Psychiatric Codes

LCD/LMRP

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Contractor’s Determination Number
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Contractor Name
TrailBlazer Health Enterprises

Contractor Number
04002 (04102, 04302, 04402).

Contractor Type
MAC – Part B.

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CMS National Coverage Policy

This LCD supplements but does not replace, modify or supersede existing Medicare applicable National Coverage Determinations (NCDs) or payment policy rules and regulations for psychiatric codes. Federal statute and subsequent Medicare regulations regarding provision and payment for medical services are lengthy. They are not repeated in this LCD. Neither Medicare payment policy rules nor this LCD replace, modify or supersede applicable state statutes regarding medical practice or other health practice professions acts, definitions and/or scopes of practice. All providers who report services for Medicare payment must fully understand and follow all existing laws, regulations and rules for Medicare payment for therapy services and must properly submit only valid claims for them. Please review and understand them and apply the medical necessity provisions in the policy within the context of the manual rules. Relevant CMS manual instructions and policies regarding psychiatric codes are found in the following Internet-Only Manuals (IOMs) published on the CMS Web site:

- Medicare Benefit Policy Manual – Pub. 100-02:
  - Chapter 13, Sections 100 and 110.
  - Chapter 15, Sections 60, 80.2, 160, 170 and 270.
- Medicare General Information, Eligibility and Entitlement – Pub. 100-01, Chapter 3.
- Medicare Claims Processing Manual – Pub. 100-04:
  - Chapter 5, Section 100.4.
  - Chapter 9, Section 60.
  - Chapter 12, Section 110, 120, 170, 190 and 210.
- Correct Coding Initiative – Medicare Contractor Beneficiary and Provider Communications Manual – Pub. 100-09, Chapter 5.
- Social Security Act (Title XVIII) Standard References, Sections:
Primary Geographic Jurisdiction
- CO.
- NM.
- OK.
- TX:
  - Indian Health Service.
  - End Stage Renal Disease (ESRD) facilities.
  - Skilled Nursing Facilities (SNFs).
  - Rural Health Clinics (RHCs).
- Transitioned WPS legacy providers.

Oversight Region
- Region IV.
- Region VI.

Original Determination Effective Date
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Original Determination Ending Date
N/A

Revision Effective Date
01/01/2011

Revision Ending Date
N/A

Indications and Limitations of Coverage and/or Medical Necessity

Notice: It is not appropriate to bill Medicare for services that are not covered (as described by this entire LCD) as if they are covered.

Approved providers of mental health services:

1. Psychiatrists are physicians (MDs and DOs) trained in mental health disorders and may provide all services described in this policy.

2. For a Clinical Psychologist (CP) to qualify as a provider, the practitioner must meet the following requirements:
   - Hold a doctoral degree in psychology.
   - Be licensed or certified on the basis of the doctoral degree in psychology by the state in which he practices, at the independent practice level of psychology to furnish diagnostic, assessment, preventive and therapeutic services directly to individuals.

For a Clinical Social Worker (CSW) to qualify as a provider, the candidate must meet the following requirements:
   - Possess a master’s or doctoral degree in social work.
   - Performed at least two years of supervised clinical social work.

Either:
   - Is licensed or certified as a clinical social worker by the state in which the services are performed.

Or:
   - In the case of an individual in a state that does not provide for licensure or certification, has completed at least two years or 3,000 hours of post-master’s degree supervised clinical social work practice under the supervision of a master’s-level social worker in an appropriate setting such as a hospital, SNF or clinic.

Note: CSWs are reimbursed for psychological/psychiatric services at 75 percent of the Medicare physician’s fee schedule allowance for services rendered.

4. Psychiatric Nurse Practitioners (PNPs) must meet the following requirements:

Either:
Be a registered professional nurse who is authorized by the state in which the services are furnished to practice as a nurse practitioner in accordance with state law. 

Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners (see additional detail in "Other Comments" section of the attached article).

Possess a master's degree or higher in nursing.

Or:

Be a registered professional nurse who is authorized by the state in which the services are furnished to practice as a nurse practitioner by December 31, 2000.

