and/or family;
★ +90838  with medical evaluation and management services (Use in conjunction with 99201–99255, 99304–99337, 99341–99350)

+90785  Interactive complexity (Use in conjunction with codes for diagnostic psychiatric evaluation [90791, 90792], psychiatric evaluation [90832, 90834, 90837], psychotherapy when performed with an evaluation and management service [90833, 90836, 90838, 99201–99255, 99304–99337, 99341–99350], and group psychotherapy [90853])

• Refers to specific communication factors that complicate the delivery of a psychiatric procedure. Common factors include more difficult communication with discordant or emotional family members and engagement of young and verbally undeveloped or impaired patients. Typical encounters include:
  o Patients who have other individuals legally responsible for their care
  o Patients who request others to be present or involved in their care such as translators, interpreters or additional family members
  o Patients who require the involvement of other third parties such as child welfare agencies, schools or probation officers

★ 90846  Family psychotherapy (without patient present), 50 min
★ 90847  Family psychotherapy (conjoint psychotherapy) (with patient present), 50 min
90849  Multiple-family group psychotherapy
90853  Group psychotherapy (other than of a multiple family group)

• For interactive group psychotherapy use code 90785 in conjunction with code 90853

Other Psychiatric Services/Procedures

★ +90863  Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (Use in conjunction with 90832, 90834, 90837)

• For pharmacologic management with psychotherapy services performed by a physician or other qualified health care professional who may report E/M codes, use the appropriate E/M codes 99201-99255, 99281-99285, 99304-99337, 99341-99350 and the appropriate psychotherapy with E/M service 90833, 90836,90838).

90885  Psychiatric evaluation of hospital records, other psychiatric reports, and psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes

90887  Interpretation or explanation of results of psychiatric, other medical exams, or other accumulated data to
Assessment and Testing

Psychological Testing

96130 Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour

+ 96131 each additional hour (List separately in addition to code 96130)

96136 Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes

+ 96137 each additional 30 minutes (List separately in addition to 96136)

96146 Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only

Assessment of Aphasia

96105 Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g., Boston Diagnostic Aphasia Examination) with interpretation and report, per hour

Emotional/Behavioral Assessment

96127 Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument

Other Qualified Nonphysician Healthcare Professional Services

CPT defines a qualified nonphysician health care professional is a professional who may independently report services but may not report the physician or other qualified health care professional E/M services. These include but not limited to speech-language pathologists, physical therapists, occupational therapists, social workers, or dietitians.

Medical Team Conference

99366 Medical team conference with interdisciplinary team of healthcare professionals, face-to-face with patient and/or family, 30 minutes or more, participation by a nonphysician qualified healthcare professional

99368 Medical team conference with interdisciplinary team of healthcare professionals, patient and/or family not present, 30 minutes or more, participation by a nonphysician qualified healthcare professional

Telephone Assessment: Nonphysician Healthcare Professional

98966 Telephone assessment and management service provided by a qualified nonphysician healthcare professional to an
established patient, parent or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

98967 11-20 minutes of medical discussion
98968 21-30 minutes of medical discussion

Online Digital Evaluation and Management Service

Refer to codes 99421-99423 for more details.

The following codes are reported by nonphysician providers who may independently bill such as physical therapists and psychologists, but are not reported for clinical staff (eg, RN) unless noted in writing by your payer.

98970 Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes

98971 11-20 minutes

98972 21 or more minutes

Health Behavior Assessment and Intervention

96156 Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)

96158 Health behavior intervention (HBI), individual, face-to-face; initial 30 minutes
96159 each additional 15 minutes (Report with 96158)
96164 HBI, group (2 or more patients), face-to-face; initial 30 minutes
96165 each additional 15 minutes (Report with 96164)
96167 HBI, family (with the patient present), face-to-face; initial 30 minutes
96168 each additional 15 minutes (Report with 96167)
96170 HBI, family (without the patient present), face-to-face; initial 30 minutes
96171 each additional 15 minutes (Report with 96170)

*Report the family HBI codes only when the intervention is centered around the family. Do not report if the parent is present because of the age of the patient, but they not involved in the intervention. Refer to the individual or group codes instead.

