

[Skip to Main Content](#)

Main Menu

[Back to Document ID Search Results](#)

FUTURE Local Coverage Determination (LCD): Psychiatric Diagnostic Evaluation and Psychotherapy Services (L33128)

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Section Navigation Go



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[Back to Top](#)

- LCD Information

Document Information



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LCD Title
Psychiatric Diagnostic Evaluation and Psychotherapy Services

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CMS National Coverage Policy

Language quoted from CMS National Coverage Determination (NCDs) and coverage provisions in interpretive manuals are italicized throughout the Local Coverage Determination (LCD). NCDs and coverage provisions in interpretive manuals are not subject to the LCD Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See §1869(f)(1)(A)(i) of the Social Security Act.

Unless otherwise specified, *italicized* text represents quotation from one or more of the following CMS sources:

CMS Manual System, Pub. 100-01, Medicare General Information, Chapter 3, Section 30
 CMS Manual System, Pub. 100-04, Medicare Claims Processing, Chapter 12, Sections 120B and 210-210.1
 CMS Manual System, Pub. 100-04, Medicare Claims Processing, Chapter 12, Sections 160-170
 CMS Manual System, Pub. 100-08, Medicare Program Integrity, Chapter 3, Section 3.3.2.6- Psychotherapy Notes
 CMS Medicare Learning Network, March 2012, Mental Health Services (accessible at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Mental_Health_Services_ICN903195.pdf)
 CMS Medicare Learning Network (MLN) Matters® Number: SE1407

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

Indications of Coverage and/or Medical Necessity:

This part of the policy has been divided into eight (8) sections addressing the following services:

- I. Psychiatric Diagnostic Evaluation and Psychiatric Diagnostic Evaluation with Medical Services
- II. Psychotherapy
- III. Group Psychotherapy
- IV. Family Psychotherapy
- V. Psychoanalysis
- VI. Interactive Complexity Services
- VII. Psychotherapy for Crisis
- VIII. Psychopharmacologic Medication Management without Psychotherapy

Section I: Psychiatric Diagnostic Evaluation and Psychiatric Diagnostic Evaluation with Medical Services (CPT codes 90791, 90792)

A. Psychiatric Diagnostic Evaluation (CPT code 90791)

A psychiatric diagnostic evaluation is an integrated biopsychosocial assessment that includes the elicitation of a complete medical history (to include past, family, and social), psychiatric history, a complete mental status exam, establishment of a tentative diagnosis, and an evaluation of the patient's ability and willingness to participate in the proposed treatment plan. Information may be obtained from the patient, other physicians, other clinicians or community providers, and/or family members or other sources. There may be overlapping of the medical and psychiatric history depending upon the problem(s).

Although the emphasis, types of details, and style of a psychiatric evaluation differ from the medical evaluation, the purpose is the same: to establish effective communication with interaction of sufficient quality between provider and patient to gather accurate data in order to formulate tentative diagnoses, determine necessity, and as appropriate, initiate an effective and comprehensive treatment plan.

Psychiatric diagnostic evaluations will be considered medically necessary when the patient has a psychiatric illness and /or is demonstrating emotional or behavioral symptoms sufficient to cause inappropriate behavior patterns or maladaptive functioning in personal or social settings, which may be suggestive of a psychiatric illness. This examination may also be medically necessary when baseline functioning is altered by suspected illness or symptoms. It is appropriate for dementia, in patients who experience a sudden and rapid change in behavior.

The psychiatric diagnostic evaluation is not considered to be medically reasonable and necessary:

- when it is rendered to a patient who has a medical/neurological condition such as dementia, delirium, or other psychiatric conditions, which have produced a severe enough cognitive defect to prevent effective communication and the ability to assess the patient; or
- when the patient has a previously established diagnosis of a neurological condition or dementia and is not amenable to the evaluation and therapy, unless there has been an acute and/or marked mental status change, a request for second opinion, or diagnostic clarification is necessary to rule out additional psychiatric or neurological processes, which may be treatable; or
- when a patient is referred with an organic diagnosis and a mental health diagnosis is established, the mental health diagnosis should be billed. Routine performance of additional psychiatric diagnostic evaluation of patients with chronic conditions is not considered medically necessary.

A psychiatric diagnostic evaluation can be conducted once, at the onset of an illness or suspected illness. The same provider may repeat it for the same patient if an extended hiatus in treatment occurs, if the patient requires admission to an inpatient status for a psychiatric illness, or for a significant change in mental status requiring further assessment. An extended hiatus is generally defined as approximately 6 months from the last time the patient was seen or treated for their psychiatric condition. A psychiatric diagnostic evaluation may also be utilized again if the patient has a previously established neurological disorder or dementia and there has been an acute and/or marked mental status change, or a second opinion or diagnostic clarification is necessary to rule out additional psychiatric or neurological processes, which may be treatable.