Note: Nurse Practitioners/Advanced Practice Nurses (NPs) may perform services within their scope of practice, as determined by the relevant State Board of Nursing. (To perform psychotherapy and other psychiatric services, they must be licensed as a nurse practitioner certified in psychiatric nursing by the state or jurisdiction.)

5. Clinical Nurse Specialists (CNSs) must meet the following requirements:

- Be a registered nurse who is currently licensed to practice in the state where he practices and be authorized to furnish the services of a CNS in accordance with state law.
- Currently possess a master's degree or higher in a defined clinical area (psychiatric services) of nursing from an accredited educational institution.
- Be certified as a CNS by a recognized national certifying body that has established standards for CNSs (see additional detail in "Other Comments" section of the attached article).

6. Physician Assistant (PA) services are covered by Medicare when they meet the following criteria:

- The PA has graduated from a physician assistant educational program that is accredited by the Accreditation Review Commission of Education for the Physician Assistant (its predecessor agencies, the Commission on Accreditation of Allied Health Education Programs (CAAHEP) and the Committee on Allied Health Education and Accreditation (CAHEA)).

Or:

- The PA has passed the national certification examination that is administered by the National Commission on Certification of Physician Assistants (NCCPA).
- The PA is licensed by the state or jurisdiction to practice as a physician assistant.
- The PA is required to bill Medicare for approved services through the provider, physician or physician group by which he is employed.

Coverage for all non-physician practitioners is limited to services that they are authorized to perform by the states in which the services are furnished. The coverage sections within this policy will provide this information for each section of listed CPT codes.

For Mental Health Services Under the "Incident to" Provision, refer to the Benefit Policy Manual, Pub. 100-02, Chapter 15, Sections 60 and 80.2.

Outpatient Mental Health Treatment Limitation:

Section 102 of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 amends Section 1833 of the Social Security Act to phase out the outpatient mental health treatment limitation over a five-year period from 2010–2014. The limitation will change as follows: 2009 and prior years = 62.5 percent; 2010–2011 = 68.75 percent; 2012 = 75 percent; 2013 = 81.25 percent; and 2014 onward = 100 percent. When the MIPPA provision is fully implemented (January 1, 2014), the outpatient mental health services will be paid at the same rate as other Part B services, and Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) will be paid at 80 percent of their encounter rate, subject to the applicable upper payment limit.

For phase--out details, see:

- Medicare General Information, Eligibility and Entitlement – Pub. 100-01:
  - Chapter 3, Section 30.

For application details, see:

- Medicare Benefit Policy Manual – Pub. 100-02:
  - Chapter 13, Sections 100.6 and 110.5.
- Medicare Claims Processing Manual – Pub. 100-04:
  - Chapter 5, Section 100.4.
  - Chapter 9, Section 60.
  - Chapter 12, Section 110.2, 120, 170.1, 210 and 210.1.

Section I: Psychiatric Diagnostic Interview Examinations (90801, 90802)

1. The diagnostic interview is indicated for initial or periodic diagnostic evaluation of a patient for suspected or diagnosed psychiatric illness. A second provider seeing the patient for the first time may also use this code.
2. It may be utilized again 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.

3. Interactive procedures are covered 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).

Coverage for the diagnostic interview is limited to MDs, DOs, CSWs, CPs, CNSs, PAs and NPs certified in the state or jurisdiction for psychiatric services.

**Section II: Psychological and Neuropsychological Testing**

1. These diagnostic tests are used when mental illness is suspected, and clarification is essential for the diagnosis and the treatment plan.

2. 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.

3. Examples of problems that might require psychological and/or neuropsychological testing include:
   - Assessment of mental functioning for individuals with suspected or known mental disorders for purposes of differential diagnosis and/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.

4. Routine re-evaluation of chronically disabled patients that is not required for a diagnosis or continued treatment is not medically necessary.

5. 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:
   - A 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.

6. 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.

7. Each test administered must be medically necessary. Standardized batteries of tests are only acceptable if each component test is medically necessary.

8. Depending on the issues to be assessed, a typical test battery may require seven to 10 hours to perform, including administration, scoring and interpretation.

9. Code 96105 represents formal evaluation of aphasia with an instrument such as the Boston Diagnostic Aphasia Examination. If this formal assessment is performed during treatment, it 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.