Prolonged Clinical Staff Services with Physician or Other Qualified Health Care Professional Supervision

Codes 99415, 99416 are used when a prolonged E/M service is provided in the office or outpatient setting that involves prolonged clinical staff face-to-face time beyond the typical face-to-face time of the E/M service, as stated in the code description.

+ 99415 Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour
+ 99416 each additional 30 minutes
Codes **99415-99416**
- Must always be reported in addition to an appropriate office/outpatient E/M service (i.e., **99201-99215**)
- Require that the physician or qualified health care professional is present to provide direct supervision of the clinical staff.
- Are used to report the total duration of face-to-face time spent by clinical staff on a given date providing prolonged services, even if the time spent by the clinical staff on that date is not continuous.
- Are not reported for time spent performing separately reported services other than the E/M service is not counted toward the prolonged services time.
- Requires a minimum of 45 minutes spent beyond the typical time of the E/M service code being reported. May require that the clinical staff spend more time if the physician does not meet the time criteria of the E/M service being reported.
- May not be reported in addition to **99354** or **99355**.

**(B) Miscellaneous Services**

**99071** Educational supplies, such as books, tapes or pamphlets, provided by the physician for the patient's education at cost to the physician

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**International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) Codes**

- Use as many diagnosis codes that apply to document the patient's complexity and report the patient's symptoms and/or adverse environmental circumstances.
- Once a definitive diagnosis is established, report the appropriate definitive diagnosis code(s) as the primary code, plus any other symptoms that the patient is exhibiting as secondary diagnoses that are not part of the usual disease course or are considered incidental.

**Anxiety Related Disorders**

**F06.4** Anxiety disorder due to known physiological condition
**F30.8** Other manic episodes
**F39** Unspecified mood [affective] disorder
**F40.00** Agoraphobia, unspecified
**F40.01** Agoraphobia with panic disorder
**F40.02** Agoraphobia without panic disorder
**F40.10** Social phobia, unspecified
**F40.11** Social phobia, generalized
**F40.8** Phobic anxiety disorders, other (phobic anxiety disorder of childhood)
**F40.9** Phobic anxiety disorder, unspecified
**F41.0** Panic disorder [episodic paroxysmal anxiety] without agoraphobia (panic attack)
**F41.1** Generalized anxiety disorder (Anxiety reaction)
**F41.8** Anxiety depression (mild or not persistent)
**F41.9** Anxiety disorder, unspecified
**F93.0** Separation anxiety disorder of childhood

**Substance Induced Anxiety Disorders**

**F10.280** Alcohol dependence with alcohol-induced anxiety disorder
**F10.980** Alcohol use, unspecified with alcohol-induced anxiety disorder
**F12.180** Cannabis abuse with cannabis-induced anxiety disorder
**F12.280** Cannabis dependence with cannabis-induced anxiety disorder

+ Codes are *add-on* codes, meaning they are reported separately in addition to the appropriate code for the service provided
* Indicates CPT allows as a telemedicine service

Codes are add-on codes, meaning they are reported separately in addition to the appropriate code for the service provided

F12.980 Cannabis use, unspecified with anxiety disorder
F13.180 Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced anxiety disorder
F13.280 Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced anxiety disorder
F13.980 Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced anxiety disorder
F14.180 Cocaine abuse with cocaine-induced anxiety disorder
F14.280 Cocaine dependence with cocaine-induced anxiety disorder
F14.980 Cocaine use, unspecified with cocaine-induced anxiety disorder
F15.180 Other stimulant abuse with stimulant-induced anxiety disorder
F15.280 Other stimulant dependence with stimulant-induced anxiety disorder
F16.180 Hallucinogen abuse with hallucinogen-induced anxiety disorder
F16.280 Hallucinogen dependence with hallucinogen-induced anxiety disorder
F16.980 Hallucinogen use, unspecified with hallucinogen-induced anxiety disorder
F18.180 Inhalant abuse with inhalant-induced anxiety disorder
F18.280 Inhalant dependence with inhalant-induced anxiety disorder
F18.980 Inhalant use, unspecified with inhalant-induced anxiety disorder
F19.280 Other psychoactive substance dependence with psychoactive substance-induced anxiety disorder
F19.980 Other psychoactive substance use, unspecified with psychoactive substance-induced anxiety disorder