B. Psychiatric Diagnostic Evaluation with Medical Services (CPT code 90792)

A psychiatric diagnostic evaluation with medical services is an integrated biopsychosocial and medical assessment, including history (to include past, family, and social), psychiatric history, a complete mental status exam, other physical examination elements as indicated, establishment of a tentative diagnosis, and an evaluation of the patient's ability and willingness to participate in the proposed treatment plan. The evaluation may include communication with family members or other sources, prescription of medications, and review and ordering of laboratory or other diagnostic studies.

When a patient is referred with an organic diagnosis and a mental health diagnosis is established, the mental health diagnosis should be billed. Routine performance of additional psychiatric diagnostic evaluation of patients with chronic conditions is not considered medically necessary.

A psychiatric diagnostic evaluation with medical services can be conducted once, at the onset of an illness or suspected illness. The same provider may repeat it for the same patient if an extended hiatus in treatment occurs, if the patient requires admission to an inpatient status for a psychiatric illness, or for a significant change in mental status requiring further assessment. An extended hiatus is generally defined as approximately 6 months from the last time the patient was seen or treated for their psychiatric condition. A psychiatric diagnostic evaluation with medical services may also be utilized again if the patient has a previously established neurological disorder or dementia and there has been an acute and/or marked mental status change, or a second opinion or diagnostic clarification is necessary to rule out additional psychiatric or neurological processes, which may be treatable.

Section II: Psychotherapy (CPT Codes 90832-90838)

Psychotherapy is the treatment of mental illness and behavior disturbances, in which the provider establishes a professional contact with the patient and through therapeutic communication and techniques, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, facilitate coping mechanisms and/or encourage personality growth and development.

Insight oriented, behavior modifying, and/or supportive psychotherapy refers to the development of insight or affective understanding, the use of behavior modification techniques, the use of supportive interactions, and the use of cognitive discussion of reality, or any combination of the above to provide therapeutic change.

Psychotherapy will be considered medically necessary when the patient has a psychiatric illness and/or is demonstrating emotional or behavioral symptoms sufficient to cause inappropriate behavior or maladaptive functioning. Psychotherapy services must be performed by a person licensed by the state where practicing, and whose training and scope of practice allow that person to perform such services.

Psychotherapy must be provided as an integral part of an active treatment plan for which it is directly related to the patient's identified condition/diagnoses. Some patients receive psychotherapy alone, and others receive psychotherapy along with medical evaluation and management services. These services involve a variety of responsibilities unique to the medical management of psychiatric patients such as medical diagnostic evaluation (i.e. evaluation of co-morbid medical conditions, drug interactions, and physical examinations), drug management when indicated, physician orders, interpretation of laboratory or other diagnostic studies and observations. The patient should be amenable to allowing insight-oriented therapy such as behavioral modification techniques, interpersonal psychotherapy techniques, supportive therapy, and cognitive/behavioral techniques to be effective.

Psychotherapy services are not considered to be medically reasonable and necessary when they are rendered to a patient who has a medical/neurological condition such as dementia, delirium or other psychiatric conditions, which have produced a severe enough cognitive deficit to prevent effective communication with interaction of sufficient quality to allow insight oriented therapy (i.e. behavioral modification techniques, interpersonal psychotherapy techniques, supportive therapy or cognitive/behavioral techniques). In these cases, evaluation and management or pharmacological codes should be used.

Psychotherapy services are not considered to be medically reasonable and necessary when they primarily include the teaching of grooming skills, monitoring activities of daily living, recreational therapy (dance, art play), or social interaction.

Psychotherapy times are for face-to-face services with the patient and/or family member. The patient must be present for all or some of the service. In reporting, choose the code closest to the actual time (i.e., 16-37 minutes for 90832 and 90833, 38-52 minutes for 90834 and 90836, and 53 or more minutes for 90837 and 90838). Do not report psychotherapy of less than 16 minutes duration.

Some psychiatric patients receive a medical evaluation and management service on the same day as a psychotherapy service by the same physician or other qualified health care professional. These services to be medically necessary should be significantly different and separately identifiable.