10. 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.
11. Psychological/neuropsychological testing codes should not be reported by the treating physician for only reading the results of the testing. The reading of the report is included in the office or floor time in the hospital and would be included in the evaluation and management service for that day.

12. Medicare does not authorize payment for psychological and neuropsychological testing when performed on an "incident to" basis (Pub. 100-02, Chapter 15, Section 80.2).

13. PTs, Occupational Therapists (OTs), and SLPs are authorized to bill three test codes as "sometimes therapy" codes. These therapists may perform CPT codes 96105, 96110 and 96111; however, they must be performed under the general supervision of a physician or a CP.

14. Non-physician practitioners (NPPs), such as NPs, CNSs and PAs who personally perform diagnostic psychological and neuropsychological tests are excluded from having to perform these tests under the general supervision of a physician or a CP (Pub. 100-02, Chapter 15, Section 80.2).

15. Independently Practicing Psychologists (IPPs) may bill for psychological and neuropsychological tests when the tests are ordered by a physician (Pub. 100-02, Chapter 15, Section 80.2).

Section III: Psychotherapy Services

1. 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.

2. 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.

3. The patient must have the capacity to actively participate in all therapies prescribed.

4. To benefit from psychotherapy, an individual must be cognitively intact to the degree that he can engage in a meaningful verbal interaction with the therapist. Psychotherapy services are not covered 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. 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 document that the patient’s cognitive level of functioning was sufficient to permit the patient to participate meaningfully in the treatment.

5. Psychotherapy services are never covered for severe and profound mental retardation (ICD-9-CM codes 318.1 and 318.2).

6. Psychotherapy codes should not be used when an E/M code would be more appropriate.

7. The duration of psychotherapy must be individualized for every patient. Prolonged treatment may warrant medical necessity review. The provider of service must document in the patient’s record the medical necessity for continued (prolonged) treatments.

8. Procedure codes 90808, 90809, 90814, 90815, 90821, 90822, 90828 and 90829 represent services lasting approximately 75 to 80 minutes. The provider must document in the patient’s medical record the medical necessity of these services and define the extended services. Medicare anticipates that these extended services will be utilized in times of exceptional need.

9. Medicare coverage of psychotherapy procedures does not include teaching grooming skills, monitoring activities of daily living, recreational therapy (dance, art, play) or social interaction. Therefore, these procedure codes should not be used to bill for Activities of Daily Living (ADL) training and/or socialization activities.

10. Interactive procedures are covered for patients whose ability to communicate is impaired by an 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).

11. Group therapy (90853 and 90857) sessions should not exceed 10 participants and 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.

12. Medicare coverage of family therapy codes 90846, 90847 and 90849 is extended whenever medically
13. Codes 90846 and 90847 will be considered for payment under Medicare only for treatment of the Medicare beneficiary’s mental illness. 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 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 covered by Medicare. 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. 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 parsimonious treatment for both.

- Code 90846 (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 these policies.
- Code 90849 (multiple family psychotherapy) is generally non-covered. Such group therapy is directed to the effect of the patient’s condition on the family and does not meet Medicare’s standards of being part of the personal service to the patient. If such is not the case, individual consideration may be given if documentation is submitted.

14. All psychotherapy services described in this section are payable to psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse practitioners, CNSs and PAs with these exceptions:

- CSWs are not eligible for payment for inpatient services (defined as inpatient hospital settings, partial hospitalization settings or skilled nursing homes for beneficiaries who are at that time receiving benefits under Medicare Part A payment for skilled services) represented by these codes: 90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828 and 90829.
- Psychoanalysis (90845) is not covered for CNSs.
- Psychotherapy codes that include an E/M component (90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827 and 90829) are payable only to MDs, DOs, qualified CNSs, nurse practitioners and PAs. Each element of these services (therapy and E/M) must be reasonable and necessary and should be documented in the patient’s records.

Section IV: Pharmacologic Management of Psychiatric Illness (90862, M0064)

Pharmacologic management (90862) is intended for use for patients who are being managed primarily by psychotropics, antidepressants, Electroconvulsive Therapy (ECT) and/or other types of psychopharmacologic medications. It refers to the in-depth management of psychopharmacologic agents that are potent medications with frequent serious side effects and represents a very skilled aspect of patient care.

