



Outpatient Psychiatric and Psychological Services

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Introduction & Instructions for Use

Introduction

Medicare Coverage Summaries are a set of objective and evidence-based behavioral health criteria used by medical necessity plans to standardize coverage determinations, promote evidence-based practices, and support members’ recovery, resiliency, and wellbeing for Medicare behavioral health benefit plans managed by Optum® .

Instructions for Use

This guideline is used to make coverage determinations as well as to inform discussions about evidence-based practices and discharge planning for behavioral health benefit plans managed by Optum. When deciding coverage, the member’s specific benefits must be referenced.

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member’s benefits prior to using this guideline. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this guideline and the member’s specific benefit, the member’s specific benefit supersedes this guideline. Other clinical criteria may apply. Optum reserves the right, in its sole discretion, to modify its clinical criteria as necessary using the process described in Clinical Criteria.

This guideline is provided for informational purposes. It does not constitute medical advice.

Optum may also use tools developed by third parties that are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice. Optum may develop clinical criteria or adopt externally-developed clinical criteria that supersede this guideline when required to do so by contract or regulation.

Outpatient Psychiatric and Psychological Services

- Outpatient psychiatric and psychological services refer to Part A and Part B services in the fields of psychiatry, psychology, clinical social work, and psychiatric nursing services rendered in a hospital outpatient facility or by individual providers for the diagnosis and treatment of various mental disorders or diseases (L33632, 2019; L34353, 2022).
- Outpatient psychiatric and psychological services refer to services provided by providers including physicians, and non-physicians, such as clinical psychologists, independent psychologist, nurse practitioners, clinical nurse specialists and physician assistants when the services performed are within the scope of their clinical practice/education and authorized under state law (L33632, 2019; L34353, 2022; L34616, 2022).
- Psychiatric care includes the therapeutic services provided to a beneficiary for the treatment of mental, psychoneurotic, and personality disorders which are directed toward identifying specific behavior patterns, factors determining such behavior, and effective goal oriented therapies. For approved providers of mental health services, the state licensure or authorization must specify that the provider's scope of practice includes the provision of clinical psychotherapy for the treatment of mental illness. Psychiatrists are physicians (MDs and Dos) trained in mental health disorders and may provide all services described in this LCD. Coverage for all non-physician practitioners is limited to services which they are authorized to perform by the state in which they practice (L35101, 2020).
- "Incident to" a physician's professional services means that services or supplies furnished as an integral, although incidental, part of a physician's personal professional services in the course of diagnostic or treatment of an illness or injury. The "incident to" provision may also apply to coverage for psychological services furnished "incident to" the professional services of certain non-physician practitioners including clinical psychologists, clinical social workers, nurse practitioners, and clinical nurse specialists (L34539, 2021).
- "Incident to" services are defined as services or supplies furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness (L34539, 2021).

Applicable States

This Medicare Coverage Summary is applicable to the following States/jurisdictions:

Note: Part A services are typically inpatient. Part B services are typically outpatient.

CMS L33252 (All states & territories Part A Inpatient Services and Part B Outpatient Services apply)

- Florida
- Puerto Rico
- Virgin Islands

CMS L33632 (All states Part A Inpatient Services and Part B Outpatient Services apply)

- Connecticut
- Illinois
- Maine
- Massachusetts
- Minnesota
- New Hampshire
- New York
- Rhode Island
- Vermont
- Wisconsin

CMS L34353 and L34539 (All states Part A Inpatient Services and Part B Outpatient Services apply)

- Kentucky
- Ohio

CMS L34616 (Part A Inpatient Services and Part B Outpatient Services vary, see each state)

- Alabama (Part A Inpatient Services)

- Alaska (Part A Inpatient Services)
- Arizona (Part A Inpatient Services)
- Arkansas (Part A Inpatient Services)
- California (Part A Inpatient Services)
- Colorado (Part A Inpatient Services)
- Connecticut (Part A Inpatient Services)
- Delaware (Part A Inpatient Services)
- Florida (Part A Inpatient Services)
- Georgia (Part A Inpatient Services)
- Hawaii (Part A Inpatient Services)
- Idaho (Part A Inpatient Services)
- Illinois (Part A Inpatient Services)
- Indiana (Part A Inpatient Services **and** Part B Outpatient Services)
- Iowa (Part A Inpatient Services **and** Part B Outpatient Services)
- Kansas (Part A Inpatient Services **and** Part B Outpatient Services)
- Kentucky (Part A Inpatient Services)
- Louisiana (Part A Inpatient Services)
- Maine (Part A Inpatient Services)
- Massachusetts (Part A Inpatient Services)
- Michigan (Part A Inpatient Services **and** Part B Outpatient Services)
- Missouri (Part A Inpatient Services **and** Part B Outpatient Services)
- Mississippi (Part A Inpatient Services)
- Montana (Part A Inpatient Services)
- Nebraska (Part A Inpatient Services **and** Part B Outpatient Services)
- New Hampshire (Part A Inpatient Services)
- New Jersey (Part A Inpatient Services)
- New Mexico (Part A Inpatient Services)
- Nevada (Part A Inpatient Services)
- North Carolina (Part A Inpatient Services)
- North Dakota (Part A Inpatient Services)
- Ohio (Part A Inpatient Services)
- Oklahoma (Part A Inpatient Services)
- Oregon (Part A Inpatient Services)
- Pennsylvania (Part A Inpatient Services)
- Rhode Island (Part A Inpatient Services)
- South Carolina (Part A Inpatient Services)
- South Dakota (Part A Inpatient Services)
- Tennessee (Part A Inpatient Services)
- Texas (Part A Inpatient Services)
- Utah (Part A Inpatient Services)
- Vermont (Part A Inpatient Services)
- Virginia (Part A Inpatient Services)
- Washington (Part A Inpatient Services)
- West Virginia (Part A Inpatient Services)
- Wisconsin (Part A Inpatient Services)
- Wyoming (Part A Inpatient Services)

CMS L35101 (All states Part A Inpatient Services and Part B Outpatient Services apply)

- Arkansas
- Colorado
- Delaware
- District of Columbia
- Louisiana
- Maryland
- Mississippi

- New Jersey
- New Mexico
- Oklahoma
- Pennsylvania
- Texas

Note: If Mental Health services are delivered in a state without an applicable LCD, please apply the LOCUS criteria. If Mental Health services are delivered in a state without an applicable LCD for ages 6-18, apply the CALOCUS-CASII criteria. If Substance Use Disorder services are delivered in a state without an applicable LCD, please apply the ASAM criteria.

Coverage Indications, Limitations, and/or Medical Necessity

Note: Part A services are typically inpatient. Part B services are typically outpatient.

Indications (CMS L33252, 2020)

- 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.
- 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.
- 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.

- 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.
- 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).
- Group therapy 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. 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.
- 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.
- Family psychotherapy will be considered 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 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.
- 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.
- 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.

- 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.

Limitations (CMS L33252)

- 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.
- For psychiatric diagnostic evaluation with medical services, 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.
- The medical record for psychiatric diagnostic evaluation with or without medical assessment 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.
- 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. The medical record must include treatment recommendations.
- 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.
- Psychoanalysis is generally considered unsuitable for psychoses.
- 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.
- 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.
- 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.
- In certain types of medical conditions, such as the unconscious or comatose patient, family psychotherapy would not be medically reasonable or necessary.
- The documentation for psychoanalysis or psychotherapy services including group and family psychotherapy 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.
- If psychotherapy services are performed 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.
- For psychotherapy and psychoanalysis services, the medical record documentation maintained by the provider must indicate the medical necessity of each psychotherapy/psychoanalysis 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
 - 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, 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.
- 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.
- For family psychotherapy services (with or without the patient present), 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.
- 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 reimbursement.
- 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. Please refer to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and 45 CFR Section 164.501 for additional guidance regarding privileged information.
- 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 patient must have the capacity to actively participate in all therapies prescribed, except for family therapy without the patient present.
- Physicians/NPP's with a high utilization of these services per patient compared to their peers may be subject to review for medical necessity.

Indications (CMS L33632, 2019)

- Approved Providers of Service:
 - A. Physicians (MD/DO)
 - B. Clinical psychologists
 - C. Clinical Social Workers
 - D. Nurse practitioners
 - E. Clinical Nurse Specialists
 - F. Physician Assistants
 - G. Other providers of mental health services licensed or otherwise authorized by the state in which they practice (e.g., licensed clinical professional counselors, licensed marriage and family therapists). These other providers may not bill Medicare directly for their services, but may provide mental health treatment services to Medicare beneficiaries under the "incident to" provision.
- General Coverage Requirements
 - This applies to psychiatric services rendered in a hospital outpatient facility, but the medical necessity parameters contained herein may also be applicable to services billed to Part B by individual providers. Hospital outpatient psychiatric services: The services must be for the purpose of diagnostic study or the services must reasonably be expected to improve the patient's condition. "Incident to" provisions do not apply to professional services performed by Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), Clinical Psychologists (CPs), Clinical Social Workers

(CSWs) or Clinical Licensed Master's Social Worker (LMSW). Physician assistants (PAs) are required to perform services under the general supervision of a physician. (See 42 CFR 410.71-76.) Psychiatric services provided incident to a physician's service must be rendered by individuals licensed or otherwise authorized by the State and qualified by their training to perform these services.

