

Coding and Billing Guidelines

Psychiatry and Psychology Services PSYCH-014 - L30489

Contractor Name

Wisconsin Physicians Service Insurance Corporation

Contractor Number

00951, 00952, 00953, 00954
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05402, 52280

Contractor Type

Carrier
Fiscal Intermediary A
MAC A
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I. General Coding

Psychiatry and Psychology are specialized fields for the diagnosis and treatment of various mental health disorders and/or diseases. References to providers include physicians and non-physicians, such as clinical psychologists, independent psychologists, nurse practitioners, clinical nurse specialists and physician assistances when the services performed are within the scope of their state license and clinical practice/education.

Individual psychotherapy CPT codes should be used only when the focus of treatment involves individual psychotherapy. Psychiatric service CPT codes should not be used when other CPT codes such as an evaluation and management (E/M) service or pharmacological codes is more appropriate.

CMS National Coverage Policy:

Section 1833(c) of the Social Security Act.

Section 1861(s)(2)(C) of the Social Security Act

Section 1861(s)(3) of the Social Security Act

Section 1842(b)(2)(A) of the Social Security Act

Chapter 15, 80.2 of the Benefits Policy Manual, Pub. 100-02 Transmittal: 55

Chapter 15, 80.2 of the Benefits Policy Manual, Pub. 100-02 Transmittal: 85

Chapter 15, section 160 of the Benefits Policy Manual, Pub. 100-02.

Chapter 15, section 200 of the Benefits Policy Manual, Pub. 100-02.

Chapter 15, section 210 of the Benefits Policy Manual, Pub. 100-02.

Chapter 15, section 190 of the Benefits Policy Manual, Pub. 100-02.

Final physician fee schedule regulation at 70 FR 70279 and 70280 under Table 29: AMA, RUC and HCPAC Recommendations and CMS Decisions for New and Revised 2006 CPT Codes

A. Psychiatry and Psychology Services:

Individual psychotherapy CPT codes should be used only when the focus of treatment involves individual psychotherapy. These CPT codes should not be used as generic psychiatric service CPT codes when other CPT codes such as an evaluation and management (E/M) service or pharmacological codes would be more appropriate.

Family psychotherapy services are covered only where the primary purpose of such psychotherapy is the treatment of the patient's condition. Examples include:

1. When there is a need to observe and correct, through psychotherapeutic techniques, the patient's interaction with family members (CPT code 90847); and/or
2. Where there is a need to assess the conflicts or impediments within the family, and assist, through psychotherapy, the family members in the management of the patient (90846 or 90847).

CPT code 90849 represents multiple-family group psychotherapy and would generally be non-covered by Medicare. Such group therapy is directed to the effects of the patient's condition on the family, and does not meet Medicare's standards of being part of the provider personal services to the patient. Claims for 90849 may be approved on individual consideration basis. CMS Publication 100-03; Medicare National Coverage Determinations Manual, Chapter 1, § 70.1

Psychiatric services must be performed by a qualified health care provider. See PSYCH-013 for incident to psychiatric services guidelines.

II. Service-specific Guidelines:

A. Psychiatric Diagnostic Interview Examination (CPT code 90801):

An E/M service may be substituted for the initial interview procedure, including consultation CPT codes, (CPT codes 99241-99263), provided required elements of the E/M service billed are fulfilled. Consultation services require, in addition to the interview and examination, the provision of a written opinion and/or advice. E/M CPT codes do not include a psychotherapy service.

B. Interactive Psychiatric Diagnostic Interview Examination (CPT code 90802):

CPT codes 90802, 90810-90815, 90823-90829 and 90857 may also be covered for any psychiatric disorder as specified in the "ICD-9-CM codes that Support Medical Necessity" section for adults who also have one of the conditions as specified in the Local Coverage Determination. Both the primary psychiatric diagnosis and secondary communication disorder must be submitted on the claim.

C. Psychiatric Therapeutic Procedures (CPT codes 90804 – 90829):

These CPT codes represent insight oriented, behavior modifying, supportive, and/or interactive psychotherapy. Of these, CPT codes 90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827, and 90829 include medical evaluation and management (E/M) services including continuing medical diagnostic evaluation as well as pharmacological management. Therefore, the same healthcare provider may not bill pharmacological management (90862) and E/M service CPT codes separately on the same day as a psychotherapy service.

D. CPT codes 90846, 90847, 90849:

CPT codes 90846 and 90847 represent psychotherapy services for the treatment of mental disorders. They should not be used when the service performed is taking a family history or E/M counseling services. E/M counseling services should be coded with the appropriate E/M CPT

code according to the time involved. Family counseling does not include the supervision of or therapy with professional caretakers or staff.

E. CPT code 90853:

The guidelines in the “Documentation” section under CPT codes 90804 through 90829 (psychotherapy) apply to CPT code 90853 - group psychotherapy. It is recommended that the time of the therapy also be documented. To establish medical necessity of the service, claims must be submitted with a covered diagnosis.

F. CPT code 90862:

CPT code 90862 is intended to refer to a visit that is focused on the monitoring and prescribing of psychopharmacologic agents. Relevant history is obtained, a mental status examination is performed, and medical decision making (i.e., assessment of treatment response and ongoing treatment formulation) occurs during such a visit providing all of the elements are documented. Psychopharmacologic agents may be initiated or adjusted during such a visit.

