CODING REFERENCE

Psychiatry E/M documentation checklist

An educational checklist for documenting common outpatient evaluation and management (E/M) visits in psychiatry. CPT codes and descriptors are copyright the American Medical Association; use official CPT and current CMS guidance.

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Current as of July 7, 2026. Laws, payer rules, and billing codes change. Confirm the current requirements for your jurisdiction and setting before you rely on anything here.

How outpatient E/M is chosen

Since 2021, outpatient E/M level is selected by either the level of medical decision making (MDM) or the total time spent on the date of the visit. Document whichever you are relying on.

Medical decision making, in plain terms

- Number and complexity of problems addressed
- Amount and complexity of data reviewed, such as records, tests, and outside notes
- Risk of the plan, including medication management and its monitoring

If you code by time

- Record total time on the calendar date of the encounter
- Time includes review, the visit, documentation, ordering, and care coordination that day
- State the total minutes clearly in the note

Codes you will see (verify with official CPT and CMS)

99213, 99214, 99215: established-patient outpatient visits at increasing MDM or time

99203, 99204, 99205: new-patient outpatient visits

Match the level to documented MDM or documented time, not to habit

Every note should still show

- A clear reason for the visit and interval history
- A mental status exam appropriate to the visit
- An assessment and a plan, including risk and follow-up
- Medication decisions and monitoring

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