- Psychiatry and psychology services must meet the following criteria:
 - Individualized Treatment Plan.
 - The plan must state the type, amount, frequency, and duration of the services to be furnished and indicate the diagnoses and anticipated goals. (A plan is not required if only a few brief services will be furnished.)
 - Reasonable Expectation of Improvement.
 - Services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The treatment must, at a minimum, be designed to reduce or control the patient's psychiatric symptoms so as to prevent relapse or hospitalization, and improve or maintain the patient's level of functioning.
 - When stability can be maintained without further treatment or with less intensive treatment, the psychological services are no longer medically necessary.
 - Frequency and Duration of Services.
 - There are no specific limits on the length of time that services may be covered. There are many factors that affect the outcome of treatment; among them are the nature of the illness, prior history, the goals of treatment, and the patient's response. As long as the evidence shows that the patient continues to show improvement in accordance with his/her individualized treatment plan, and the frequency of services is within accepted norms of medical practice, coverage may be continued.
 - 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 outpatient psychiatric services are no longer considered reasonable or medically necessary.
- Unless otherwise indicated services addressed here may be used by psychiatrists or other physicians trained in the treatment of mental illness (MDs/DOs), clinical psychologists, clinical social workers, clinical nurse specialists and other nurses with special training and/or experience in psychiatric nursing beyond the standard curriculum required for a registered nurse (e.g., Masters of Science in psychiatric nursing, or its equivalent [Advanced Registered Nurse Practitioner with a Master's degree in Mental Health, or equivalent to a Master's prepared, certified Clinical Nurse Specialist]).
- Psychiatric diagnostic procedure codes require the elicitation of a complete medical (including past, family, social) and psychiatric history, a mental status examination, establishment of an initial diagnosis, an evaluation of the patient's ability and capacity to respond to treatment, and an initial plan of treatment. Information may be obtained from not only the patient, but also other physicians, healthcare providers, and/or family if the patient is unable to provide a complete history.
- Interactive complexity may be reported with psychotherapy when at least one of the following is present:
 - Maladaptive communication (e.g., high anxiety, high reactivity, repeated questions or disagreement)
 - Emotional or behavioral conditions inhibiting implementation of treatment plan
 - Mandated reporting/event exists (e.g., abuse or neglect) or
 - Play equipment, devices, interpreter, or translator required due to inadequate language expression or different language spoken between patient and professional
- Interactive complexity may also be used in the evaluation of adult patients with organic mental deficits, or for those who are catatonic or mute.
- The duration of a course of psychotherapy must be individualized for each patient. Prolonged treatment may be subject to medical necessity review. The provider must document the medical necessity for prolonged treatment.
- While a variety of psychotherapeutic techniques are recognized for coverage, the services must be performed by persons authorized by their state to render psychotherapy services. Healthcare providers would include physicians, clinical psychologists, registered nurses with special training (as described in the "Indications" section), and clinical social workers. Psychotherapy does not include teaching grooming skills, monitoring activities of daily living (ADL), recreational therapy (dance, art, play) or social interaction.
- The practice of psychoanalysis involves using special techniques to gain insight into and treat 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. Comments: The physician or other healthcare professional using this technique must be trained by an accredited program of psychoanalysis.
- Description: Services involving the treatment of the family unit when maladaptive behaviors of family members are exacerbating the beneficiary's mental illness or interfering with the treatment, or to assist the family in addressing the maladaptive behaviors of the patient and to improve treatment compliance.

- Comments: Family psychotherapy services are covered only where the primary purpose of such psychotherapy is the treatment of the patient's condition. Examples include:
 - When there is a need to observe and correct, through psychotherapeutic techniques, the patient's interaction with family members.
 - 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.
- The term "family" may apply to traditional family members, live-in companions, or significant others involved in the care of the patient.
- Multiple-family group psychotherapy is generally non-covered by Medicare. Such group therapy is usually directed to the effects of the patient's condition on the family and its purpose is to support the affected family members.
- Description: Psychotherapy administered in a group setting: Psychotherapy administered in a group setting, involving no more than 12 participants, facilitated by a trained therapist simultaneously providing therapy to these multiple patients. The group therapy session typically lasts 45 to 60 minutes. Personal and group dynamics are discussed and explored in a therapeutic setting allowing emotional catharsis, instruction, insight, and support.
- Comments: Group therapy, since it involves psychotherapy, must be led by a person who is licensed or otherwise authorized by the state in which he or she practices to perform this service. This will usually mean a psychiatrist, psychologist, clinical social worker, clinical nurse specialist, or other person authorized by the state to perform this service. Registered nurses with special training may also be considered eligible for coverage. For Medicare coverage, group therapy does not include: socialization, music therapy, recreational activities, art classes, excursions, sensory stimulation or eating together, cognitive stimulation, or motion therapy, etc.
- Narcosynthesis for psychiatric diagnostic and/or therapeutic purposes. Description: Narcosynthesis is defined as the administration of sedative or tranquilizer drugs, usually intravenously, to relax the patient and remove inhibitions for discussion of subjects difficult for the patient to discuss freely in the fully conscious state.
- Psychotherapy in Crisis: "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." (CPT 2013, Professional Edition, p.486)
- Psychiatric Somatotherapy, electroconvulsive therapy (ECT), is described as the application of electric current to the brain, through scalp electrodes to produce a seizure. It is used primarily to treat major depressive disorder when antidepressant medication is contraindicated and for certain other clinical conditions.
- 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) is restricted. Medicare does not cover biofeedback for the treatment of psychosomatic disorders.
- Hypnotherapy. Hypnosis is an artificially induced alteration of consciousness in which the patient is in a state of increased suggestibility.
- Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions is not covered by Medicare.
- Psychiatric evaluation of hospital records, reports, testing, or data for diagnosis. A physician or advanced mental health practitioner may be 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.
- Reporting of examinations, procedures, and other accumulated data. The treatment of the patient may require explanations to the family, employers, or other involved persons for their support in the therapy process.
- Preparation of reports for insurance companies, agencies, courts, etc.: Administrative services that do not involve face to face contact with the patient and are considered bundled services and are not separately payable by Medicare.
- Psychological testing includes the administration, interpretation, and scoring of the tests and other medically accepted tests for evaluation of intellectual strengths, psychopathology, psychodynamics, mental health risks, insight, motivation, and other factors influencing treatment and prognosis. These tests do not represent psychotherapeutic modalities, but are diagnostic aids. Use of such tests when mental illness is not suspected would be a screening procedure not covered by Medicare. Each test performed must be medically necessary. Therefore, standardized batteries of tests are not acceptable unless each test in the battery is medically necessary.
- Changes in mental illness may require psychological testing to determine new diagnoses or the need for changes in therapeutic measures. Repeat testing not required for diagnosis or continued treatment would be considered medically unnecessary. Nonspecific behaviors that do not indicate the presence of, or change in, a mental illness would not be an

acceptable indication for testing. Psychological or psychiatric evaluations that can be accomplished through the clinical interview alone (e.g., response to medication) would not require psychological testing, and such testing might be considered as medically unnecessary. Adjustment reactions or dysphoria associated with moving to a nursing facility do not constitute medical necessity for psychological testing.

- Testing which is intended to diagnose and characterize the neurocognitive effects of medical disorders that impinge directly or indirectly on the brain. Examples of problems that might lead to neuropsychological testing are:
 - Detection of neurologic diseases based on quantitative assessment of neurocognitive abilities (e.g., mild head injury, anoxic injuries, AIDS dementia)
 - Differential diagnosis between psychogenic and neurogenic syndromes
 - Delineation of the neurocognitive effects of central nervous system disorders
 - Neurocognitive monitoring of recovery or progression of central nervous system disorders; or
 - Assessment of neurocognitive functions for the formulation of rehabilitation and/or management strategies among individuals with neuropsychiatric disorders.
- The content of neuropsychological testing procedures differs from that of psychological testing in that neuropsychological testing consists primarily of individually administered ability tests that comprehensively sample cognitive and performance domains that are known to be sensitive to the functional integrity of the brain (e.g., abstraction, memory and learning, attention, language, problem solving, sensorimotor functions, constructional praxis, etc.). These procedures are objective and quantitative in nature and require the patient to directly demonstrate his/her level of competence in a particular cognitive domain. Neuropsychological testing does not rely on self-report questionnaires such as the Minnesota Multiphasic Personality Inventory 2 (MMPI-2), rating scales such as the Hamilton Depression Rating Scale, or projective techniques such as the Rorschach or Thematic Apperception Test (TAT) when questions of how brain damage or degenerative disease processes (e.g. right hemisphere CVA) may be affecting emotional expression or how significant emotional distress or mood impairment might be affecting cognitive function (e.g. question of presence of "pseudodementia") arise.
- Typically, psychological testing will require from four (4) to six (6) hours to perform, including administration, scoring and interpretation. Supporting documentation in the medical record must be present to justify greater than 8 hours per patient per evaluation. 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 eight (8) hours, medical necessity for extended time should be documented. Medical records may be requested.

