

Coding and Billing Guidelines

*Psychiatry and Psychology Services PSYCH-014 - L30489

Contractor Name

Wisconsin Physicians Service (WPS)

Contractor Number

00951, 00952, 00953, 00954
05101, 05201, 05301, 05401,
05102, 05202, 05302,
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 an 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.

B. Psychological Testing and Neuropsychological Testing

Psychiatric tests and Neuropsychological tests are diagnostic procedures and therefore incident to provisions do not apply. The person described in the CPT code must perform the psychiatric test. The time spent on the interpretation and report performed by a technician or computer must be billed using an appropriate CPT code and may not be added to any other CPT code.

Under the diagnostic tests provision, all diagnostic tests are assigned a certain level of supervision. Generally, regulations governing the diagnostic tests provision require that only physicians can provide the assigned level of supervision for diagnostic tests.

However, there is a regulatory exception to the supervision requirement for diagnostic psychological and neuropsychological tests in terms of who can provide the supervision. That is, regulations allow a clinical psychologist (CP) or a physician to perform the general supervision assigned to diagnostic psychological and neuropsychological tests.

In addition, nonphysician practitioners such as nurse practitioners (NPs), clinical nurse specialists (CNSs) and physician assistants (PAs) who personally perform diagnostic psychological and neuropsychological tests are excluded from having to perform these tests under the general supervision of a physician or a CP. Rather, NPs and CNSs must perform such tests under the requirements of their respective benefit instead of the requirements for diagnostic psychological and neuropsychological tests. Accordingly, NPs and CNSs must perform tests in collaboration (as defined under Medicare law at section 1861(aa)(6) of the Act) with a physician. PAs perform tests under the general supervision of a physician as required for services furnished under the PA benefit.

Furthermore, physical therapists (PTs), occupational therapists (OTs) and speech language pathologists (SLPs) are authorized to bill three test codes as "sometimes therapy" codes. Specifically, CPT codes 96105, 96110 and 96111 may be performed by these therapists.

However, when PTs, OTs and SLPs perform these three tests, they must be performed under the general supervision of a physician or a CP.

Who May Bill for Diagnostic Psychological and Neuropsychological Tests

- CPs – see qualifications under chapter 15, section 160 of the Benefits Policy Manual, Pub. 100-02.
- NPs –to the extent authorized under State scope of practice. See qualifications under chapter 15, section 200 of the Benefits Policy Manual, Pub. 100-02.
- CNSs –to the extent authorized under State scope of practice. See qualifications under chapter 15, section 210 of the Benefits Policy Manual, Pub. 100-02.
- PAs – to the extent authorized under State scope of practice. See qualifications under chapter 15, section 190 of the Benefits Policy Manual, Pub. 100-02.
- Independently Practicing Psychologists (IPPs), agency, or physician’s office are covered when a physician orders such tests.
- PTs, OTs and SLPs – see qualifications under chapter 15, sections 220-230.6 of the Benefits Policy Manual, Pub. 100-02.

Physical therapists (PTs), occupational therapists (OTs) and speech language pathologists (SLPs) are authorized to bill three test codes as “sometimes therapy” codes. Specifically, CPT codes 96105, 96110 and 96111 may be performed by these therapists. However, when PTs, OTs and SLPs perform these three tests, they must be performed under the general supervision of a physician or a CP.

CPT code 96125 is used by OTs or SLP. Other providers should use the appropriate code CPT code from the 96101-96103 or 96118-96120.

NOTE: Independent Psychologist

When diagnostic psychological tests are performed by a psychologist who is not practicing independently, but is on the staff of an institution, agency, or clinic, that entity bills for the psychological tests.

Psychologists are considered to be practicing independently when they render services on their own responsibility, free of the administrative and professional control of an employer such as a physician, institution or agency; the persons they treat are their own patients; and they have the right to bill directly, collect and retain the fee for their services.

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.

V. 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).

F. CPT codes 96101 - 96125

Medicare Part B coverage of psychological tests and neuropsychological tests is authorized under section 1861(s)(3) of the Social Security Act. Payment for psychological and neuropsychological tests is authorized under section 1842(b)(2)(A) of the Social Security Act. The payment amounts for the new psychological and neuropsychological tests (CPT codes 96102, 96103, 96119 and 96120) that are effective January 1, 2006, and are billed for tests administered by a technician or a computer reflect a site of service payment differential for the facility and non-facility settings. Additionally, there is no authorization for payment for diagnostic tests when performed on an “incident to” basis. (Pub. 100-02 Transmittal: 85; Rev. 85, Issued: 02-29-08, Effective: 01-01-06, Implementation: 12-28-06)

1. Payment for Diagnostic Psychological and Neuropsychological Tests

Expenses for diagnostic psychological and neuropsychological tests are not subject to the outpatient mental health treatment limitation, that is, the payment limitation on treatment services for mental, psychoneurotic and personality disorders as authorized under Section 1833(c) of the Act. The payment amount for the new psychological and neuropsychological tests (CPT codes 96102, 96103, 96119 and 96120) that are billed for tests performed by a technician or a computer reflect a site of service payment differential for the facility and non-facility settings. CPs, NPs, CNSs and PAs are required by law to accept assigned payment for psychological and neuropsychological tests. However, while IPPs are not required by law to accept assigned payment for these tests, they must report the name and address of the physician who ordered the test on the claim form when billing for tests.