Codes 90862 and M0064 describe a physician service and cannot be billed by a non-physician or “incident to” a physician’s service, with the exception of nurse practitioners, CNSs and PAs whose scope of license in their states permits them to prescribe.

Section V: Other Psychiatric and Psychological Services (90865, 90870)

- Narcosynthesis is indicated for patients who have difficulty verbalizing psychiatric problems without the aid of the drug.
- ECT is used in the treatment of depression and related disorders and other severe psychiatric conditions.
- When a psychiatrist administers the anesthesia for the ECT procedure, no separate payment is made for the anesthesia service.

Allowed unit limitations (once per provider, per discipline, per date of service, per patient) by discipline for CPT codes 96110 and 96111 are described in the “Utilization Guidelines” section below.

Notice: This LCD imposes diagnosis limitations that support diagnosis to procedure code automated denials. However, services performed for any given diagnosis must meet all of the indications and limitations stated in this policy, the general requirements for medical necessity as stated in CMS payment policy manuals, any and all existing CMS national coverage determinations, and all Medicare payment rules.

As published in CMS IOM 100-08, Section 13.5.1, to be covered under Medicare, a service shall be reasonable and necessary. When appropriate, contractors shall describe the circumstances under which the proposed LCD for the service is considered reasonable and necessary under Section 1862(a)(1)(A). Contractors shall consider a service to be reasonable and necessary if the contractor determines that the service is:

- Safe and effective.
- Not experimental or investigational (exception: routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000, which meet the requirements of the clinical trials NCD are considered reasonable and necessary).
- Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
○ Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member.
○ Furnished in a setting appropriate to the patient's medical needs and condition.
○ Ordered and furnished by qualified personnel.
○ One that meets, but does not exceed, the patient's medical need.
○ At least as beneficial as an existing and available medically appropriate alternative.

**Bill Type Codes**

N/A

**Revenue Codes**

N/A

**CPT/HCPCS Codes**

**Note:** Providers are reminded to refer to the long descriptors of the CPT codes in their CPT books. The American Medical Association (AMA) and the Centers for Medicare & Medicaid Services (CMS) require the use of short CPT descriptors in policies published on the Web.

90801© Psy dx interview
90802© Intac psy dx interview
90804© Psytx, office, 20–30 min
90805© Psytx, off, 20–30 min w/e&m
90806© Psytx, office, 45–50 min
90807© Psytx, office, 45–50 min w/e&m
90808© Psytx, office, 75–80 min
90809© Psytx, office, 75–80 min w/e&m
90810© Intac psytx, off, 20–30 min
90811© Intac psytx, off, 20–30 min w/e&m
90812© Intac psytx, off, 45–50 min
90813© Intac psytx, off, 45–50 min w/e&m
90814© Intac psytx, off, 75–80 min
90815© Intac psytx, off, 75–80 min w/e&m
90816© Psytx, hosp, 20–30 min
90817© Psytx, hosp, 20–30 min w/e&m
90818© Psytx, hosp, 45–50 min
90819© Psytx, hosp, 45–50 min w/e&m
90821© Psytx, hosp, 75–80 min
90822© Psytx, hosp, 75–80 min w/e&m
90823© Intac psytx, hosp, 20–30 min
90824© Intac psytx, hosp, 20–30 min w/e&m
90826© Intac psytx, hosp, 45–50 min
90827© Intac psytx, hosp, 45–50 min w/e&m
90828© Intac psytx, hosp, 75–80 min
90829© Intac psytx, hosp, 75–80 min w/e&m
90845© Psychoanalysis
90846© Family psytx w/o patient
90847© Family psytx w/ patient
90849© Multiple family group psytx
90853© Group psychotherapy
90857© Intac group psytx
90862© Medication management
90865© Narcosynthesis
90870© Electroconvulsive therapy
90880© Hypnotherapy
90889© Preparation of report
90899© Psychiatric service/therapy
96101© Psycho testing by psych/phys
96102© Psycho testing by technician
96103© Psycho testing admin by comp
96105© Assessment of aphasia
96110© Developmental test, lim
96111© Developmental test, extend
96116© Neurobehavioral status exam

**Note:** Must be accomplished by psychologist or physician (see CPT code long description).

96118© Neuropsych tст by psych/phys
96119© Neuropsych testing by tech
96120© Neuropsych tст admin w/comp
96125© Cognitive test by hc pro

M0064 Brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental psychoneurotic and personality disorders

**ICD-9-CM Codes That Support Medical Necessity**

The CPT/HCPCS codes included in this LCD will be subjected to procedure to diagnosis editing. The following lists include only those diagnoses for which the identified CPT/HCPCS procedures are covered. If a covered diagnosis is not on the claim, the edit will automatically deny the service as not medically necessary.