Limitations (CMS L33632)

- Severe and profound intellectual disabilities are never covered for psychotherapy services or psychoanalysis. In such cases, rehabilitative, evaluation and management (E/M) services should be reported.
- Patients with dementia represent a very vulnerable population in which co-morbid psychiatric conditions are common. However, for such a patient to benefit from psychotherapy services requires that their dementia be mild (e.g., Mini Mental Status Examination score above 15) and that they retain their capacity to recall the therapeutic encounter from one session, individual or group, to another. This capacity to meaningfully benefit from psychotherapy must be documented in the medical record. Psychotherapy services are not covered when documentation indicates that dementia has produced a severe enough cognitive defect to prevent psychotherapy from being effective.
- Any diagnostic or psychotherapeutic procedure rendered by a practitioner not practicing within the scope of his/her licensure or other State authorization will be denied.
- Psychiatric services billed under the hospital outpatient benefit must be provided in distinct outpatient settings. Outpatient hospital services provided in conjunction with inpatient services, or under the auspices of an excluded inpatient unit, residential treatment center, residential facility, or skilled nursing facility, are not in compliance with Medicare regulations and payment will be denied. Payment may be made for psychiatric services in these settings by individual providers billing Part B.
- The following services do not represent reasonable and necessary outpatient psychiatric services and/or coverage is excluded:
 - Day care programs, which provide primarily social, recreational, or diversional activities, custodial or respite care;
 - Programs attempting to enhance emotional wellness, e.g., day care programs;
 - Services to a skilled nursing facility resident that should be expected to be provided by the nursing facility staff;
 - Vocational training when services are related solely to specific employment opportunities, work skills, or work settings;
 - Biofeedback training for psychosomatic conditions;
 - Recovery meetings such as Alcoholics Anonymous, 12 Step, Al Anon, Narcotics Anonymous, due to their free availability in the community;

- Telephone calls to patients, collateral resources, and agencies;
- Evaluation of records, reports, tests, and other data;
- Explanation of results to family, employers, or others;
- Preparation of reports for agencies, courts, schools, or insurance companies, etc. for medicolegal or informational purposes;
- Screening procedures provided routinely to patients without regard to the signs and symptoms of the patient's mental illness;
- The following services are excluded from the scope of outpatient hospital psychiatric services:
 - Services to hospital inpatients;
 - Meals, transportation;
 - Supervision or administration of self-administered medications and supplying medications for home use.
- Evaluations of the mental status that can be performed within the clinical interview, such as a list of questions concerning symptoms of depression or organic brain syndrome, corresponding to brief questionnaires such as the Folstein Mini Mental Status Examination or the Beck Depression Scale, should not be billed as psychological testing, but are considered included in the clinical interview.
- Adjustment reactions or dysphoria associated with moving to a nursing facility do not constitute medical necessity for psychological testing. However, if a more serious mood disorder (e.g., major depression) is suspected upon admission to a nursing facility, psychological or neuropsychological testing may be indicated for differential diagnostic purposes and to develop appropriate treatment planning.
- Routine testing of nursing home patients is considered screening and is not covered.
- Each psychological test administered must be individually medically necessary. A standard battery of tests is only medically necessary if each individual test in the battery is medically necessary.
- Psychological testing should not be reported by the treating physician for only reading the testing report generated by another clinician or explaining the results of a neuropsychological assessment generated by another clinician to the patient or family. Payment for these services is included in the payment for other services rendered to the patient, including both services provided by neuropsychologists and psychologists and evaluation and management services billed provided by physicians, e.g., neurologists, rehabilitation medicine physicians, and psychiatrists.
- Psychological testing is limited to physicians, clinical psychologists, and on a limited basis, to qualified non-physician practitioners (e.g., speech language pathologists for aphasia evaluation).
- General Comments Regarding Coverage of Outpatient Hospital Diagnostic and Therapeutic Services:
 - Therapeutic services defined as hospital services and provided by a hospital on an outpatient basis are incident to the services of physicians in the treatment of patients.

Indications (CMS L34353, 2022)

- Approved Providers of Service:
 - Physicians (MD/DO)
 - Clinical psychologists
 - Clinical Social Workers
 - Nurse practitioners
 - Clinical Nurse Specialists
 - Physician Assistants
 - Other providers of mental health services licensed or otherwise authorized by the state in which they practice (e.g., licensed clinical professional counselors, licensed marriage and family therapists). These other providers may not bill Medicare directly for their services, but may provide mental health treatment services to Medicare beneficiaries under the "incident to" provision.
- General Coverage Requirements:
 - This applies to psychiatric services rendered in a hospital outpatient facility, but the medical necessity parameters contained herein may also be applicable to services billed to Part B by individual providers.
 - Hospital outpatient psychiatric services must be: [1] incident to a physician's service, and [2] reasonable and necessary for the diagnosis or treatment of the patient's condition (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 6, Section 70.1). This means the services must be for the purpose of diagnostic study or the services must reasonably be expected to improve the patient's condition. "Incident to" provisions do not apply to professional services performed by nurse practitioners (NPs), clinical nurse specialists (CNSs), clinical psychologists (CPs) or clinical social workers (CSWs). Physician assistants (PAs) are required to perform services under the general supervision of a physician. (See 42 CFR 410.71-76.) Psychiatric services provided incident to a physician's service must

be rendered by individuals licensed or otherwise authorized by the State and qualified by their training to perform these services.

- The services must meet the following criteria:
 - Individualized Treatment Plan. Services must be prescribed by a physician and provided under an individualized written plan of treatment established by a physician after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency, and duration of the services to be furnished and indicate the diagnoses and anticipated goals. (A plan is not required if only a few brief services will be furnished.) (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 6, Section 70.1).
 - Reasonable Expectation of Improvement. Services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The treatment must, at a minimum, be designed to reduce or control the patient's psychiatric symptoms so as to prevent relapse or hospitalization, and improve or maintain the patient's level of functioning (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 6, Section 70.1).
 - It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness, although this may be appropriate for some patients. For many other psychiatric patients, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. 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 would be met (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 6, Section 70.1).
 - Some patients may undergo a course of treatment which increases their level of functioning, but then reach a point where further significant increase is not expected (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 6, Section 70.1). When stability can be maintained without further treatment or with less intensive treatment, the psychological services are no longer medically necessary.
 - Frequency and Duration of Services. There are no specific limits on the length of time that services may be covered. There are many factors that affect the outcome of treatment; among them are the nature of the illness, prior history, the goals of treatment, and the patient's response. As long as the evidence shows that the patient continues to show improvement in accordance with his/her individualized treatment plan, and the frequency of services is within accepted norms of medical practice, coverage may be continued (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 6, Section 70.1).
 - 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 outpatient psychiatric services are no longer considered reasonable or medically necessary.
- Mental Health Services provided in a CORF include:
 - Social and psychological services include the assessment and treatment of a CORF patient's mental health and emotional functioning and the response to, and rate of progress of the patient's rehabilitation plan of treatment including physical therapy services, occupational therapy services, speech-language pathology services and respiratory therapy services.
 - CORF social and/or psychological covered services are the same, regardless of whether they are provided by a qualified social worker, as defined at 42CFR485.70(i), or a psychologist, as defined at 42CFR485.70(g). Therefore, a CORF may elect to provide these services when they are indicated. Qualifications for individuals providing CORF social and psychological services are, at a minimum, a Bachelor's of Science Degree for a social worker and a Masters-level degree for a psychologist. (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 12, Section 40.7).
- Outpatient Mental Health Treatment Limitation:
 - Medicare will pay outpatient mental health services at the same level as other Part B services. That is, at 80 percent of the physician fee schedule.
 - The outpatient mental health treatment limitation does not apply to psychiatric diagnostic evaluations, diagnostic psychological and neuropsychological testing, or inpatient hospital services.
 - The limitation applies to procedures for psychiatric therapy evaluation codes except in in-patient hospital and inpatient psychiatric facility.
 - When evaluation and management (E&M) codes are reported for treatment of psychiatric illness, except Alzheimer's Disease and related dementias, the psychiatric limitation also applies to those services. For patients with Alzheimer's Disease or related dementias, if the primary treatment rendered is psychotherapy, the limitation applies to the therapy services. The limitation does not apply to an E&M service, or a non-psychotherapy service, rendered for the management of Alzheimer's Disease or related dementias.

