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Comments and Responses Regarding Draft Local Coverage Determination: Outpatient Psychiatry and Psychology Services

As an important part of Medicare Local Coverage Determination (LCD) development, National Government Services solicits comments from the provider community and from members of the public who may be affected by or interested in our LCDs. The purpose of the advice and comment process is to gain the expertise and experience of those commenting.

We would like to thank those who suggested changes to the draft Outpatient Psychiatry and Psychology Services LCD. The official notice period for the final LCD begins on May 15, 2008, and the final determination will become effective on July 1, 2008.

Comment: One commenter stated that New York State (NYS) scope of practice allows other mental health providers, such as psychologists to establish treatment plans. In other LCD's, it is noted that for the purposes of the LCD, the term "physician" refers to all approved providers of service or all providers acting within their scope of practice. Is this not the case here or is more definition necessary as to who may create a treatment plan? Wouldn't a treatment plan be prescribed and written by all/any non-physician practitioners (NPPs) eligible to perform the prescribed service(s) under their scope of practice in the state in which they provide the service? It is implied that ALL services require a "formal" treatment plan. Generally, a "formal" treatment plan is established for psychotherapy services; however, for other services such as medication management or ECT the initial and ongoing treatment plan is outlined in the initial evaluation and ongoing progress notes. Please clarify if all services require this formal treatment plan.

Response: The policy's requirement for a formal written plan of care and that only a physician (MD/DO) may establish that plan of care is a technical requirement for hospitals and hospital outpatient settings. This technical requirement does not apply to services of psychologists or other NPPs billing their services to the Part B carrier.

Comment: The same commenter stated that on Page 7, paragraph 3, the terms treatment and therapy seem to be used interchangeably. The term therapy implies psychotherapy when associated with mental health services whereas the term treatment is broader and refers to all types of psychiatric & psychological services.

Response: The italicized language in the LCD is a direct quote from CMS manuals and the contractor does not have discretion to make changes to this language. It is our understanding that in this instance CMS is using the terms interchangeably.

Comment: The same commenter felt that the descriptor for ICD-9-CM code 319 should be added to page 24 under the "Limitations" section. Diagnosis code 319 is defined as unspecified mental retardation.

Response: ICD-9-CM code 319, mental retardation, unspecified, is a nonspecific diagnosis code and may encompass patients with severe and profound mental retardation. Full ICD-9-CM or Diagnostic and Statistical Manual of Mental Disorders DSM-IV-TR™ descriptors may be found in their respective publications.

Comment: The same commenter requested clarification on the qualifications, if any, for a "technician" who may render psychological testing, codes 96102 & 96119, that is, who would qualify as a technician and be allowed to administer these tests under the psychologist's general supervision (CR 4400, 6/23/06).

Response: At present the licensing and training requirements for a psychometric technician are outside the scope of this LCD.

Comment: One commenter felt that the title of the draft LCD is not comprehensive since the LCD addresses more than the services of psychiatrists and psychologists, but also the services of social workers and nurse specialists.

Response: We are using the umbrella terms of psychiatry and psychology to denote the scope of the services within the LCD. These terms are not intended to specify professional disciplines.

Comment: The same commenter suggested that Part A services and Part B services should be addressed in separate policies or in separate identified sections of the same policy.

Response: With the advent of the new Medicare Administrative Contractors (MACs) a single contractor will be responsible for administering both Part A and Part B Medicare. The medical necessity parameters for the services in the policy are the same no matter which setting, hospital outpatient or physicians office, the services are rendered. The supplemental instructions article (SIA) has different sections for Part A and Part B billing.

Comment: The same commenter stated that LCDs should include the definitions of CPT codes only as stated in the CPT, and felt that our further description of code 90801 was outside the CPT definition.

Response: Our discussion of CPT code 90801 and other CPT codes is not meant to redefine the code but to elaborate its use and to underscore the conditions under which the services may be medically necessary.

Comment: The same commenter stated that on page 11, the *Note* in the section on 90801 correctly states that an evaluation and management (E/M) service may be used in lieu of a 90801, but cites the following incorrect range of E/M codes (CPT 99241-99263).

Response: We appreciate the correction on the appropriate CPT code range and the policy has been changed to reflect it.

Comment: The same commenter stated that on pages 11-12, the same comments regarding use of E/M codes for an initial diagnostic evaluation should also be included in the section on code 90802 regarding the interactive initial diagnostic interview.

Response: We regard 90802 as a special psychiatric procedure and have set limitations on the ICD-9-CM codes that support its use. Billing the service represented by 90802 using an evaluation and management E/M code would bypass those restrictions.