2. CPT Codes for Diagnostic Psychological and Neuropsychological Tests

CPT codes 96101, 96102, 96103, 96105, 96110, and 96111 are appropriate for use when billing for psychological tests. CPT codes 96116, 96118, 96119 and 96120 are appropriate for use when billing for neuropsychological tests. All of the tests under this CPT code range 96101-96120 are indicated as active codes under the physician fee schedule database and are covered if medically necessary.

3. Payment and Billing Guidelines for Psychological and Neuropsychological Tests

The technician and computer CPT codes for psychological and neuropsychological tests include practice expense, malpractice expense and professional work relative value units. Accordingly, CPT psychological test code 96101 should not be paid when billed for the same tests or services performed under psychological test codes 96102 or 96103. CPT neuropsychological test code 96118 should not be paid when billed for the same tests or services performed under neuropsychological test codes 96119 or 96120. However, CPT codes 96101 and 96118 can be paid separately on the rare occasion when billed on the same date of service for different and separate tests from 96102, 96103, 96119 and 96120. Under the physician fee schedule, there is no payment for services performed by students or trainees. Accordingly, Medicare does not pay for services represented by CPT codes 96102 and 96119 when performed by a student or a trainee. However, the presence of a student or a trainee while the test is being administered does not prevent a physician, CP, IPP, NP, CNS or PA from performing and being paid for the psychological test under 96102 or the neuropsychological test under 96119.

4. Payment and Billing Guidelines for Psychological and Neuropsychological Tests

Occupational therapists and speech language pathologists uses CPT code 96125 when they perform test on patients who have compromised functioning abilities due to acute neurological events such as traumatic brain injury or cerebrovascular accident (CVA) and

must undergo assessment to determine if function abilities such as orientation, memory and high-level language function have been compromised and to what extent

For psychological and neuropsychological testing by a physician or psychologist, see 96101-96103, 96118-96120.

5. Reading of the report is included in the office time or floor time in the hospital and, is not considered a separate service when performed by the treating provider.
6. CPT code 96101, 96102, 96105, 96110, 96111, 96116, 96118 or 96119, is reported as one unit per hour. If 30 - 1 hr of time is spent performing the test, interpretation and report one unit of time should be billed. If the psychological testing, interpretation and report takes less than 30 minutes, the definition of the CPT code has not been met and the testing may not be billed.

G. CPT codes 96101, 96118 and 96125

1. CPT codes 96101, 96118 and 96125 are used to bill, in hourly units, the provider's time both face-to-face with the patient and the time spent interpreting test results and preparing the report.
2. The codes may not used to bill for the interpretation of tests administered by a technician or computer.
3. When a provider performs some tests and a technician or computer performs other tests, documentation must demonstrate medical necessity for all tests. The provider time spent on the interpretation of the tests performed by the technician/computer may not be added to the units billed under CPT code 96101 or 96118.
4. Medicare will not pay twice for the same test or the interpretation of tests.

H. CPT codes 96102, 96119

1. CPT codes 96102 and 96119 include both the face-to-face technician time and the qualified health care provider's time for the interpretation and report.
2. The provider who interprets the report must be available to furnish assistance and direction to the technician administering the test.
3. Add the time the provider spends interpreting and reporting the test to the time technician spends administrating the tests.

I. CPT codes 96103, 96120

1. CPT codes 96103 and 96120 describe tests administered by a computer and the interpretation and report performed by a qualified health care professional.
2. Billed one service regardless of the number of tests taken by the patient
3. The provider who interprets the report must be available during the time the patient is taking the test.
4. The interpretation of the test is included in the codes and is not separately billable.
5. These codes may not be billed for scoring of tests

J. Tests

1. When performed by a provider, procedures such as the Minnesota Multiphasic Personality Inventory 2 (MMPI-2), rating scales (e.g., the Hamilton Depression Rating Scale), or projective techniques (e.g., the Rorschach or Thematic Apperception Test [TAT]), are intended for psychological testing and should be reported as CPT code 96101
2. The Folstein Mini Mental Status Exam, in isolation, should not be classified separately as neuropsychological testing since it is typically part of a more general clinical exam.

Note:

When a provider and a technician administer different medically necessary tests, the interpretation must be allocated to the appropriate CPT code. Computerized tests are billed once and include the interpretation and report.

Typically, the total time for all tests (regardless who performs them) will be 5-7 hours including administration, scoring and interpretation. If the testing is done over several days, the testing time should be combined and reported on the last date of service. If the testing time exceeds 8 hours, to determine the medical necessity for the extended testing, a copy of the test report may be requested.

IV. 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 is limited to 62.5 percent of the Medicare allowed amount for those services. 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:

*07/01/2010, Revised – removed CPT codes – to match current format, no change in coverage/ claims processing;