- Pharmacologic management or any successor code is not subject to the limitation.
- Brief office visit for the purpose of monitoring or changing drug prescriptions or any successor code is not subject to the limitation.
- Unless otherwise indicated these services may be used by psychiatrists or other physicians trained in the treatment of mental illness (MDs/DOs), clinical psychologists, clinical social workers, clinical nurse specialists and other nurses with special training and/or experience in psychiatric nursing beyond the standard curriculum required for a registered nurse (e.g., Masters of Science in psychiatric nursing, or its equivalent [Advanced Registered Nurse Practitioner with a Master's degree in Mental Health, or equivalent to a Master's prepared, certified Clinical Nurse Specialist]).
- Psychiatric Diagnostic Interview Examination:
 - The psychiatric diagnostic procedure codes require the elicitation of a complete medical (including past, family, social) and psychiatric history, a mental status examination, establishment of an initial diagnosis, an evaluation of the patient's ability and capacity to respond to treatment, and an initial plan of treatment. Information may be obtained from not only the patient, but also other physicians, healthcare providers, and/or family if the patient is unable to provide a complete history.
 - This service may be reported once per day and not on the same day as an evaluation and management service performed by the same individual for the same patient.
 - The medical record must reflect the elements outlined in the above description and must be rendered by a qualified provider.
 - 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 an inpatient status due to complications of the underlying condition. 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.
- Interactive Complexity:
 - The interactive complexity component code may be used in conjunction with codes for diagnostic psychiatric evaluation and psychotherapy, psychotherapy when performed with an evaluation and management service, and group psychotherapy.
 - The code is used principally to evaluate children and also adults who do not have the ability to interact through ordinary verbal communication. The healthcare provider uses 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 one who does not speak the same language as the healthcare provider.
 - Interactive complexity may also be used in the evaluation of adult patients with organic mental deficits, or for those who are catatonic or mute.
 - Interactive complexity may be reported with psychotherapy when at least one of the following is present:
 - Maladaptive communication (e.g., high anxiety, high reactivity, repeated questions, or disagreement)
 - Emotional or behavioral conditions inhibiting implementation of treatment plan
 - Mandated reporting/event exists (e.g., abuse or neglect) or
 - Play equipment, devices, interpreter, or translator required due to inadequate language expression or different language spoken between patient and professional.
- Documentation: The medical record must reflect the elements outlined in the above description and must be rendered by a qualified provider (see "Limitations" subsection below) and must indicate that the person being evaluated does not have the ability to interact through normal verbal communicative channels. Additionally, the medical record must include adaptations utilized in the session and the rationale for employing these interactive techniques. If the patient is capable of ordinary verbal communication, this code should not be used. The medical record must include treatment recommendations.
- Psychotherapy Psychiatric Therapeutic Procedures:
 - Codes representing insight oriented, behavior modifying, supportive, and/or interactive psychotherapy:
 - Procedures for psychotherapy are defined as "the treatment for mental illness and behavioral disturbances in which the physician or other qualified health care professional through definitive therapeutic communication attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage personality growth and development." (CPT 2013, Professional Edition, p.485)
 - The medical record must indicate the time spent in the psychotherapy encounter and the therapeutic maneuvers, such as behavior modification, supportive or interpretive interactions that were applied to produce a therapeutic change. Behavior modification is not a separate service, but is an adjunctive measure in psychotherapy. Additionally, a periodic summary of goals, progress toward goals, and an updated treatment plan must be included in the medical record.

Prolonged periods of psychotherapy must be well-supported in the medical record describing the necessity for ongoing treatment.

- Procedure for psychotherapy are timed codes that are used to represent the actual time spent with the patient. There are add on codes that should be used in conjunction with evaluation and management (E/M) codes.
- For psychotherapy sessions lasting 90 minutes or longer, the appropriate prolonged service code should be used . The duration of a course of psychotherapy must be individualized for each patient. Prolonged treatment may be subject to medical necessity review. The provider must document the medical necessity for prolonged treatment.
- While a variety of psychotherapeutic techniques are recognized for coverage under these codes, the services must be performed by persons authorized by their state to render psychotherapy services. Healthcare providers would include: physicians, clinical psychologists, registered nurses with special training (as described in the "Indications" section), and clinical social workers. Medicare coverage of procedure codes for psychiatric therapy does not include teaching grooming skills, monitoring activities of daily living (ADL), recreational therapy (dance, art, play) or social interaction. Therefore, these should not be used to bill for ADL training and/or teaching social interaction skills.
- Psychotherapy codes that include an evaluation and management component are payable only to physicians, NPPs and CNSs. The evaluation and management component of the services must be documented in the record. A psychotherapy code should not be billed when the service is not primarily a psychotherapy service, that is, when the service could be more accurately described by an evaluation and management or other code.
- The duration of a course of psychotherapy must be individualized for each patient. Prolonged treatment may be subject to medical necessity review. The provider must document the medical necessity for prolonged treatment.
- Codes representing psychoanalysis, group psychotherapy, family psychotherapy, and/or interactive group psychotherapy:
 - Psychoanalysis
 - Procedure code involves the practice of psychoanalysis using special techniques to gain insight into and treat 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 the psychoanalytic techniques used.
 - The physician or other healthcare professional using this technique must be trained by an accredited program of psychoanalysis. The code for this service is not time defined, but is usually 45 to 50 minutes and is billed once for each daily session.
 - Family Psychotherapy
 - Procedure codes that describe the treatment of the family unit when maladaptive behaviors of family members are exacerbating the beneficiary's mental illness or interfering with the treatment, or to assist the family in addressing the maladaptive behaviors of the patient and to improve treatment compliance. Family Psychotherapy can be done without or with the patient is present. Group therapy sessions to support multiple families when similar dynamics are occurring due to common issues confronted in the family members under treatment.
 - The medical record must document the conditions relative to codes for family psychotherapy.
 - The Medicare National Coverage Determinations Manual, Chapter 1, Section 70.1, states that family psychotherapy services are covered only where the primary purpose of such psychotherapy is the treatment of the patient's condition. Examples include:
 - When there is a need to observe and correct, through psychotherapeutic techniques, the patient's interaction with family members.
 - 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.
- The term "family" may apply to traditional family members, live-in companions, or significant others involved in the care of the patient. The codes representing these services are not timed but are typically 45 to 60 minutes in duration.
- These services do not pertain to consultation and interaction with paid staff members at an institution. Facility staff members are not considered "significant others" for the purposes of this LCD.
- Multiple-family group psychotherapy and is generally non-covered by Medicare. Such group therapy is usually directed to the effects of the patient's condition on the family and its purpose is to support the affected family members. Therefore, multiple-family group psychotherapy does not meet Medicare's standards of being a therapy primarily directed toward treating the beneficiary's condition. These may be approved on an individual consideration basis.
- Group Psychotherapy
 - Code(s) representing psychotherapy administered in a group setting, involving no more than 12 participants, facilitated by a trained therapist simultaneously providing therapy to these multiple patients. The group therapy session typically

lasts 45 to 60 minutes. Personal and group dynamics are discussed and explored in a therapeutic setting allowing emotional catharsis, instruction, insight, and support.

- Group therapy, since it involves psychotherapy, must be led by a person who is licensed or otherwise authorized by the state in which he or she practices to perform this service. This will usually mean a psychiatrist, psychologist, clinical social worker, clinical nurse specialist, or other person authorized by the state to perform this service. Registered nurses with special training, as described in the "Indications and Limitations of Coverage and/or Medical Necessity" section, may also be considered eligible for coverage. For Medicare coverage, group therapy does not include socialization, music therapy, recreational activities, art classes, excursions, sensory stimulation or eating together, cognitive stimulation, or motion therapy, etc.
- Codes interactive psychotherapy: As a reminder, this is used when the patient or patients in the group setting do not have the ability to interact by ordinary verbal communication and therefore, non-verbal communication skills are employed, or an interpreter may be necessary.
- Narcosynthesis for psychiatric diagnostic and/or therapeutic purposes
 - This therapy is used for the administration of sedative or tranquilizer drugs, usually intravenously, to relax the patient and remove inhibitions for discussion of subjects difficult for the patient to discuss freely in the fully conscious state.
 - The medical record should document the medical necessity of this procedure (e.g., the patient had difficulty verbalizing their psychiatric problems without the aid of the drug). The record should also document the specific pharmacological agent, dosage administered, and whether the technique was effective or non-effective.
 - Use of this type of therapy is restricted to physicians (MD/DO) only.
- Psychiatric in Crisis
 - "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." (CPT 2013, Professional Edition, p.486).
 - "Codes 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." (CPT 2013, Professional Edition, p.486).
- Psychiatric Somatotherapy
 - These codes describe medication management and/or electroconvulsive therapy.
 - Electroconvulsive therapy (ECT), is described as the application of electric current to the brain, through scalp electrodes to produce a seizure. It is used primarily to treat major depressive disorder when antidepressant medication is contraindicated and for certain other clinical conditions.
 - When a psychiatrist performs both the ECT and the associated anesthesia, no separate payment is made for the anesthesia. Code 90870 is limited to use by physicians (MD/DO) only.
- Other Psychiatric Services
 - 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).
 - The Medicare National Coverage Determinations Manual, Chapter 1, Section 30.1, restricts the use of biofeedback. Medicare does not cover biofeedback for the treatment of psychosomatic disorders.
- Hypnotherapy
 - Hypnosis is an artificially induced alteration of consciousness in which the patient is in a state of increased suggestibility.
 - Claims must be submitted with a covered diagnosis.
- Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions is not covered by Medicare.
- When a physician or advanced mental health practitioner 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.