Section III: Group Psychotherapy (CPT Code 90853)

Group Psychotherapy is a form of treatment administered in a group setting with a trained group leader in charge of several patients. Since it involves psychotherapy it must be led by a person, authorized by state statute to perform this service. This will usually mean a psychiatrist, clinical psychologist, licensed clinical social worker, certified nurse practitioner, or clinical nurse specialist. The group is a carefully selected group of patients meeting for a prescribed period of time during which common issues are presented and generally relate to and evolve towards a therapeutic goal. Personal and group dynamics are discussed and explored in a therapeutic setting allowing emotional outpouring, instruction, and support. Medical diagnostic evaluation and pharmacological management may continue by a physician when indicated. The group size should be of a size that can be considered therapeutically successful (i.e., maximum 12 people).

Medicare will consider group therapy to be medically necessary when the patient has a psychiatric illness and /or is demonstrating emotional or behavioral symptoms sufficient to cause inappropriate behavior patterns or maladaptive functioning in personal or social settings. The issues presented and explored in the group setting should evolve towards a

theme or a therapeutic goal. Group psychotherapy must be ordered by a provider as an integral part of an active treatment plan for which it is directly related to the patient's identified condition/diagnosis. This treatment plan must be adhered to and should be endorsed and monitored by the treating physician or physician of record. The specialized skills of a mental health care professional must be required.

Group psychotherapy services are not considered to be medically reasonable and necessary when they are rendered to a patient who has a medical/neurological condition such as dementia, delirium, or other psychiatric conditions, which have produced a severe enough cognitive deficit to prevent effective communication including interaction of sufficient quality with the therapist and members of the group. Other services such as music therapy, socialization, recreational activities/recreational therapy, art classes/art therapy, excursions, sensory stimulation, eating together, cognitive stimulation, or motion therapy are not considered to be medically reasonable and necessary.

Section IV: Family Psychotherapy (CPT Codes 90846, 90847)

Family Psychotherapy is a specialized therapeutic technique for treating the identified patients' mental illness by intervening in a family system in such a way as to modify the family structure, dynamics, and interactions which exert influence on the patient's emotions and behaviors.

Family psychotherapy sessions may occur with or without the patient present. The process of family psychotherapy helps reveal a family's repetitious communication patterns that are sustaining and reflecting the identified patient's behavior. For the purposes of this policy, a family member is any individual who spends a significant amount of the time with the patient and provides psychological support to the patient, which may include but is not limited to a caregiver or significant other.

Medicare will consider family psychotherapy medically reasonable and necessary only in clinically appropriate circumstances and when the primary purpose of such psychotherapy is the treatment/management of the patient's condition. Examples are as follows:

- when there is a need to observe and correct, through psychotherapeutic techniques, the patient's interaction with family members; and/or
- where there is a need to assess the conflicts or impediments within the family, and assist, through psychotherapeutic techniques, the family members in the management of the patient.

Family psychotherapy must be ordered by a provider as an integral part of an active treatment plan for which it is directly related to the patient's identified condition/diagnosis.

Family psychotherapy must be conducted face to face by physicians (MD/DO), psychologists, or other mental health professionals licensed or authorized by state statutes and considered eligible for Medicare B reimbursement.

Family psychotherapy is considered to be medically reasonable and necessary when the patient has a psychiatric illness and/or is demonstrating emotional or behavioral symptoms sufficient to cause inappropriate behavior or maladaptive functioning.

In certain types of medical conditions, such as the unconscious or comatose patient, family psychotherapy would not be medically reasonable or necessary. Also, CPT code 90849 (Multiple family group psychotherapy) would not be considered treatment directly related to the patient's care and therefore would not be considered medically necessary.

A family psychotherapy session generally lasts for at least 45-50 minutes.

Section V: Psychoanalysis (CPT Code 90845)

Psychoanalysis is a treatment modality that uses psychoanalytic theories as the frame for formulation and understanding of the therapy process. These theories provide a focus on increasing self-understanding and deepening insight into emotional issues and conflicts which underlie presenting emotional difficulties. Typically therapists make use of exploration of unconscious thoughts and feelings which may relate to underlying emotional conflicts, interpretation of defensive processes which obstruct emotional awareness, and consideration of issues related to sense of self-esteem.

Psychoanalysis uses a special technique to gain insight into a patient's unconscious motivations and conflicts using the development and resolution of a therapeutic transference to achieve therapeutic effect. It is a different therapeutic modality than psychotherapy.

The medical record must document the indications for psychoanalysis, description of the transference, and that psychoanalytic techniques were used. The physician using this technique must be trained and credentialed in its use. Clinical nurse specialists (CNS) and nurse practitioners (NP) are not eligible for payment for psychoanalysis. It is not a time-related code, but the service is usually 45 to 50 minutes in duration. The code may be billed once for each daily session regardless of the time involved. Psychoanalysis is generally considered unsuitable for psychoses.