Comment: The same commenter stated that on pages 13-14, the citation from CPT Assistant and following clause contains an error. The clause “or support current evaluation of functioning” is incorrect. “Evaluation” should be replaced with “level.”

Response: We appreciate the correction and will change the word to “level”.

Comment: The same commenter stated that on page 13-14, the discussion in the paragraph entitled “Description” regarding “maintenance” is confusing. The draft LCD states that “maintenance per se is not covered”, but “helping a patient maintain his or her highest level of functioning, such as a patient with Borderline Personality Disorder, may be covered.” This distinction seems to conflict with the explanation of “improvement” on page 7 of the draft LCD where “improvement” is defined to include “comparing the effect of continued treatment versus discontinuing it. . .” The draft LCD goes on to state: “Where there is a reasonable expectation that if treatment services were withdrawn the patient’s condition would deteriorate, relapse further, or require hospitalization, this criterion [i.e., the requirement for “improvement”] would be met.”

Response: We agree the sentence is confusing and it has been removed from the LCD.

Comment: The same commenter stated that on page 13, the section on the psychotherapy codes should be renamed “Psychiatric Therapeutic Procedures” (replacing “Services”) to conform to the terminology in CPT.

Response: We agree and the word “Services” has been changed to “Procedures”.

Comment: The same commenter stated that the first sentence in the “Documentation” section for these CPT codes requires that the time spent in psychotherapy session must be included in the treatment record. Time is not an element of the following psychotherapy codes 90845, 90846, 90847, 90849, 90853 and 90857. Therefore, the draft LCD should be modified to indicate that time is not required for these psychotherapy procedures.

Response: For all psychotherapy services we recommend documentation of the time involved in rendering the service to support medical necessity even though the CPT descriptors do not specify a time requirement.

Comment: The same commenter stated that on page 14, the assertions that codes 90808, 90809, 90814, 90815, 90821, 90822, 90828 and 90829 (psychotherapy of 75 to 80 minutes) should only be used in “exceptional circumstances” is not included in their current LCD or in the CPT descriptors for these codes. While these extended psychotherapy visits would not be used routinely, there is no basis for limiting their use to “exceptional circumstances.”

Response: The use of the psychotherapy sessions in excess of 60 minutes is not the standard of care in most jurisdictions. To support the medical necessity for the extra time and payment these services represent, the provider must document the patient’s need for these extended time codes.

Comment: The same commenter stated that the limited list of diagnostic codes for which psychoanalysis may be provided is too restrictive. In their current LCD, the list of diagnostic codes covered for psychotherapy also applies to psychoanalysis. The commenter feels we should recognize the same list of diagnostic codes for both psychotherapy and psychoanalysis.

Response: The statement that all mental conditions for which psychotherapy may be appropriate also applies to psychoanalysis is simply not true. Those conditions amenable to psychoanalytic technique are a subset of general psychiatric disorders. If the requestor wishes specific conditions be added to the list of diagnosis codes that support medical necessity for psychoanalysis, the requestor may ask for a reconsideration and supply supportive psychoanalytic literature.

Comment: The same commenter stated that on page 16, in the first sentence in the “Description” section on the family therapy codes (90846, 90847 and 90849), the definition is far too limiting. “Family therapy is also covered to assist the family in addressing the maladaptive behaviors of the patient and to improve treatment compliance.” The recommendation is to include the entire language from the Medicare Carriers Manual 35-14.

Response: While we added the requested language, the Medicare Carriers Manual 35-14 is not a definition of family psychotherapy. It largely describes family counseling activities rendered as a part of E/M services.

Comment: The same commenter stated that on page 17, the statement that code 90849 (multiple-family group therapy) is only approvable “on an individual consideration basis” is also too restrictive. He was unaware of any CMS national coverage decision or Medicare policy that imposed a requirement that this service should require special approval by the Medicare carrier.

Response: Since the purpose of multiple-family group therapy is to treat the effects of the patients’ illness on the family and is not directly a treatment for the beneficiary’s illness, it is usually not covered under Section 1862(a)(1)(A) of the Social Security Act. However, since we cannot anticipate every possible use of this code we have allowed individual consideration for its use.

Comment: The same commenter stated that the section on Psychotherapy omits any discussion of the special documentation provisions regarding psychotherapy notes required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Response: The Documentation Requirements section of the LCD makes reference to HIPAA requirements regarding psychotherapy notes, but it is not exhaustive. The references supplied in that section lead the reader to a complete discussion of HIPAA requirements.