**Sections I and II: Diagnostic/Assessment Services**

Medicare is establishing the following limited coverage for **CPT/HCPCS codes 90801, 90802, 96101, 96102, 96103, 96105, 96110, 96111, 96116, 96118, 96119, 96120 and 96125:**

**Covered for:**

290.0 Senile dementia, uncomplicated
290.10-290.13 Presenile dementia
290.20–290.21 Senile dementia with delusional or depressive features
290.3 Senile dementia with delirium
290.40–290.43 Atherosclerotic dementia
290.8–290.9 Senile and presenile organic psychotic conditions
291.0–291.5 Alcoholic psychosis
291.81–291.82 Other specified alcohol-induced mental disorders
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tr>
<td>291.89</td>
<td>Other specified alcohol-induced mental disorders</td>
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<td>Unspecified alcohol-induced mental disorders</td>
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<tr>
<td>292.0</td>
<td>Drug withdrawal</td>
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<td>292.11–292.12</td>
<td>Paranoid and/or hallucinatory states induced by drugs</td>
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<td>292.2</td>
<td>Pathological drug intoxication</td>
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<td>292.81–292.85</td>
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<td>292.89</td>
<td>Other specified drug-induced mental disorders</td>
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<td>292.9</td>
<td>Unspecified drug-induced mental disorder</td>
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<td>293.0–293.1</td>
<td>Transient organic psychotic conditions</td>
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<tr>
<td>293.81–293.84</td>
<td>Other specified transient organic mental disorders</td>
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<tr>
<td>293.89</td>
<td>Other specified transient mental disorders due to conditions classified elsewhere, other</td>
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<td>293.9</td>
<td>Unspecified transient mental disorder in conditions classified elsewhere</td>
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<td>Amnestic disorder in conditions classified elsewhere</td>
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<td>294.10–294.11</td>
<td>Dementia in conditions classified elsewhere</td>
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<td>294.8–294.9</td>
<td>Other specified/ unspecified organic brain syndromes</td>
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<td>295.00–295.05</td>
<td>Schizophrenic disorders (simple)</td>
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<td>295.10–295.15</td>
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<td>295.70–295.75</td>
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<td>295.80–295.85</td>
<td>Schizophrenic disorders (other specified types)</td>
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<td>Schizophrenic disorders (unspecified schizophrenia)</td>
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<td>296.00–296.06</td>
<td>Affective disorders (manic - single episode)</td>
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<td>296.10–296.16</td>
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<td>Affective disorders (bipolar affective – mixed)</td>
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<td>296.7</td>
<td>Bipolar I disorder, most recent episode (or current) unspecified</td>
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<td>296.80–296.82</td>
<td>Affective disorders (manic-depressive psychosis)</td>
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<td>296.89</td>
<td>Other and unspecified bipolar disorders, other</td>
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<td>296.90</td>
<td>Unspecified episodic mood disorder</td>
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<td>296.99</td>
<td>Other specified episodic mood disorder</td>
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<td>Paranoid states (delusional disorders)</td>
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<td>Psychoses with origin specific to childhood (infantile autism)</td>
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<td>Sexual deviations and disorders (psychosexual dysfunction)</td>
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<td>Alcohol dependence syndrome (acute alcoholic intoxication)</td>
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<td>Drug dependence (barbiturate &amp; similarly acting sedative or hypnotic)</td>
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<td>Drug dependence (cocaine)</td>
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<td>Code Range</td>
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<td>Drug dependence (cannabis)</td>