Section VI: Interactive Complexity Services (CPT Code 90785)

Interactive complexity 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.

The interactive complexity techniques are utilized primarily to evaluate children and/or adults who do not have the ability to interact through ordinary verbal communication. In the aforementioned instances, it involves the use of physical aids and nonverbal communication to overcome barriers to the therapeutic interaction between the clinician and the patient who has not

yet developed or has lost either the expressive language communication skills to explain his/her symptoms and response to treatment or the receptive communication skills to understand the clinician if he/she were to use ordinary adult language for communication. An interactive technique may include the use of inanimate objects such as toys and dolls for a child, physical aids, and non-verbal communication to overcome barriers to therapeutic interaction, or an interpreter for a person who is deaf or in situations where the patient does not speak the same language as the provider of care.

If a patient is unable to communicate by any means, the interactive complexity codes should not be billed. This service is used in conjunction with codes for diagnostic psychiatric evaluation (90791, 90792), psychotherapy (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).

Interactive complexity may be reported with psychotherapy when at least one of the following communication factors is present during the visit:

- The need to manage maladaptive communication among participants (related to, e.g., high anxiety, high reactivity, repeated questions, or disagreement) that complicates delivery of care.
- Caregiver emotions or behaviors that interfere with implementation of the treatment plan.
- Evidence or disclosure of a sentinel event and mandated report to a third party (e.g., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.
- Use of play equipment, physical devices, interpreter, or translator to overcome barriers to diagnostic or therapeutic interaction with a patient who is not fluent in the same language or who has not developed or has lost expressive or receptive language skills to use or understand typical language.

Section VII: Psychotherapy for Crisis (CPT Codes 90839-90840)

Psychotherapy for crisis is an urgent assessment and history of a crisis state, a mental status exam, and a disposition. The treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma. The presenting problem is typically life threatening or complex and requires immediate attention to a patient with high distress. The crisis codes are used to report the total duration of time face-to-face with the patient and/or family spent by the physician or other qualified health care professional providing psychotherapy for crisis, even if the time spent on that date is not continuous. For any given period of time spent providing psychotherapy for crisis state, the physician or other qualified health care professional must devote his or her full attention to the patient and, therefore, cannot provide service to any other patient during the same time period. The patient must be present for all or some of the service.

[Back to Top](#)

- Coding Information



Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

N/A

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

N/A

CPT/HCPCS Codes

Group 1 Paragraph:

N/A

Group 1 Codes:

90785	INTERACTIVE COMPLEXITY (LIST SEPARATELY IN ADDITION TO THE CODE FOR PRIMARY PROCEDURE)
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90791	PSYCHIATRIC DIAGNOSTIC EVALUATION
90792	PSYCHIATRIC DIAGNOSTIC EVALUATION WITH MEDICAL SERVICES
90832	PSYCHOTHERAPY, 30 MINUTES WITH PATIENT AND/OR FAMILY MEMBER
90833	PSYCHOTHERAPY, 30 MINUTES WITH PATIENT AND/OR FAMILY MEMBER WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE (LIST SEPARATELY IN ADDITION TO THE CODE FOR PRIMARY PROCEDURE)
90834	PSYCHOTHERAPY, 45 MINUTES WITH PATIENT AND/OR FAMILY MEMBER
90836	PSYCHOTHERAPY, 45 MINUTES WITH PATIENT AND/OR FAMILY MEMBER WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE (LIST SEPARATELY IN ADDITION TO THE CODE FOR PRIMARY PROCEDURE)
90837	PSYCHOTHERAPY, 60 MINUTES WITH PATIENT AND/OR FAMILY MEMBER
90838	PSYCHOTHERAPY, 60 MINUTES WITH PATIENT AND/OR FAMILY MEMBER WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE (LIST SEPARATELY IN ADDITION TO THE CODE FOR PRIMARY PROCEDURE)
90839	PSYCHOTHERAPY FOR CRISIS; FIRST 60 MINUTES
90840	PSYCHOTHERAPY FOR CRISIS; EACH ADDITIONAL 30 MINUTES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY SERVICE)
90845	PSYCHOANALYSIS
90846	FAMILY PSYCHOTHERAPY (WITHOUT THE PATIENT PRESENT)
90847	FAMILY PSYCHOTHERAPY (CONJOINT PSYCHOTHERAPY) (WITH PATIENT PRESENT)
90853	GROUP PSYCHOTHERAPY (OTHER THAN OF A MULTIPLE-FAMILY GROUP)