Comment: The same commenter stated that on page 18-19, the Description section for code 90862 (medication management) requires documentation of “relevant history obtained.” This requirement should be modified to insert “interval” before “history” to read “relevant interval history obtained” to mean that the documentation should include a statement of the patient’s response to treatment since the last visit.

Response: We appreciate the correction and will add the word “interval”.

Comment: Relative value units (RVUS) do not support 25 minutes for CPT code 90862.

Response: We altered the statement to say 15-20 minutes.

Comment: The same commenter stated that on page 26, the “Other Comments” section of the draft LCD should include an additional comment that E/M codes for office/outpatient visits (i.e., 99201-99205 office visits for new patient and 99211-99215 office visits for an established patient) are appropriate for the provision of medical care and treatment of patients with mental illness provided the coding protocols and requirements applicable to E/M codes are documented in the treatment notes.

Response: Providers should bill the CPT code that most closely resembles the service provided. Providers who bill an E/M for the encounter for psychiatric patients may bill those codes if a code within the psychiatric section is not more appropriate. It should be remembered, however, that the counseling portion of an E/M code does not represent a psychotherapy service. If a psychiatric patient is given medication management or some other medical service only, then an E/M code may be used.

Comment: Several commenters stated that the list of covered ICD-9-CM diagnosis codes omits many diagnoses included in the psychiatric section of the ICD-9-CM and that each one should be added to the list in the draft LCD.

Response: In general, to support the medical necessity of services billed, this policy includes only those diagnoses that appear in the ICD-9-CM and that are also defined in the DSM-IV-TR™. Although there are many medical illnesses that may have a psychiatric component, the ICD-9-CM code for these medical illnesses do not themselves support medical necessity for the rendering of psychiatric services in the absence of psychiatric signs and symptoms. If signs or symptoms of a psychiatric disorder are present, the ICD-9-CM code(s) for those signs or symptoms should be used to support the medical necessity of the service. If there are specific codes which the requestor feels should be added despite these coding conventions, a reconsideration request may be made.

Comment: One commenter would like the language in the section, Diagnostic Interview Examination (90801) paragraph 4, changed to: “Comments: This service may be covered once, at the outset of an illness or suspected illness. It may be utilized again for the same patient if a new episode of illness occurs after a hiatus or on admission or readmission to inpatient status due to complications of the underlying condition; or when re-evaluation is required in order to address a new referral question. Certain patients, especially children, may require more than one visit for the completion of the initial diagnostic evaluation. The medical record must support the reason for more than one diagnostic interview.”

Response: It is unclear exactly what the commenter meant by a “new referral question.” In order for 90801 to be repeated the “new referral question” would need to represent an entirely new episode of illness. The psychotherapy codes imply a continuing diagnostic evaluation during the course of therapy.

Comment: In section, Psychiatric Therapeutic Services, subsection on family therapy, codes 90846, 90847, 90849, the same commenter suggested that specifying a typical duration of family therapy session is valuable, and we should clarify providers should not bill 90846 or 90847 when meeting with professional caregivers who are facility staff. In addition, codes 90846 and 90847 are not timed but are typically 45 to 60 minutes in duration, and may be billed only once per day.

Codes 90846 and 90847 do not pertain to consultation and interaction with paid staff members at an institution. Facility staff members are not considered "significant others" for purposes of this LCD.

Response: We agree to add the inserted language.

Comment: The same commenter would like to change the language in "Section VI: Central Nervous System Assessments/Tests," the tenth and final paragraph of this section to: "Depending on the issues to be assessed, a typical test battery may require from 6 to 10 hours to perform, including administration, scoring and interpretation. If the testing is done over several days, the testing time should be combined and reported all on the last date of service. If the testing time exceeds ten (10) hours, a report may be requested to indicate the medical necessity for extended testing."

Response: Claims data analysis indicates that a typical test for a Medicare beneficiary requires 4 to 6 hours. Eight hours according to our data would be a reasonable limit for which to request records.

Comment: The same commenter suggested that in the last paragraph of the section "General Information, Documentation Requirements," the following sentence be removed: "The estimated duration of treatment in terms of number of sessions should be specified." Prediction of the estimated duration of treatment is exceedingly difficult and unreliable due to co-morbidities, changes in health status, unpredictable environmental conditions and stressors, and individual differences in response to treatment. There is concern that predictions will have a low level of validity, and that ongoing revisions may be misleading in suggesting that treatment is extending beyond what is medically necessary.

Response: The sentence will be removed. We agree that this is difficult to prognosticate.