G. CPT codes 90875 and 90876

CPT codes 90875 and 90876 are described as individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy).

H. Medicare does not cover biofeedback for the treatment of psychosomatic disorders.

III. Billing Guidelines

A. CPT codes 90810-90815 and 90823-90829 should not be billed on the same dates of service as CPT codes 90804-90809 or 90816-90822.

B. CPT code 90857 should not be billed on the same date of service as 90853. CPT code 90857 should also not be billed more than once per day for the same beneficiary unless he/she has participated in a separate and distinct group therapy session.

C. In the infrequent event that a patient has a separate and distinct individual psychotherapy and group therapy session in one day, modifier -59 should be appended to the CPT code for the second session.

D. CPT code 90862 pharmacological management

CPT code 90862 refers to the in-depth management of psychopharmacologic agents that are potent medications with frequent serious side effects, and represents a very skilled aspect of patient care.

CPT code 90862 is not intended to be used for the actual administration of medication, nor is it intended to be used for observation of the patient taking an oral medication. Administration and supply of oral medication is not a separately payable service.

E. CPT codes 90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827, 90829

1. These CPT codes include medical evaluation and management (E/M) services which includes continuing medical diagnostic evaluation as well as pharmacological management. Therefore, the same healthcare provider may not bill pharmacological

management (90862) and an E/M service separately on the same day as a psychotherapy service.

2. When the qualified health care provider supplies other services in addition to pharmacological management at the visit, an E/M CPT code may be used.
3. HCPCS code M0064 should be used for a lesser level of drug monitoring such as simple dosage adjustment. M0064 is defined as a brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental, psychoneurotic and personality disorders. Based on the assignment of RVUs, the work involved in M0064 is similar to CPT code 99212. Time spent is generally less than ten minutes.

IV. Other Information

A. CPT codes 90885, 90887, 90889 are considered incidental services and are not separately payable.

B. CPT code 90885

Description:

CPT code 90885 is used when a provider is asked to do a review of records for psychiatric evaluation without direct patient contact. This may be accomplished at the request of an agency or peer review organization. It may also be employed as part of an overall evaluation of a patient's psychiatric illness or suspected psychiatric illness, to aid in the diagnosis and/or treatment plan.

C. CPT codes 90887

Description:

CPT code 90887 is used when the treatment of the patient may require explanations to the family, employers or other involved persons for their support in the therapy process. This may include reporting of examinations, procedures, and other accumulated data.

D. CPT codes 90889

Description:

CPT code 90889 is defined as "Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other physicians, agencies, or insurance carriers

E. CPT code 90899:

Use CPT code 90899 when a psychiatric service cannot be described by any other psychiatric CPT code(s) (90801-90880).

V. Outpatient Mental Health Treatment Limitation:

*Regardless of the actual expenses a beneficiary incurs for treatment of mental, psychoneurotic, and personality disorders while the beneficiary is not an inpatient of a hospital at the time such expenses are incurred, the amount of those expenses that may be recognized for Part B deductible and payment purposes. Per Section 102 of MIPPA, the current 62.5% outpatient mental health treatment limitation (effective since the inception of the Medicare program until December 31, 2009) will be reduced as follows:

January 1, 2010 – December 31, 2011, the limitation percentage is 68.75% (of which Medicare pays 55% and the patient pays 45%);

January 1, 2012 – December 31, 2012, the limitation percentage is 75% (of which Medicare pays 60% and the patient pays 40%);
January 1, 2013 – December 31, 2013, the limitation percentage is 81.25% (of which Medicare pays 65% and the patient pays 35%); and,
January 1, 2014 – onward, the limitation percentage is 100%, at which time Medicare pays 80% and the patient pays 20%.

*For Rural Health Clinics and Federally Qualified Health Centers, the amount the patient pays may differ from the percentages shown above.

This limitation is called the outpatient mental health treatment limitation. Expenses for diagnostic services (e.g., psychiatric testing and evaluation to diagnose the patient's illness) are not subject to this limitation. This limitation applies only to therapeutic services and to services performed to evaluate the progress of a course of treatment for a diagnosed condition (CMS Internet-Only Manual, Publication 100-04, Medicare Claims Processing Manual, Chapter 12, §210).

Please refer to the Supplemental Instructions Article (SIA): Psychiatry and Psychology Services: associated with this policy for coding guidelines.

This coverage determination does not reflect the sole opinion of the contractor or contractor medical director. Although the final decision rests with the contractor, this policy was developed in cooperation with the Carrier Advisory Committee that includes representatives from various state and local physician/provider organizations.

Limitation of liability and refund requirements apply when denials are based on medical necessity. They do not apply when the test, item or procedure is done for screening purposes. The physician/provider must notify the beneficiary in writing if the physician/provider is aware that Medicare may not cover the test, item or procedure.

A claim that does not fulfill the coverage requirements described above may be given individual consideration based on review of all pertinent medical information.

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Revision History:

06/01/2012 -This guideline is effective for J-8 providers in Michigan MAC B 07/16/12, Michigan MAC A 07/23/12, Indiana MAC A 07/23/12 and Indiana MAC B 08/20/12.

04/01/2012, Information regarding Neuropsychological Testing removed from LCD and placed in L31990 (PSYCH-017 Neuropsychological Testing); 02/01/2011, Updated information on outpatient mental health treatment limitation; 07/01/2010, Revised – removed CPT codes – to match current format, no change in coverage/ claims processing;