- 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.
- Preparation of reports for insurance companies, agencies, courts, etc.
 - Administrative services that do not involve face to face contact with the patient and are not covered by Medicare.
- Unlisted psychiatric service or procedure codes should not be used if the service is described by a specified codes. Psychiatric procedures billed using an unlisted code may be covered on an individual consideration basis.
- Central Nervous System Assessments/Tests (e.g., Neuro-Cognitive, Mental Status, Speech Testing):
 - Psychological testing includes the administration, interpretation, and scoring of the tests mentioned in the CPT descriptions and other medically accepted tests for evaluation of intellectual strengths, psychopathology, psychodynamics, mental health risks, insight, motivation, and other factors influencing treatment and prognosis.
 - The medical record must indicate the presence of mental illness or signs of mental illness for which psychological testing is indicated as an aid in the diagnosis and therapeutic planning. The record must show the tests performed, scoring and interpretation, as well as the time involved.
 - These codes do not represent psychotherapeutic modalities, but are diagnostic aids. Use of such tests when mental illness is not suspected would be a screening procedure not covered by Medicare. Each test performed must be medically necessary. Therefore, standardized batteries of tests are not acceptable unless each test in the battery is medically necessary.
 - Changes in mental illness may require psychological testing to determine new diagnoses or the need for changes in therapeutic measures. Repeat testing not required for diagnosis or continued treatment would be considered medically unnecessary. Nonspecific behaviors that do not indicate the presence of, or change in, a mental illness would not be an acceptable indication for testing. Psychological or psychiatric evaluations that can be accomplished through the clinical interview alone (e.g., response to medication) would not require psychological testing, and such testing might be considered as medically unnecessary. Adjustment reactions or dysphoria associated with moving to a nursing facility do not constitute medical necessity for psychological testing.
 - The formal evaluation of aphasia using a psychometric instrument such as the Boston Diagnostic Aphasia Examination. This testing is typically performed once during treatment and the medical necessity for such testing should be documented. Repeat testing should only be done if there is a significant change in the patient's aphasic condition.
 - Testing which is intended to diagnose and characterize the neurocognitive effects of medical disorders that impinge directly or indirectly on the brain. Examples of problems that might lead to neuropsychological testing are:
 - Detection of neurologic diseases based on quantitative assessment of neurocognitive abilities (e.g., mild head injury, anoxic injuries, AIDS dementia)
 - Detection of neurologic diseases based on quantitative assessment of neurocognitive abilities (e.g., mild head injury, anoxic injuries, AIDS dementia)
 - Differential diagnosis between psychogenic and neurogenic syndromes
 - Delineation of the neurocognitive effects of central nervous system disorders
 - Neurocognitive monitoring of recovery or progression of central nervous system disorders; or
 - Assessment of neurocognitive functions for the formulation of rehabilitation and/or management strategies among individuals with neuropsychiatric disorders.
 - The content of neuropsychological testing procedures differs from that of psychological testing in that neuropsychological testing consists primarily of individually administered ability tests that comprehensively sample cognitive and performance domains that are known to be sensitive to the functional integrity of the brain (e.g., abstraction, memory and learning, attention, language, problem solving, sensorimotor functions, constructional praxis, etc.). These procedures are objective and quantitative in nature and require the patient to directly demonstrate his/her level of competence in a particular cognitive domain. Neuropsychological testing does not rely on self-report questionnaires such as the Minnesota Multiphasic Personality Inventory 2 (MMPI-2), rating scales such as the Hamilton Depression Rating Scale, or projective techniques such as the Rorschach or Thematic Apperception Test (TAT).
 - Typically, psychological testing will require from four (4) to six (6) 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 eight (8) hours, a report may be requested to indicate the medical necessity for extended testing.

Limitations (CMS L34353)

- Severe and profound mental retardation is never covered for psychotherapy services. In such cases, rehabilitative, evaluation and management (E/M) codes, or pharmacological management codes should be reported.

- Patients with dementia represent a very vulnerable population in which co-morbid psychiatric conditions are common. However, for such a patient to benefit from psychotherapy services requires that their dementia to be mild and that they retain the capacity to recall the therapeutic encounter from one session, individual or group, to another. This capacity to meaningfully benefit from psychotherapy must be documented in the medical record. Psychotherapy services are not covered when documentation indicates that dementia has produced a severe enough cognitive defect to prevent psychotherapy from being effective.
- Any diagnostic or psychotherapeutic procedure rendered by a practitioner not practicing within the scope of his/her licensure or other State authorization will be denied.
- Psychiatric services billed under the hospital outpatient benefit must be provided in distinct outpatient settings. Outpatient hospital services provided in conjunction with inpatient services, or under the auspices of an excluded inpatient unit, residential treatment center, residential facility, or skilled nursing facility, are not in compliance with Medicare regulations and payment will be denied. Payment may be made for psychiatric services in these settings by individual providers billing Part B.
- The following services do not represent reasonable and necessary outpatient psychiatric services and/or coverage is excluded under section 1862(a)(1)(A) of the Social Security Act:
 - day care programs, which provide primarily social, recreational, or diversional activities, custodial or respite care;
 - programs attempting to enhance emotional wellness, e.g., day care programs;
 - services to a skilled nursing facility resident that should be expected to be provided by the nursing facility staff;
 - vocational training when services are related solely to specific employment opportunities, work skills, or work settings;
 - biofeedback training for psychosomatic conditions;
 - recovery meetings such as Alcoholics Anonymous, 12 Step, Al Anon, Narcotics Anonymous, due to their free availability in the community;
 - telephone calls to patients, collateral resources, and agencies;
 - evaluation of records, reports, tests, and other data;
 - explanation of results to family, employers, or others;
 - preparation of reports for agencies, courts, schools, or insurance companies, etc. for medicolegal or informational purposes;
 - screening procedures provided routinely to patients without regard to the signs and symptoms of the patient's mental illness.
- The following services are excluded from the scope of outpatient hospital psychiatric services defined in Section 1927(k) of the Social Security Act:
 - services to hospital inpatients;
 - meals, transportation;
 - supervision or administration of self-administered medications and supplying medications for home use.
- Evaluations of the mental status that can be performed within the clinical interview, such as a list of questions concerning symptoms of depression or organic brain syndrome, corresponding to brief questionnaires such as the Folstein Mini Mental Status Examination or the Beck Depression Scale, should not be billed as psychological testing (96101-96120), but is considered included in the clinical interview.
- Psychological testing to evaluate adjustment reactions or dysphoria associated with placement in a nursing home is not medically necessary. Routine testing of nursing home patients is considered screening and is not covered.
- Each psychological test administered must be individually medically necessary. A standard battery of tests is only medically necessary if each individual test in the battery is medically necessary.
- The psychological testing codes should not be reported by the treating physician for reading the testing report or explaining the results to the patient or family.
- Payment for these services is included in the payment for other services rendered to the patient, such as evaluation and management services. Payment for psychological testing is limited to physicians, clinical psychologists, and on a limited basis, to qualified non-physician practitioners (e.g., speech language pathologists for aphasia evaluation).

Indications (CMS L34539, 2021)

- "Incident to" a physician's professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness. (CMS Pub 100-02, Chapter 15, Section 60.1) The "incident to" provision may also apply to coverage for psychological services furnished "incident to" the professional services of certain non-physician practitioners including clinical psychologists, clinical social workers, nurse practitioners, and clinical nurse specialists (CMS Pub 100-02, Chapter

15, Section 60.2). Section 1862(a)(1)(A) of the Social Security Act governs payment for the provision of medical care to Medicare beneficiaries.

- The training requirements and state licensure or authorization of individuals who perform psychological services are intended to ensure an adequate level of expertise in the cognitive skills required for the performance of diagnostic and therapeutic psychological services. Therefore, only the types of individuals listed later in this policy are considered qualified to perform medically necessary psychological services addressed in this policy. Delegation of diagnostic and therapeutic psychological services to personnel not performing within the scope of practice as authorized by state law, under the "incident to" provision, would bypass the safeguards afforded by professional credentialing and state licensure requirements. Such delegated services under the "incident to" provision would be inappropriate, unreasonable, and medically unnecessary, and therefore not covered by Medicare.
- Coverage of services and supplies "incident to" the professional services of a physician in private practice is limited to situations in which there is direct physician supervision of auxiliary personnel.
- For psychological services rendered under the "incident to" provision, the billing provider must first evaluate the patient personally and initiate the course of treatment. The appropriately trained therapists may then render psychological services to the patient under the billing provider's direct supervision.
 - Doctorate or Masters level Clinical Psychologist: 90785, 90804, 90806, 90808, 90810, 90812, 90814, 90816, 90818, 90821, 90823, 90826, 90828, 90832-90834, 90836-90840, 90846, 90847, 90849, 90853, 90857, 90880, 90899.
 - Doctorate or Masters level Clinical Social Worker: 90785, 90804, 90806, 90808, 90810, 90812, 90814, 90816, 90818, 90821, 90823, 90826, 90828, 90832-90834, 90836-90840, 90846, 90847, 90849, 90853, 90857, 90899.
 - Clinical Nurse Specialist (CNS): 90785, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, 90829, 90832-90834, 90836-90840, 90846, 90847, 90849, 90853, 90857, 90899 (90862, if authorized by the state to prescribe medication; this code was deleted effective 12/31/12. 90863, if authorized by the state to prescribe medication.)
 - Nurse Practitioner* (NP): 90785, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, 90829, 90846, 90847, 90849, 90853, 90857, 90899 (90862, if authorized by the state to prescribe medication; this code was deleted effective 12/31/12. 90863, if authorized by the state to prescribe medication.) *limited to advanced registered nurse practitioners with a master's degree in the mental health equivalent to a masters prepared certified clinical nurse specialist.
 - The psychological services referenced in the above HCPCS codes may only be delegated to employees who qualify for one of the categories of individuals listed above. For example, a psychiatrist may hire a clinical social worker to perform services designated by the HCPCS codes listed in #2 above. Individuals who are performing services "incident to" a qualified Medicare practitioner are not required to be separately enrolled as an independent practitioner in Medicare.
 - It is not permissible for the billing provider to hire and supervise a professional whose scope of practice is outside the provider's own scope of practice as authorized under State law, or whose professional qualifications exceed those of the "supervising" provider. For example, a certified nurse-midwife (CNM) may not hire a psychologist and bill for that psychologist's services under the "incident to" provision, because a psychologist's services are not integral to a CNM's personal professional services and are not regularly included in the CNM's bill. Even though sections 1861(s)(2)(l) and 1861(gg) (l) of the Social Security Act authorize coverage for services furnished "incident to" a CNM's services, psychological services are not commonly furnished in CNM's offices nor within their scope of practice. Similarly, even though section 1861(s)(2)(K)(iv) authorizes coverage for services furnished "incident to" a physician assistant's services, a physician assistant would not be qualified to supervise psychological services performed by the types of individuals listed above.
 - Individuals who are not licensed or otherwise authorized by state law to provide psychological services may not provide psychological services under the "incident to" provision. This level of professional credentialing is necessary to furnish appropriate medically necessary services under the "incident to" provision. Psychological services furnished to Medicare beneficiaries under the "incident to" provision by individuals other than those listed above are not covered. (Note: the standards for professional credentialing are higher for these services billed to Medicare Part B than for similar services performed by other mental health professionals not under the "incident to" provision and billed to Medicare Part A. Under the "incident to" provision, services are performed in the place of the billing provider. In order for services performed and billed under the "incident to" provision to be commensurate with the services performed by the billing provider, and therefore medically necessary, this higher standard of professional credentialing is necessary.)
 - The practice of "marriage and family therapy" includes the identification and treatment of cognitive, affective and behavioral conditions related to marital and family dysfunctions that involve the professional application of psychotherapeutic and systems theories and techniques in the delivery of services to individuals, couples, and families.