ICD-9 Codes that Support Medical Necessity

Group 1 Paragraph:

N/A

Group 1 Codes:

<u>290.0 - 299.91</u>	SENILE DEMENTIA UNCOMPLICATED - UNSPECIFIED PERVASIVE DEVELOPMENTAL DISORDER, RESIDUAL STATE
<u>300.00 - 316</u>	ANXIETY STATE UNSPECIFIED - PSYCHIC FACTORS ASSOCIATED WITH DISEASES CLASSIFIED ELSEWHERE
317	MILD INTELLECTUAL DISABILITIES
318.0	MODERATE INTELLECTUAL DISABILITIES
318.1	SEVERE INTELLECTUAL DISABILITIES
318.2	PROFOUND INTELLECTUAL DISABILITIES
331.0	ALZHEIMER'S DISEASE

ICD-9 Codes that DO NOT Support Medical Necessity

N/A

[Back to Top](#)

- **General Information**



Associated Information Documentation Requirements

The patient's medical record must contain documentation that clearly supports the medical necessity for services included within this LCD. (See "Indications and Limitations of Coverage and/or Medical Necessity" section.)

The medical record for **psychiatric diagnostic evaluation with or without medical assessment (CPT codes 90791, 90792)** should indicate the presence of a psychiatric illness and/or the demonstration of emotional or behavioral symptoms which may be suggestive of a psychiatric illness or are sufficient to significantly alter baseline functioning. The diagnostic evaluation should include:

- The reason for the evaluation/patient's chief complaint
- A referral source (if applicable)
- History of present illness, including length of existence of problems/symptoms/conditions
- Past history (psychiatric)
- Significant medical history and current medications
- Social history
- Family history
- Mental status exam
- Strengths/liabilities
- Multi-axis diagnosis or diagnostic impression list-including problem list
- Treatment plan (including methods of therapy, anticipated length of treatment to the extent possible, and a description of the planned measurable and objective goals related to expected changes in behavior or thought processes)

In circumstances where other informants (family or other sources) are interviewed in lieu of the patient, documentation must include the elements outlined previously, as well as the specific reason(s) for not evaluating the patient. Any notations where family members provided patient history should be included. This should be a rare occurrence.

Note: If a psychiatric diagnostic evaluation with medical assessment is performed, the physician or NPP may use CPT code 90792 or an evaluation and management (E/M) code. If an E/M code is chosen, refer to the 1995 or 1997 Documentation Guidelines for Evaluation and Management Services accessible at <http://medicare.fcso.com/Landing/233030.asp>.

All documentation for **interactive complexity services (CPT code add-on code 90785)** must clearly reflect the requirements of the corresponding non-interactive procedure codes. Documentation to support the medical necessity for an interactive complexity procedure code should be in addition to these guidelines. Any time that an interactive complexity service is reported, the medical record must clearly support the rationale for this approach. Otherwise stated, there must be an explanation of what specific communication factors complicated the delivery of a psychiatric procedure. The medical record must indicate that the person being evaluated has one of the following communication factors present during the visit:

- The need to manage maladaptive communication among participants (related to, e.g., high anxiety, high reactivity, repeated questions, or disagreement) that complicates delivery of care.
- Caregiver emotions or behaviors that interfere with implementation of the treatment plan.
- Evidence or disclosure of a sentinel event and mandated report to a third party (e.g., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.
- Use of play equipment, physical devices, interpreter, or translator to overcome barriers to diagnostic or therapeutic interaction with a patient who is not fluent in the same language or who has not developed or has lost expressive or receptive language skills to use or understand typical language.

Additionally, the medical record must include adaptations utilized in the session to overcome the difficulty in communication and the rationale for employing these techniques justifying the interactive complexity of the service. When billed in conjunction with time based codes, the documentation must indicate the amount of time spent in providing interactive complexity services. The medical record must include treatment recommendations.

The documentation for **psychotherapy for crisis (CPT codes 90839, 90840)** must clearly support that for any given period of time spent providing psychotherapy for crisis state, the physician or other qualified health care professional must devote his or her full attention to the patient and, therefore, cannot provide service to any other patient during the same time period. The patient must be present for all or some of the service. These are time-based codes and are used to report the total

duration of time face-to-face with the patient and/or family spent by the physician or other qualified health care professional providing psychotherapy for crisis, even if the time spent on that date is not continuous. Do not report with CPT codes 90791 or 90792.