**Depression/Depressive Disorders**
F34.1 Dysthymic disorder (depressive personality disorder, dysthymia neurotic depression)
F32.9 Major depressive disorder, single episode, unspecified
F32.A Depression, unspecified

**Feeding and Eating Disorders/Elimination Disorders**
F50.89 Eating disorders, other (psychogenic vomiting)
F50.9 Eating disorder, unspecified
F98.0 Enuresis not due to a substance or known physiological condition
F98.1 Enopresis not due to a substance or known physiological condition
F98.3 Pica (infancy or childhood)

**Impulse Disorders**
F63.9 Impulse disorder, unspecified

**Neurodevelopmental Disorders**
F70 Mild intellectual disabilities
F71 Moderate intellectual disabilities
F72 Severe intellectual disabilities
F73 Profound intellectual disabilities
F79 Unspecified intellectual disabilities
F80.4 Speech and language developmental delay due to hearing loss (code also hearing loss)
F80.89 Other developmental disorders of speech and language
F80.9 Developmental disorder of speech and language, unspecified
F95.0 Transient tic disorder
F95.1 Chronic motor or vocal tic disorder
F95.2 Tourette's disorder
F95.9 Tic disorder, unspecified

**Obsessive-Compulsive and Related Disorders**

+ Codes are add-on codes, meaning they are reported separately in addition to the appropriate code for the service provided
★ Indicates CPT allows as a telemedicine service

Codes are add-on codes, meaning they are reported separately in addition to the appropriate code for the service provided.

### Somatoform Disorders

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tr>
<td>F45.41</td>
<td>Pain disorder exclusively related to psychological factors</td>
</tr>
<tr>
<td>F45.42</td>
<td>Pain disorder with related psychological factors (code also associated acute or chronic pain (G89.-)</td>
</tr>
<tr>
<td>F45.8</td>
<td>Other somatoform disorders (psychogenic hyperventilation, teeth grinding)</td>
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</tbody>
</table>

### Trauma and Stressor-Related Disorders

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
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<tr>
<td>F43.0</td>
<td>Acute stress reaction</td>
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<tr>
<td>F43.20</td>
<td>Adjustment disorder, unspecified</td>
</tr>
<tr>
<td>F43.22</td>
<td>Adjustment disorder with anxiety</td>
</tr>
<tr>
<td>F43.23</td>
<td>Adjustment disorder with mixed anxiety and depressed mood</td>
</tr>
<tr>
<td>F43.29</td>
<td>Adjustment disorder with other symptoms</td>
</tr>
<tr>
<td>F43.8</td>
<td>Other reactions to severe stress</td>
</tr>
<tr>
<td>F43.9</td>
<td>Reaction to severe stress, unspecified</td>
</tr>
</tbody>
</table>

### Substance-Related and Addictive Disorders:

If a provider documents multiple patterns of use, only one should be reported. Use the following hierarchy: use–abuse–dependence (eg, if use and dependence are documented, only code for dependence).