Local laws regulating their professional practice do not authorize any licensed marriage and family therapist or marriage and family therapy associate to administer or interpret psychological tests. Please refer to applicable state laws.

- Coverage of services and supplies "incident to" the professional services of a physician in private practice is limited to situations in which there is direct physician supervision of auxiliary personnel. (CMS Pub 100-02, Chapter 15, Section 60.2). This also applies to the services of certain non - physician practitioners who are being licensed by the states under various programs to assist or act in the place of the physician, including nurses, clinical psychologists, clinical social workers, and other therapists. Direct supervision in the office setting does not mean that the physician must be present in the same room with his or her aide. However, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the aide is performing services (CMS Pub 100-02, Chapter 15, Section 60.1 - Section 60.3). Services and supplies incident to a physician's service in a physician directed clinic or group association are generally the same as those described for the office setting (CMS Pub 100-02, Chapter 15, Section 60.3).
- For hospital patients and for SNF patients who are in a Medicare covered stay, there is no Medicare Part B coverage of the services of physician-employed auxiliary personnel as services incident to physicians' services under §1891(s)(2)(A) of the Act. Such services can be covered only under the hospital outpatient or inpatient benefit and payment for such services can be made to only the hospital by a Medicare intermediary (CMS Pub 100-02, Chapter 15, Section 60).
- For "incident to" services to be covered when a physician's office is in an institution, the auxiliary medical personnel must be members of the office staff rather than of the institution's staff, and the cost of supplies must represent an expense to the physician's office practice. In addition, services performed by the employees of the physician outside the "office" area must be directly supervised by the physician; his presence in the facility as a whole would not suffice to meet this requirement. (In any setting, of course, supervision of auxiliary personnel in and of itself is not considered a "physician's professional service" to which the services of the auxiliary personnel could be an incidental part, i.e., in addition to supervision, the physician must perform or have performed a personal professional service to the patient to which the services of the auxiliary personnel could be considered an incidental part). Denials for failure to meet any of these requirements would be based on §1861(s)(2)(A) of the Act. (CMS Pub 100-03; Medicare National Coverage Determinations Manual, Chapter 1, Part 1, 70.3)
- If auxiliary personnel perform services outside the office setting, e.g., in a patient's home or in an institution (other than a hospital or SNF), their services are covered incident to a physician's service only if there is direct supervision. The availability of the physician by telephone or the presence of the physician somewhere in the institution does not constitute direct personal supervision (CMS Pub 100-02, Chapter 15, Section 60.1).

Indications (CMS L34616, 2022)

- Psychiatry Services with Evaluation and Management (E/M)
 - Some psychiatry services may be reported with evaluation and management (E/M) services or other services when performed. An E/M code may be used to report evaluation and management services alone (no other service reported that day) or used to report an E/M service with psychotherapy. An E/M service is based on the physician's work and includes services medically necessary to evaluate and treat the patient.
- Psychiatric Diagnostic Evaluation
 - A psychiatric diagnostic evaluation is an integrated assessment that includes history, mental status and recommendations. It may include communicating with the family and ordering further diagnostic studies. A psychiatric diagnostic evaluation with medical services includes a psychiatric diagnostic evaluation and a medical assessment. It may require a physical exam, communication with the family, prescription medications and ordering laboratory or other diagnostic studies. A psychiatric diagnostic evaluation with medical services also includes physical examination elements.
- The following information pertains to both psychiatric diagnostic evaluation; and psychiatric diagnostic evaluation with medical services:
 - Cannot be reported with an E/M code on the same day by the same provider
 - Cannot be reported with a psychotherapy service code on the same day
 - May only be reported once per day
 - May be reported more than once for a patient when separate evaluations are conducted with the patient and other informants (i.e., family members, guardians, significant others) on different days. This service is considered medically necessary once every 6 months per episode of illness. *However, if reported more than once per episode of illness, documentation will be required for the establishment of medical necessity.
 - In certain circumstances family members, guardians, or significant others may be seen in lieu of the patient.

- Interactive Complexity
 - Interactive Complexity refers to communication difficulties during the psychiatric procedure.
 - When performed with psychotherapy, the interactive complexity component relates only to the increased work intensity of the psychotherapy service, but does not change the time for the psychotherapy service.
 - The medical record for interactive complexity reported with the psychiatric procedures must indicate that the person being evaluated does not have the ability to interact through normal verbal communicative channels, include adaptations utilized in the session and the rationale for employing these interactive techniques, and recommendations for future care.
- Psychotherapy
 - Psychotherapy is defined as the treatment for mental illness and behavioral disturbances in which the clinician establishes a professional contract with the patient and through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage personality growth and development or support current evaluation of functioning. Psychotherapy services include ongoing assessment and adjustment of psychotherapeutic interventions and may include involvement of family member(s) or others in the treatment process. Although maintenance per se is not covered, helping a patient maintain his/her highest level of functioning, such as a patient with borderline personality disorder, may be covered on a case-by-case basis. These case-by-case considerations must be supported by the evaluation and a plan with clearly identified goal(s).
 - Psychotherapy time may include face to face time with family members as long as the patient is present for part of the service.
 - To report both E/M and psychotherapy, the two services must be significant and separately identifiable:
 - The type and level of E/M service is selected first based upon the key components of history, examination, and medical decision-making. For office services on or after 01/01/2021, choose the level of E/M service based on either medical decision making or time.
 - Time associated with activities used to meet criteria for the E/M service is not included in the time used for reporting the psychotherapy service (i.e., time spent on history, examination, and medical decision making when used for the E/M service is not psychotherapy time). Time may not be used to determine E/M code selection. Prolonged Services may be reported when E/M and psychotherapy are reported.
 - A separate diagnosis is not required for the reporting of E/M and psychotherapy on the same date of service.
- Psychotherapy for Crisis
 - A major concept and addition to the psychotherapy section is the addition of codes for psychotherapy for crisis when psychotherapy services are provided to a patient who presents in high distress with complex or life-threatening circumstances that require immediate attention.
 - These codes do not include medical services. In a crisis situation, psychiatrists may prefer the appropriate E/M code.
- Documentation for Psychotherapy Services
 - The medical record must indicate the time spent in the psychotherapy encounter and the therapeutic maneuvers, such as behavior modification, supportive or interpretive interactions that were applied to produce a therapeutic change.
 - Behavior modification is not a separate service, but is an adjunctive measure in psychotherapy. Additionally, a periodic summary of goals, progress toward goals, and an updated treatment plan must be included in the medical record.
 - Prolonged treatment must be well supported by the content of the medical documentation. Documentation must be present in the medical record supporting the medical necessity for ongoing treatment.
 - To establish medical necessity of the service, claims must be submitted with a covered diagnosis.
- Family Psychotherapy
 - Family psychotherapy services are covered only where the primary purpose of such psychotherapy is the treatment of the patient's condition. Examples include:
 - 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 and impediments within the family, and assist, through psychotherapy, the family members in the management of the patient.
- Group Psychotherapy
 - Group Psychotherapy is psychotherapy administered in a group setting with a trained therapist simultaneously providing therapy to several patients. To establish medical necessity of the service, claims must be submitted with a covered diagnosis.

