IP/CSU/RES PSYCHIATRIST DOCUMENTATION



Primary Billable Documentation

Inpatient Med Support (99252-99255) based on time.

- Can select either IP Admission versus IP Progress Note
- Can backdate within 24 hours of admission (eg patient was admitted at night on Day 1, but MD/DO sees pt on Day 2)

Can use, but ONLY on DAY of Admission

- AssessmentMD (90792): can use this if reviewing any data with evaluation and assessment (eg MSE) that is separate from the IP Medication and Support Admission/Progress Note. Can be used in the context of meeting with other providers.
- Medical Team Conference, Participation by Physician. Pt and/or Family Not Present (99368) Use in the context of meeting with other providers >30m to discuss pt.
- Consults for New and Established Patients 99242, 99243, 99244, 99245: Used by provider, who is consulted to evaluate and manage a patient.
- **Physician Consultation (99451):** used when meeting with other MD/DO to discuss about a patient.
- Review of Medical Records (90085): Used when reviewing any medical record that influences diagnosis decision-making
- Medication Support and Training (H0034): Any medication education/training/support with patient/family.
- TCM/ICC (1017): Any care coordination, including medical.

Other documentation: (non-billable)

- Interdisciplinary Treatment Plan
- History and Physical
- Discharge Summary
- Discharge Instructions
- Transfer Summary
- Brief Contact Note
- Shift/Quick Note
- For Seclusion and Restraint, can document by clicking "Next Check" on Whiteboard and it will open the S&R flowsheet.
- Can use Medication Injection (96372) throughout stay





Can use, but ONLY on DAY of Admission

- Medication Support and Training (H0034): Any medication education/training/support with patient/family.
- TCM/ICC (1017): Any care coordination, including medical.
- Team Case Conference with Client/Family present (99366): used by non-MD providers (with allowable permission/role) meeting together with pt/family
- Team Case Conference with Client/Family absent (99367): used by non-MD providers (with allowable permission/role) meeting together without pt/family

Other documentation: (nonbillable)

- Shift Summary
- Personal Effects Inventory
- Nursing Assessment
- Nutritional Screening
- · History and Physical
- Interdisciplinary Treatment Plan
- Discharge Summary
- Discharge Instructions
- Transfer Summary
- Shift/Quick Note (can access from Whiteboard)
- For Seclusion and Restraint, can document by clicking "Next Check" on Whiteboard and it will open the S&R flowsheet.
- Can use Medication Injection (96372) throughout stay for RN (For LVT/PT, if on first day of admission can use Medication Training and Support (H0034), otherwise on subsequent days, use Brief Contact note- Nonbillable or Shift/Quick Note-Nonbillable)