When a minus symbol (-) is included in codes F10–F17, a last digit is required. Be sure to include the last digit from the following list:

- 0 anxiety disorder
- 2 sleep disorder
- 8 other disorder
- 9 unspecified disorder

#### Alcohol

- **F10.10** Alcohol abuse, uncomplicated (alcohol use disorder, mild)
- **F10.20** Alcohol dependence, uncomplicated
- **F10.21** Alcohol dependence, in remission

#### Cannabis

- **F12.10** Cannabis abuse, uncomplicated (cannabis use disorder, mild)
- **F12.18** Cannabis abuse with cannabis-induced
- **F12.19** Cannabis abuse with unspecified cannabis-induced disorder
- **F12.20** Cannabis dependence, uncomplicated
- **F12.21** Cannabis dependence, in remission
- **F12.90** Cannabis use, unspecified, uncomplicated

#### Sedatives

- **F13.10** Sedative, hypnotic or anxiolytic abuse, uncomplicated (use disorder, mild)
- **F13.129** Sedative, hypnotic or anxiolytic abuse with intoxication, unspecified
- **F13.14** Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced mood disorder
- **F13.18** Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced

---

+ Codes are add-on codes, meaning they are reported separately in addition to the appropriate code for the service provided
* Indicates CPT allows as a telemedicine service

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F13.21</td>
<td>Sedative, hypnotic or anxiolytic dependence, in remission</td>
</tr>
<tr>
<td>F13.90</td>
<td>Sedative, hypnotic, or anxiolytic use, unspecified, uncomplicated</td>
</tr>
</tbody>
</table>

**Stimulants (eg, Caffeine, Amphetamines)**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F15.10</td>
<td>Other stimulant (amphetamine-related disorders or caffeine) abuse, uncomplicated (use disorder, mild)</td>
</tr>
<tr>
<td>F15.14</td>
<td>Other stimulant (amphetamine-related disorders or caffeine) abuse with stimulant-induced mood disorder</td>
</tr>
<tr>
<td>F15.19</td>
<td>Other stimulant (amphetamine-related disorders or caffeine) abuse with unspecified stimulant-induced disorder</td>
</tr>
<tr>
<td>F15.20</td>
<td>Other stimulant (amphetamine-related disorders or caffeine) dependence, uncomplicated</td>
</tr>
<tr>
<td>F15.21</td>
<td>Other stimulant (amphetamine-related disorders or caffeine) dependence, in remission</td>
</tr>
<tr>
<td>F15.90</td>
<td>Other stimulant (amphetamine-related disorders or caffeine) use, unspecified, uncomplicated</td>
</tr>
</tbody>
</table>

**Nicotine (eg, Cigarettes)**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F17.200</td>
<td>Nicotine dependence, unspecified, uncomplicated (tobacco use disorder, mild, moderate or severe)</td>
</tr>
<tr>
<td>F17.201</td>
<td>Nicotine dependence, unspecified, in remission</td>
</tr>
<tr>
<td>F17.203</td>
<td>Nicotine dependence unspecified, with withdrawal</td>
</tr>
<tr>
<td>F17.210</td>
<td>Nicotine dependence, cigarettes, uncomplicated</td>
</tr>
<tr>
<td>F17.211</td>
<td>Nicotine dependence, cigarettes, in remission</td>
</tr>
<tr>
<td>F17.213</td>
<td>Nicotine dependence, cigarettes, with withdrawal</td>
</tr>
</tbody>
</table>

**Trauma- and Stressor-Related Disorders**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F43.22</td>
<td>Adjustment disorder with anxiety</td>
</tr>
<tr>
<td>F43.23</td>
<td>Adjustment disorder with mixed anxiety and depressed mood</td>
</tr>
<tr>
<td>F43.25</td>
<td>Adjustment disorder with mixed disturbance of emotions and conduct</td>
</tr>
<tr>
<td>F43.29</td>
<td>Adjustment disorder with other symptoms</td>
</tr>
<tr>
<td>F43.0</td>
<td>Acute stress reaction</td>
</tr>
<tr>
<td>F43.8</td>
<td>Other reactions to severe stress</td>
</tr>
<tr>
<td>F43.9</td>
<td>Reaction to severe stress, unspecified</td>
</tr>
</tbody>
</table>