- Group therapy, since it involves psychotherapy, must be led by a person who is authorized by state statute to perform this service. This will usually mean a physician, clinical psychologist, clinical social worker, physician assistant, certified nurse practitioners, clinical nurse specialist, or other person authorized by the state to perform this service.
- Limitations for Psychotherapy
 - While a variety of psychotherapeutic techniques are recognized for coverage, the services must be performed by persons authorized by their state to render psychotherapy services.
 - Psychotherapy services must be performed by persons authorized by their state to render psychotherapy services.
 - Psychotherapy does not include teaching grooming skills, monitoring activities of daily living (ADL), recreational therapy (dance, art, play) or social interaction. It also does not include oversight activities such as housing, or financial management.
 - Severe and profound mental retardation is never covered for psychotherapy services.
 - Psychotherapy services are not covered when documentation indicates that senile dementia has produced a severe enough cognitive defect to prevent psychotherapy from being effective.
 - Multiple-family group psychotherapy is for those situations where family dynamics are occurring due to a commonality of problems in the family members under treatment 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.
 - Group therapy does not include socialization, music therapy, recreational activities, art classes, excursions, sensory stimulation or eating together, cognitive stimulation, or motion therapy.
 - Self-help groups or support groups without a qualified professional present are not covered. When covered the group size should be of a size that can be successfully led (e.g., maximum of 12 people).
- Psychoanalysis
 - The practice of psychoanalysis is using special techniques to gain insight into and treat 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 the psychoanalytic techniques used. To establish medical necessity of the service, claims must be submitted with a covered diagnosis.
 - The provider using this technique must be trained by an accredited program of psychoanalysis.
- Narcosynthesis
 - Narcosynthesis is used for the administration of sedative or tranquilizer drugs, usually intravenously, to relax the patient and remove inhibitions for discussion of subjects difficult for the patient to discuss freely in the fully conscious state.
 - The medical record should document the medical necessity of this procedure (e.g., the patient had difficulty verbalizing his/her psychiatric problems without the aid of the drug). The record should also document the specific pharmacological agent, dosage administered, and whether the technique was effective or non-effective.
 - Limitation of Narcosynthesis: Narcosynthesis is restricted to physicians (M.D., D.O.) only.
- Hypnotherapy
 - Hypnosis is an artificially induced alteration of consciousness in which the patient is in a state of increased suggestibility.
 - To establish medical necessity of the service, claims must be submitted with a covered diagnosis.
 - Hypnosis may be used for diagnostic or therapeutic purposes.
- Documentation Requirements
 - The medical record should document the target symptoms; goals of therapy and methods of monitoring outcomes; and why the chosen therapy is the appropriate treatment modality (either in lieu of, or in addition to, another form of psychiatric treatment).
 - The patient's medical record should contain documentation that fully supports the medical necessity for psychiatry and psychology services as Medicare covers it. This documentation includes, but is not limited to, relevant medical history, physical examination, results of pertinent diagnostic tests or procedures.
 - Individual psychotherapy CPT codes should be used only when the focus of treatment involves individual psychotherapy.
 - Medical records must document the patient's capacity to participate in, and benefit from, psychotherapy, if psychotherapy is the chosen treatment. The estimated duration of treatment (number of sessions) should be specified. There should be documentation in the medical record that the treatment is expected to improve the health status or function of the patient. These CPT codes would not be used as generic psychiatric service CPT codes when other CPT codes such as an Evaluation and Management service or pharmacological CPT codes would be more appropriate.

- Documentation must be available and may be requested prior to payment. If the claim does not indicate that documentation is available, it will be denied.

Indications (CMS L35101, 2020)

- Psychiatric care includes the therapeutic services provided to a beneficiary for the treatment of mental, psychoneurotic, and personality disorders which are directed toward identifying specific behavior patterns, factors determining such behavior, and effective goal oriented therapies.
- Providers of Mental Health Services
 - For approved providers of mental health services, the state licensure or authorization must specify that the provider's scope of practice includes the provision of clinical psychotherapy for the treatment of mental illness. It is the responsibility of providers to be aware of their own state licensure laws and written agreements or protocols required, including changes as they occur.
 - Psychiatrists are physicians (MDs and DOs) trained in mental health disorders and may provide all services described in this policy.
 - Coverage for all non-physician practitioners is limited to services which they are authorized to perform by the state in which they practice.
- Mental Health Services Under the "Incident to" Provision
 - Please see CMS IOM, Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 60 and Section 80.2, for information regarding "incident to" services.
 - A billing provider may not hire and supervise a professional whose scope of practice is outside the hiring provider's own scope of practice as authorized under State law, or whose professional qualifications exceed those of the supervising provider.
 - The training requirements and state licensure or authorization of individuals who perform psychological services are intended to ensure an adequate level of expertise in the cognitive skills required for the performance of diagnostic and therapeutic psychological services.
 - Please see IOM 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 80.2 for information regarding tests performed by technicians.
- Psychiatric Diagnostic Evaluation Indications
 - The diagnostic evaluation is a biopsychosocial assessment.
 - The diagnostic evaluation with medical services is a biopsychosocial and medical assessment.
 - Both of these evaluations may include discussion with family or other sources in addition to the patient.
 - The diagnostic interview is indicated for initial or periodic diagnostic evaluation of a patient for suspected or diagnosed psychiatric illness.
 - An additional diagnostic evaluation service may be considered medically reasonable and necessary for the same patient if a new episode of illness occurs, an admission or a readmission to inpatient status due to complications of the underlying condition occurs, or when re-evaluation is required to address a new referral question. Certain patients, especially children and geriatric patients may require more than one visit for the completion of the initial diagnostic evaluation. The indication for the assessment should be based on medical necessity and supported in the medical record.
 - Interactive procedures may be necessary and considered reasonable and necessary for patients whose ability to communicate is impaired by expressive or receptive language impairment from various causes. These may include conductive or sensorineural hearing loss, deaf mutism, aphasia, language barrier, or lack of mental development (childhood).
 - The Bariatric Surgical Management of Morbid Obesity LCD (L35022) provides specific criteria that support the medical necessity of the psychiatric diagnostic interview. Please refer to LCD L35022 for the specific criteria.
 - Coverage for the diagnostic interview is limited to physicians (MDs, DOs), Clinical Social Workers (CSWs), Clinical Psychologists (CPs), Clinical Nurse Specialists (CNSs), Physician Assistants (PAs) and Nurse Practitioners (NPs) certified in the state or jurisdiction for psychiatric services.
- Psychological and Neuropsychological Testing Indications
 - These diagnostic tests are used when mental illness is suspected, and clarification is essential for the diagnosis and the treatment plan.
 - Testing conducted when no mental illness/disability is suspected would be considered screening and would not be covered by Medicare. Non-specific behaviors that do not suggest the possibility of mental illness or disability are not an acceptable indication for testing.

- Examples of problems that might require psychological or neuropsychological testing include:
 - Assessment of mental functioning for individuals with suspected or known mental disorders for purposes of differential diagnosis or treatment planning.
 - Assessment of patient strengths and disabilities for use in treatment planning or management when signs or symptoms of a mental disorder are present.
 - Assessment of patient capacity for decision-making when impairment is suspected that would affect patient care or management.
 - Differential diagnosis between psychogenic and neurogenic syndromes (e.g., depression versus dementia).
 - Detection of neurologic disease based on quantitative assessment of neurocognitive abilities (e.g., mild head injury, anoxic injuries, Acquired Immune Deficiency Syndrome [AIDS] dementia).
 - Delineation of the neurocognitive effects of central nervous system disorders.
 - Neurocognitive monitoring of recovery or progression of central nervous system disorders.
- When a psychiatric condition or the presence of dementia has already been diagnosed, there is value to the testing only if the information derived from the testing would be expected to have significant impact on the understanding and treatment of the patient. Examples include:
 - Significant change in the patient's condition.
 - The need to evaluate a patient's capacity to function in a given situation or environment.
 - The need to specifically tailor therapeutic and or compensatory techniques to particular aspects of the patient's pattern of strengths and disabilities.
- Adjustment reactions or dysphoria associated with moving to a nursing home do not automatically constitute medical necessity for testing. Testing of every patient upon entry to a nursing home would be considered a routine service and would not be covered by Medicare. However, some individuals enter a nursing home at a time of physical and cognitive decline, and may require psychological testing to arrive at a diagnosis and plan of care. Decisions to test individuals who have recently entered a nursing home need to be made judiciously, on a case-by-case basis. Medical necessity of such evaluations should be documented and maintained in the medical record.
- Each test administered must be medically necessary. Standardized batteries of tests are only acceptable if each component test is medically necessary.
- Depending on the issues to be assessed, a typical test battery may require 7 to 10 hours to perform, including administration, scoring and interpretation.
- Formal evaluation of aphasia with an instrument such as the Boston Diagnostic Aphasia Examination performed during treatment, is typically performed only once during treatment and its medical necessity should be documented. If the test is repeated during treatment, the medical necessity of the repeat administration of the test must also be documented.
- Rendering Providers
 - Physical Therapists (PTs), Occupational Therapists (OTs), and Speech Language Pathologists (SLPs) may perform assessment of aphasia with interpretation and report, developmental test administration performed by physician or other qualified health care professional, with interpretation and report and development testing, with interpretation and report, per standardized instrument form under the general supervision of a physician or a CP.
 - Independently Practicing Psychologists (IPPs) may provide psychological and neuropsychological tests when the tests are ordered by a physician. Please see CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 80.2 for information regarding non-physician practitioners (NPPs), such as NPs, CNSs and PAs who personally perform diagnostic psychological and neuropsychological tests and psychological and neuropsychological tests on an "incident to" basis.
- Limitations
 - The following are considered not medically reasonable:
 - Routine re-evaluation of chronically disabled patients that is not required for a diagnosis or continued treatment is not medically reasonable and necessary.
 - Brief screening measures such as the Folstein Mini-Mental Status Exam or use of other mental status exams in isolation should not be classified separately as psychological or neuropsychological testing since they are typically part of a more general clinical exam or interview.
- Psychotherapy Services Indications
 - Psychotherapy will be considered medically necessary when the patient has a psychiatric illness or is demonstrating emotional or behavioral symptoms sufficient to cause inappropriate behavior or maladaptive functioning.