The documentation for **psychoanalysis or psychotherapy services including group and family psychotherapy (CPT codes 90832-90838, 90845, 90846, 90847, and 90853)** should include on a periodic basis the patient's capacity to participate and benefit from psychotherapy/psychoanalysis. Such periodic documentation should include the estimated duration of treatment in terms of number of sessions required and the target symptoms, measurable and objective goals of therapy related to changes in behavior, thought processes and/or medications, methods of monitoring outcome, and why the chosen therapy is an appropriate modality either in lieu of or in addition to another form of psychiatric treatment. For an acute problem, there should be documentation that the treatment is expected to improve the mental health status or function of the patient. For chronic problems, there must be documentation indicating that stabilization of mental health status or function is expected. Documentation will reflect adjustments in the treatment plan that reveals the dynamics of treatment.

Psychotherapy/psychoanalysis services are not considered to be medically reasonable and necessary when they are rendered to a patient who has a medical/neurological condition such as dementia, delirium or other psychiatric conditions, which have produced a severe enough cognitive deficit to prevent effective communication with interaction of sufficient quality to allow insight oriented therapy.

It is expected that the treatment plan for a patient receiving outpatient psychotherapy or psychoanalysis services, (i.e., measurable and objective treatment goals, descriptive documentation of therapeutic intervention, frequency of sessions, and estimated duration of treatment) will be updated on a periodic basis, generally at least every three months.

For services billed as CPT codes 90832-90838, 90853, and 90845, the medical record documentation maintained by the provider must indicate the medical necessity of each psychotherapy/psychoanalysis session and include the following:

- Psychotherapy services (CPT codes 90832-90838) are time based codes. Start and stop times must be documented for CPT codes 90832, 90834, and 90837. For psychotherapy services performed with an evaluation and management (E/M) service (CPT codes 90833, 90836, and 90838), it is recognized that the psychotherapy time may not be continuous in a combined psychotherapy with an E/M service. However, since psychotherapy is a time-based code, the expectation would be documentation of the start and stop time of the psychotherapy with an E/M service and documentation of the total minutes devoted to psychotherapy. The total time does not include the E/M time. Also note that when psychotherapy is performed with an E/M by the same physician or NPP, the documentation should show that they are separately identifiable services. Psychotherapy times are for face-to-face services with the patient and/or family member. The patient must be present for all or some of the service. In reporting, choose the code closest to the actual time (i.e., 16-37 minutes for 90832 and 90833, 38-52 minutes for 90834 and 90836, and 53 or more minutes for 90837 and 90838). Do not report psychotherapy of less than 16 minutes duration.

Some psychiatric patients receive a medical evaluation and management service on the same day as a psychotherapy service by the same physician or other qualified health care professional. These services to be medically necessary should be significantly different and separately identifiable.

Prolonged services may not be reported when psychotherapy services billed with an E/M service (i.e., add-on codes 90833, 90836, 90838) are reported. For code 90837 (psychotherapy, 60 minutes with patient and/or family member), a physician or other qualified health care professional can report a prolonged service code if the psychotherapy service, not performed with an E/M service, is 90 minutes or longer involving direct patient contact.

If psychotherapy codes are billed incident-to, all incident-to rules must be met, and the person providing the psychotherapy service must be licensed in the state to perform psychotherapy.

- The presence of a psychiatric illness and/or the demonstration of emotional or behavioral symptoms sufficient to alter baseline functioning; and
- A detailed summary of the session, including descriptive documentation of therapeutic interventions such as examples of attempted behavior modification, supportive interaction, and discussion of reality; and
- The degree of patient participation and interaction with the therapist, the reaction of the patient to the therapy session, documentation toward goal oriented outcomes and the changes or lack of changes in patient symptoms and/or behavior as a result of the therapy session.
- The rationale for any departure from the plan or extension of therapy should be documented in the medical record. The therapist must document patient/therapist interaction in addition to an assessment of the patient's problem(s).

Additionally, for psychoanalysis (CPT code 90845), the medical record must document the indications for psychoanalysis, description of the transference, and that psychoanalytic techniques were used. The physician using this technique must be trained and credentialed in its use. CNS's and NP's are not eligible for payment for psychoanalysis. It is not time-related, but the service is usually 45 to 50 minutes in duration. The code may be billed once for each daily session regardless of the time involved.

For family psychotherapy services (with or without the patient present) billed as CPT code 90846 or 90847, the medical record documentation maintained by the provider must indicate the medical necessity of each family psychotherapy session and include the following:

- The presence of a psychiatric illness and/or the demonstration of emotional or behavioral symptoms sufficient to alter baseline functioning; and

- The summary of themes addressed in the family psychotherapy session, including descriptive documentation of therapeutic interventions such as examples of attempted behavior modification, supportive interaction, and discussion of reality; and
- The degree of patient participation and interaction with the family members and leader, the reaction of the patient to the group, the group's reaction to the patient and the changes or lack of changes in patient symptoms and/or behavior as a result of the family psychotherapy session.