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<td>Drug dependence (amphetamine &amp; other psychostimulant)</td>
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<td>Drug dependence (hallucinogen)</td>
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<td>Drug dependence (other specified)</td>
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<td>304.70–304.73</td>
<td>Drug dependence (combination opioid + any other)</td>
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<td>Drug dependence (combination excluding opioid)</td>
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<td>304.90–304.93</td>
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<td>305.00–305.03</td>
<td>Non-dependent abuse of drugs (alcohol)</td>
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<td>Tobacco use disorder</td>
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<td>305.20–305.23</td>
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<td>305.30–305.33</td>
<td>Non-dependent abuse of drugs (hallucinogen)</td>
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<td>Non-dependent abuse of drugs (amphetamine &amp; other psychostimulant)</td>
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<td>Non-dependent abuse of drugs (antidepressant)</td>
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<td>Non-dependent abuse of drugs (other mixed or unspecified)</td>
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<td>Physiological malfunction arising from mental factors</td>
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<td>Physiological malfunction arising from mental factors (genitourinary)</td>
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<td>Special symptoms or syndromes, not elsewhere classified (sleep disorders, nonorganic)</td>
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<td>Other, pain disorder related to psychological factors</td>
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<td>Other and unspecified symptoms or syndromes, NEC</td>
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<td>Acute reaction to stress</td>
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<td>309.0–309.1</td>
<td>Adjustment reaction</td>
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<td>309.21–309.24</td>
<td>Adjustment reaction with predominant disturbance of other emotions</td>
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<td>Adjustment reaction with predominant disturbance of other emotions</td>
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<td>Adjustment reaction (other specified)</td>
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<td>Adjustment reaction (unspecified)</td>
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<td>Undersocialized conduct disorder, aggressive type</td>
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<td>Mixed disturbance of conduct and emotions</td>
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<td>Disturbance of emotions specific to childhood and adolescence</td>
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<td>313.21–313.23</td>
<td>Sensitivity, shyness, and social withdrawal disorder</td>
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<td>Relationship problems</td>
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<td>Other or mixed emotional disturbances of childhood or adolescence</td>
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<td>Specific reading disorder</td>
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<td>Specific delays in development</td>
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<td>315.31–315.32</td>
<td>Developmental speech or language disorder</td>
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<td>Specific delays in development</td>
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<td>Secondary Parkinsonism</td>
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333.1 Essential and other specified forms of tremor
333.71–333.72 Acquired torsion dystonia
333.79 Other acquired torsion dystonia
333.82 Orofacial dyskinesia
333.85 Subacute dyskinesia due to drugs
333.90 Unspecified extrapyramidal disease and abnormal movement disorder
333.92 Neuroleptic malignant syndrome
333.99 Other unspecified extrapyramidal disease and abnormal movement disorder (neuroleptic-induced acute akathisia)
389.7 Deaf, nonspeaking, not elsewhere classified
780.09 Alteration of consciousness, other
780.95 Excessive crying of child, adolescent, or adult
780.97 Altered mental status
784.3 Aphasia
784.51 Dysarthria
784.59 Other speech disturbance
784.60–784.61 Other symbolic dysfunction
784.69 Other symbolic dysfunction
995.20 Unspecified adverse effect of unspecified drug, medicinal and biological substance
995.50–995.55 Child maltreatment syndrome
995.59 Child maltreatment syndrome
995.80–995.85 Adult maltreatment