- Psychotherapy services must be comprised of clinically recognized therapies that are pertinent to the patient's illness or condition. The type, frequency and duration of services must be medically necessary for the patient's condition under accepted practice standards.
- 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 disorders.
- The patient must have the capacity to actively participate in all therapies prescribed.
- To benefit from psychotherapy, an individual must be cognitively intact to the degree that he/she can engage in a meaningful verbal interaction with the therapist.
- For patients suffering from dementia, the type and degree of dementia must be taken into account in planning and evaluating effective psychotherapeutic interventions. If psychotherapy is provided to a patient with dementia, the patient's record should support that the patient's cognitive level of functioning was sufficient to permit the patient to participate meaningfully in the treatment.
- The duration of psychotherapy must be individualized for every patient. The provider of service must document in the patient's record the medical necessity for continued (prolonged) treatments.
- Group therapy is defined as psychotherapy administered in a group setting with a trained group leader in charge of several patients. The group should not exceed 10 participants and the sessions should be at least 45 to 60 minutes in duration. While a video or movie may be used as an adjunct to the sessions, this modality should not be used as a replacement for the therapist's active participation and the majority of the session should involve the interaction between the participants and the therapist leading the session. If group psychotherapy is provided to a patient with dementia, the patient's record should document that the patient's cognitive level of functioning was sufficient to permit the patient to participate meaningfully in the treatment.
- Family therapy will be considered medically reasonable and necessary only for treatment of the Medicare beneficiary's mental illness and not the family member's problems. Family therapy is appropriate when intervention in the family interactions would be expected to improve or stabilize the patient's emotional/behavioral disturbance. Family therapy is commonly the major treatment, especially for children and also for the elderly. Where both husband and wife are covered by Medicare, such therapy may be the most effective treatment for both individuals.
- Family psychotherapy without the patient present does not represent routine consultation with staff about the patient's progress and treatment. Facility staff members are not considered caregivers for purposes of this policy; however, caretakers in group-living facilities may be considered caregivers for the purpose of this policy.
- Rendering Providers
 - Psychiatrists, CPs, CSWs, psychiatric nurse practitioners, CNSs and PAs may provide all psychotherapy services described in this section with the following exceptions:
 - CNSs may not render psychoanalysis services.
 - Please see CMS IOM 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 170 regarding CSW services.
 - Please see CMS IOM 100-02, Medicare Benefit Policy Manual, Chapter 15, for information on providers that may render psychotherapy codes that include an evaluation and management (E/M) component. Each element of these services (therapy and E/M) must be medically reasonable and necessary and should be documented in the patient's records.
- Limitations
 - Psychotherapy services are not considered reasonable and necessary when documentation indicates that dementia has produced a severe enough cognitive defect to prevent establishment of a relationship with the therapist, which allows insight-oriented, behavior-modifying, or supportive therapy to be effective.
 - Psychotherapy services are never covered for severe and profound mental retardation. Severe mental retardation is defined as an IQ 20-34 and profound mental retardation is defined as an IQ under 20.
 - Psychotherapy services are not considered reasonable and necessary when they primarily include teaching grooming skills, monitoring activities of daily living, recreational therapy (dance, art, play) or social interaction.
 - Family therapy sessions with a patient whose emotional disturbance would be unaffected by changes in the patterns of family interaction (i.e., a comatose patient) would not be considered reasonable and necessary. Similarly, an emotional disturbance in a family member, which does not impact on the Medicare patient's status, would not be covered by that patient's Medicare benefits.
- Other Psychiatric and Psychological Services Indications
 - Narcosynthesis is indicated for patients who have difficulty verbalizing psychiatric problems without the aid of the drug.
 - Electroconvulsive therapy (ECT) is used in the treatment of depression and related disorders and other severe psychiatric conditions.

- When a psychiatrist administers the anesthesia for an ECT procedure, the anesthesia service is considered part of the ECT procedure.
- General Documentation Requirements
 - All documentation must be maintained in the patient's medical record and made available to the contractor upon request.
 - Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service[s]). The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient.
 - The medical record documentation must support the medical necessity of the services as stated in this policy.
 - The total number of timed minutes must be documented in the patient's medical record.
- Specific Documentation Requirements
 - Psychiatric Diagnostic Evaluation
 - The medical records must reflect in legible form the elements outlined in the above description of the services and contain all of the following elements:
 - Date
 - Referral source
 - Length of session (these are not timed codes; however, the standard length of time is generally considered to be between 45 minutes and one hour)
 - Content of session
 - Therapeutic techniques and approaches, including medications
 - Assessment of the patient's ability to adhere to the treatment plan
 - Identity of person performing service (legible signature)
 - For interactive therapy, the medical record should indicate the adaptations utilized in the session and the rationale for employing these interactive techniques.
 - For services that include an E/M component, the E/M services should be documented.
 - The medical records must indicate the diagnosis, including psychological and/or medical conditions, as well as any psychosocial and environmental stressors.
- Psychological and Neuropsychological Testing
 - The medical record should include all of the following information:
 - Reason for referral
 - Tests administered, scoring/interpretation and time involved
 - Present evaluation
 - Diagnosis (or suspected diagnosis that was the basis for the testing if no mental illness was found)
 - Recommendations for interventions, if necessary
 - Identity of person performing service
- Psychotherapy Services
 - The medical record must indicate in legible form, the time spent in the psychotherapy encounter and the therapeutic maneuvers such as behavior modification, supportive interactions and interpretation of unconscious motivation that were applied to produce therapeutic change or stabilization.
 - All the following elements should be contained in or readily inferred from the medical record:
 - Type of service (individual, group, family, interactive, etc.)
 - Content of session
 - Therapeutic techniques and approaches, including medications
 - Identity of person performing service
 - For interactive therapy, the medical record should indicate the adaptations utilized in the session and the rationale for employing these interactive techniques.
 - For services that include an E/M component, the E/M services should be documented.
 - Group therapy session notes can be organized according to the general session note guidelines for individual therapy appearing above, or the clinician may elect to use the following group note format:
 - One group note that is common to all patients, documenting date, length of time for each session, along with key issues presented. Other group members' names should not appear in this note.
 - An additional notation or addendum to the group note, for each patient's record commenting on that particular patient's participation in the group process and any significant changes in patient status.
- Utilization Guidelines

- In accordance with CMS Ruling 95-1 (V), utilization of these services should be consistent with locally acceptable standards of practice.
- It is not reasonable and necessary for a PT, OT, SLP, Physician or NPP not under a therapy Plan of Care to report developmental test administration services more than once per provider, per discipline, per date of service, per patient.
- Medicare will not cover more than three psychiatric diagnostic evaluations, psychiatric diagnostic evaluation with medical services (or a combination of both) per year, per beneficiary, by the same provider. When providers are part of a Group NPI, the same limitation of 3 per year per Group NPI will apply.
- Notice: This LCD imposes utilization guideline limitations that support automated frequency denials. Despite Medicare's allowing up to these maximums, each patient's condition and response to treatment must medically warrant the number of services reported for payment. Medicare requires the medical necessity for each service reported to be clearly demonstrated in the patient's medical record. Medicare expects that patients will not routinely require the maximum allowable number of services.

References

Centers for Medicare and Medicaid Services. (2022). Local Coverage Determination, Outpatient Psychiatry and Psychology Services, L34353-CGS Administrators, Kentucky & Ohio. CMS website: www.cms.gov.

Centers for Medicare and Medicaid Services. (2020). Local Coverage Determination, Psychiatric Codes, L35101-Novitas, Arkansas, Colorado, Delaware, District of Columbia, Louisiana, Maryland, New Jersey, New Mexico, Mississippi, Oklahoma, Pennsylvania, Texas. CMS website: www.cms.gov.

Centers for Medicare and Medicaid Services. (2020). Local Coverage Determination, Psychiatric Diagnostic Evaluation and Psychotherapy Services, L33252-First Coast Service Options, Florida, Puerto Rico, Virgin Islands. CMS website: www.cms.gov.

Centers for Medicare and Medicaid Services. (2019). Local Coverage Determination, Psychiatry and Psychology Services, L33632-National Government Services, Connecticut, Illinois, Maine, Massachusetts, Minnesota, New Hampshire, New York, Rhode Island, Vermont, Wisconsin. CMS website: www.cms.gov.

Centers for Medicare and Medicaid Services. (2022). Local Coverage Determination, Psychiatry and Psychology Services, L34616-Wisconsin Physicians Service. CMS website: www.cms.gov.

Centers for Medicare and Medicaid Services. (2021). Local Coverage Determination, Psychological Services Under the Incident to Provision, L34539-CGS Administrators, Kentucky, Ohio. CMS website: www.cms.gov.

Revision History

Date	Summary of Changes
April, 2014	Version 1
August, 2015	Version 2
September, 2016	Version 3
April, 2017	Version 4
January, 2018	Version 5
May, 2019	Version 6
August, 2019	Updates per CMS LCDs and to clarify Part A and Part B services
October, 2019	Updates to add LCD titles to page 1
July, 2020	Version 7; Annual Review and Update
September, 2021	Version 8; Annual Review and Update
April, 2022	Update to L34616

Date	Summary of Changes
September, 2022	Version 9; Annual Review and Update