It is the provider's responsibility not to submit privileged information. This information should be kept apart from the clinical note in a separate section of the patient's medical record. The following are some examples of privileged information:

- Information or facts of intimate personal content
- Topics of themes discussed in therapy sessions
- The annotations taken during the psychotherapy session
- Details of fantasies and dreams
- Sensitive information about other individuals in the patient's life, etc.

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and 45 CFR§164.501 establish that the psychotherapy notes that are separated from the rest of the individual's medical record do not include the following information, which should be part of the clinical note of the psychotherapy service:

- Medication prescription and monitoring,
- Counseling session start and stop times,
- The modalities and frequencies of treatment furnished,
- Results of clinical tests and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

Psychotherapy notes are defined in 45 CFR§164.501 as "notes recorded by a mental health professional which document or analyze the contents of a counseling session and that are separated from the rest of a medical record." The definition of psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of administered treatment, results of clinical tests, and any summary of diagnosis, functional status, treatment plan, symptoms prognosis, ongoing progress and progress to date. This class of information does not qualify as psychotherapy note material. Physically integrating information excluded from the definition of psychotherapy notes and protected information into one document or record does not transform the non-protected information into protected psychotherapy notes.

Under no circumstances shall the MACs, CERT, Recovery Auditors or ZPICs request that a provider submit psychotherapy notes defined in 45 CFR §164.501. The refusal of a provider to submit such information shall not result in the automatic denial of a claim.

If the medical documentation includes any of the information included in the definition of psychotherapy notes in §164.501, as stated above, the provider is responsible for extracting information required to support that the claim is for reasonable and necessary services. MACs, Recovery Auditors, CERT or ZPICs shall review the claim using the supporting documentation submitted by the provider. If the provider does not submit information sufficient to demonstrate that services were medically necessary, the claim shall be denied.

Utilization Guidelines

It is expected that these services would be performed as indicated by current medical literature and/or standards of practice. Individual patient requirements may differ; however, clear and concise documentation supporting medical necessity should be available upon request. Patient progress may be small or not be measurable at each visit. However, a trend should be measurable presenting signs of progression or regression in changes relating to behavior, thought processes, or medication management. When services are performed in excess of established parameters, they may be subject to review for medical necessity.

There must be a reasonable expectation of improvement in the patient's disorder or condition, demonstrated by an improved level of functioning or maintenance of level of functioning where decline would otherwise be expected in the case of a disabling mental illness or condition or chronic mental disorder. When a patient reaches a point in his/her treatment where further improvement does not appear to be indicated and there is no reasonable expectation of improvement, the psychological services are no longer considered reasonable or medically necessary. The documentation must support that the patient's mental stability cannot be maintained without further psychotherapy treatment. The duration of a course of psychotherapy must be individualized for each patient.

Psychiatric and/or psychological services routinely performed to evaluate and/or treat an adjustment disorder associated with placement in a nursing home do not constitute medical necessity. It is not expected that every patient upon entry to a nursing home receives a psychiatric diagnostic evaluation and/or psychotherapy services. The routine use of these services is considered screening and is not medically reasonable and necessary for Medicare coverage. However, some individuals enter a nursing home at a time of physical and cognitive decline and may require these services to arrive at a diagnosis, plan of care, and/or treatment. Decisions to perform these services to individuals who have recently entered a nursing home need to be made judiciously, on a case-by-case basis, and the medical record documentation must clearly support the medical necessity for the performance of these services.

The medical record documentation for psychotherapy must be clear and concise. Statements such as "supportive psychotherapy given" are not adequate. A clear and detailed description of what the psychotherapy entailed and how it is addressing the presenting problem of the patient should be evident.

The patient must have the capacity to actively participate in all therapies prescribed, except for family therapy without the patient present (code 90846).

Psychotherapy services are not considered to be medically reasonable and necessary when they primarily include the teaching of grooming skills, monitoring activities of daily living, recreational therapy (dance, art play), or social interaction. Therefore, procedure codes 90832-90838 should not be used to bill for these services.

Physicians/NPP's with a high utilization of these services per patient compared to their peers may be subject to review for medical necessity.