**Other**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F07.81</td>
<td>Postconcussional syndrome</td>
</tr>
<tr>
<td>F07.89</td>
<td>Personality and behavioral disorders due to known physiological condition, other</td>
</tr>
<tr>
<td>F07.9</td>
<td>Personality and behavioral disorder due to known physiological condition, unspecified</td>
</tr>
<tr>
<td>F45.41</td>
<td>Pain disorder exclusively related to psychological factors</td>
</tr>
<tr>
<td>F45.42</td>
<td>Pain disorder with related psychological factors (code also associated acute or chronic pain (G89.-)</td>
</tr>
<tr>
<td>F48.8</td>
<td>Other specified nonpsychotic mental disorders (Neurasthenia)</td>
</tr>
<tr>
<td>F48.9</td>
<td>Nonpsychotic mental disorder, unspecified</td>
</tr>
<tr>
<td>F93.8</td>
<td>Childhood emotional disorders, other</td>
</tr>
</tbody>
</table>

**Symptoms, Signs, and Ill-Defined Conditions**

Use these codes in absence of a definitive mental diagnosis or when the sign or symptom is not part of the disease course or considered incidental.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G44.201</td>
<td>Tension-type headache, unspecified, intractable</td>
</tr>
<tr>
<td>G44.209</td>
<td>Tension-type headache, unspecified, not intractable</td>
</tr>
<tr>
<td>G44.221</td>
<td>Chronic tension-type headache, intractable</td>
</tr>
<tr>
<td>G44.229</td>
<td>Chronic tension-type headache, not intractable</td>
</tr>
<tr>
<td>G47.9</td>
<td>Sleep disorder, unspecified</td>
</tr>
</tbody>
</table>
Codes are add-on codes, meaning they are reported separately in addition to the appropriate code for the service provided.

Indicates CPT allows as a telemedicine service.

K59.00 Constipation, unspecified
N39.44 Nocturnal enuresis
R00.0 Tachycardia, unspecified
R03.0 Elevated blood-pressure reading, without diagnosis of hypertension
R06.02 Shortness of breath
R06.4 Hyperventilation
R07.9 Chest pain, unspecified
R10.0 Acute abdomen pain
R11.0 Nausea
R11.11 Vomiting without nausea
R11.2 Nausea with vomiting, unspecified
R12 Heartburn
R14.1 Gas pain
R14.2 Eructation
R14.3 Flatulence
R19.7 Diarrhea, unspecified
R19.8 Other specified symptoms and signs involving the digestive system and abdomen
R45.0 Nervousness
R45.82 Worries
R45.83 Excessive crying of child, adolescent or adult
R45.89 Other symptoms and signs involving emotional state
R51 Headache
R63.3 Feeding difficulties
R63.4 Abnormal weight loss
R63.5 Abnormal weight gain
R68.89 Other general symptoms and signs

T56.0X1- Toxic effect of lead and its compounds, accidental (unintentional), initial encounter (requires a 7th digit –refer to the ICD manual)

Z Codes

Z codes represent reasons for encounters. Categories Z00–Z99 are provided for occasions when circumstances other than a disease, injury, or external cause classifiable to categories A00–Y89 are recorded as 'diagnoses' or 'problems'. This can arise in 2 main ways.

(a) When a person who may or may not be sick encounters the health services for some specific purpose, such as to receive limited care or service for a current condition, to donate an organ or tissue, to receive prophylactic vaccination (immunization), or to discuss a problem is in itself not a disease or injury.

(b) When some circumstance or problem is present which influences the person's health status but is not in itself a current illness or injury.

(c) When a social determinant of health is identified during an encounter and it is either addressed or shown to complicate the encounter, it should be coded.

Z13.4 Encounter for screening for certain developmental disorders in childhood (not for routine screen)
Z13.89 Encounter for screening for other disorder (anxiety)
Z59.00 Homelessness unspecified
Z59.5 Extreme poverty
Z59.6 Low income

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