Sources of Information and Basis for Decision

American Psychiatric Association. Current Procedural Terminology (CPT) Code Changes for 2013. Accessed at: <http://www.psych.org/practice/managing-a-practice/cpt-changes-2013/current-procedural-terminology-cpt-code-changes-for-2013>

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CPT Changes 2013: An Insider's View, pages 232-244.

CPT 2013, Professional Edition, pages 483-487.

CPT 2014, Professional Edition, pages 527-530.

Evidence-Based Caregiver Interventions in Geriatric Psychiatry. Richard Schultz PhD, et al. Psychiatric Clinics of North America. December 2005: 28, 1007-1038. Accessed at: http://www.ucsur.pitt.edu/files/schulz/PsychClinicsofNA-CaregiverIntervention_001.pdf

Guidelines for Managing Alzheimer's Disease: Parts 1 and 2. Assessment. Jeffrey Cummings, et al. American Family Physician, 2002, Accessed at: <http://www.aafp.org/afp/2002/0601/p2263.html> and <http://www.aafp.org/afp/2002/0615/p2525.html>

Kaplan, H.I., Sadock, B.J., Grebb, J.A. (2002). Kaplan and Sadock's Synopsis of Psychiatry (9th ed.). Baltimore: Williams & Wilkins.

HCPCS Level II 2013 Book, Professional Edition

LCDs and policies from other Medicare contractors

[Back to Top](#)

- Revision History Information

Please note: Most Revision History entries effective on or before 01/24/2013 display with a Revision History Number of "R1" at the bottom of this table. However, there may be LCDs where these entries will display as a separate and distinct row.

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
02/07/2015	R4	Revision Number:3 Publication:December 2014 Connection LCR B2014-068 Explanation of revision: Medical review identified utilization issues upon review of claims for psychotherapy services. The "Utilization Guidelines" section of the LCD was revised to address these issues. Based on 2015 Annual HCPCS changes, M0064 has been deleted. The following sections of this LCD have been revised to remove references to M0064, "Indications of Coverage and/or	<ul style="list-style-type: none"> Provider Education/Guidance

01/01/2015	R3	Medical Necessity", "CPT/HCPCS CODES" and "Documentation Requirements." The effective date of this revision is based on date of service.	<ul style="list-style-type: none"> • Revisions Due To CPT/HCPCS Code Changes
		<p>Revision Number: 2 Publication: December 2014 Connection LCR B2015-013</p> <p>Explanation of revision: Based on 2015 Annual HCPCS changes, M0064 has been deleted. Section 102 of the Medicare Improvements for Patients and Providers Act (Pub. L. 110- 275, enacted on July 15, 2008) (MIPPA) required that effective January 1, 2014, 100% of expenses incurred for mental health treatment services be considered as incurred for purposes of Medicare, resulting in the same beneficiary cost sharing for these services as for other PFS services. Since the statute was amended to phase out the limitation, and the phase-out was complete effective January 1, 2014, Medicare no longer has a need to distinguish services subject to the mental health limitation from those that are not. Accordingly, the appropriate CPT code can now be used to bill Medicare for the services that would have otherwise been reported using M0064. The following sections of this LCD have been revised to remove references to M0064, "Indications of Coverage and/or Medical Necessity", "CPT/HCPCS CODES" and "Documentation Requirements." The effective date of this revision is based on date of service.</p>	
04/01/2014	R2	corrected typographical error	<ul style="list-style-type: none"> • Typographical Error
04/01/2014	R1	<p>Revision Number: 1 Publication: April 2014 Connection LCR B2014-033</p> <p>Explanation of revision: The Comprehensive Error Rate Testing (CERT) program identified improper payments based on review of claims for Psychiatry and Psychotherapy Services. The "Documentation Requirements" section of the LCD was revised to provide clarification on psychotherapy as an incident-to service and clarification on prolonged services. The effective date of this revision is based on date of service.</p>	<ul style="list-style-type: none"> • Other

[Back to Top](#)

Associated Documents

Attachments

[Coding Guidelines effec 1/1/15 \(PDF - 166 KB \)](#)

[Comment Summary 10/2/14-11/15/14 \(a comment and response document\) \(PDF - 51 KB \)](#)

Related Local Coverage Documents

N/A

Related National Coverage Documents

N/A

Public Version(s)

Updated on 12/19/2014 with effective dates 02/07/2015 - N/A

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Updated on 07/01/2014 with effective dates 04/01/2014 - 12/31/2014

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Updated on 04/03/2014 with effective dates 04/01/2014 - N/A

Updated on 04/09/2013 with effective dates 06/04/2013 - N/A

[Back to Top](#)

- **Keywords**

N/A

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[Back to Top](#)