Sections III, IV and V: Therapeutic Services

Medicare is establishing the following limited coverage for CPT/HCPCS codes 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, 90829, 90845, 90846, 90847, 90849, 90853, 90857, 90862, 90865, 90870, 90880, 90899 and M0064:

Covered for:

290.0 Senile dementia, uncomplicated
290.10–290.13 Pre Senile dementia
290.20–290.21 Senile dementia with delusional or depressive features
290.3 Senile dementia with delirium
290.40–290.43 Atherosclerotic dementia
290.8–290.9 Senile and presenile organic psychotic conditions
291.0–291.5 Alcoholic psychosis
291.81–291.82 Other specified alcohol-induced mental disorders
291.89 Other specified alcohol-induced mental disorders
291.9 Unspecified alcohol-induced mental disorders
292.0 Drug withdrawal
292.11–292.12 Paranoid and/or hallucinatory states induced by drugs
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<td>293.0–293.1</td>
<td>Transient organic psychotic conditions</td>
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<td>293.81–293.84</td>
<td>Other specified transient organic mental disorders</td>
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<td>Other specified transient mental disorders due to conditions classified elsewhere, other</td>
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<td>Unspecified transient mental disorder in conditions classified elsewhere</td>
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<td>294.0</td>
<td>Amnestic disorder in conditions classified elsewhere</td>
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<td>Schizophrenic disorders (paranoid)</td>
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<td>Schizophrenic disorders (acute schizophrenic episode)</td>
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<td>Schizophrenic disorders (latent schizophrenia)</td>
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<td>Schizophrenic disorders (residual schizophrenia)</td>
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<td>Affective disorders (major depressive – single episode)</td>
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<td>Affective disorders (major depressive – recurrent episode)</td>
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<td>Affective disorders (bipolar affective–mixed)</td>
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<td>Bipolar I disorder, most recent episode (or current) unspecified</td>
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<td>Other and unspecified bipolar disorders, other</td>
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<td>Other specified episodic mood disorder</td>
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<td>Psychoses with origin specific to childhood (disintegrative psychosis)</td>
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299.80–299.81 Psychoses with origin specific to childhood (other specified)
299.90–299.91 Psychoses with origin specific to childhood (unspecified)
300.00–300.02 Anxiety states
300.09 Anxiety states
300.10–300.16 Hysteria
300.19 Hysteria
300.20–300.23 Phobic disorders
300.29 Other isolated or specific phobias
300.3–300.7 Neurotic disorders
300.81–300.82 Other neurotic disorders
300.89 Other somatoform disorders
300.9 Unspecified nonpsychotic mental disorder
301.0 (Paranoid) personality disorder
301.10–301.13 (Affective) personality disorder
301.20–301.22 (Schizoid) personality disorder
301.3–301.4 Personality disorders
301.50–301.51 (Histrionic) personality disorder
301.59 (Histrionic) personality disorder
301.6–301.7 Personality disorders
301.81–301.84 Personality disorder (other)
301.89 Personality disorder (other)
301.9 Personality disorder (unspecified)
302.0–302.4 Sexual deviations and disorders
302.50–302.53 Sexual deviations and disorders (trans-sexualism)
302.6 Gender identity disorder in children
302.70–302.76 Sexual deviations and disorders (psychosexual dysfunction)
302.79 Sexual deviations and disorders (psychosexual dysfunction)
302.81–302.85 Sexual deviations and disorders (other specified disorders)
302.89 Sexual deviations and disorders (other specified disorders)
302.9 Sexual deviations and disorders (unspecified)
303.00–303.03 Alcohol dependence syndrome (acute alcoholic intoxication)
303.90–303.93 Alcohol dependence syndrome (other and unspecified)
304.00–304.03 Drug dependence (opioid type)
304.10–304.13 Drug dependence (barbiturate & similarly acting sedative or hypnotic)
304.20–304.23 Drug dependence (cocaine)
304.30–304.33 Drug dependence (cannabis)
304.40–304.43 Drug dependence (amphetamine & other psychostimulant)
304.50–304.53 Drug dependence (hallucinogen)
304.60–304.63 Drug dependence (other specified)
<table>
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<td>Drug dependence (combination opioid + any other)</td>
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<td>304.80–304.83</td>
<td>Drug dependence (combination excluding opioid)</td>
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<td>304.90–304.93</td>
<td>Drug dependence (unspecified)</td>
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<td>Non-dependent abuse of drugs (alcohol)</td>
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<td>Tobacco use disorder</td>
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<td>Non-dependent abuse of drugs (cannabis)</td>
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<td>Non-dependent abuse of drugs (hallucinogen)</td>
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<td>Special symptoms or syndromes, not elsewhere classified (tics)</td>
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<td>307.3</td>
<td>Stereotyped movement disorder</td>
</tr>
<tr>
<td>307.40–307.49</td>
<td>Special symptoms or syndromes, not elsewhere classified (sleep disorders – nonorganic)</td>
</tr>
<tr>
<td>307.50–307.54</td>
<td>Special symptoms or syndromes, not elsewhere classified (eating disorders)</td>
</tr>
<tr>
<td>307.6–307.7</td>
<td>Other and unspecified disorders of eating</td>
</tr>
<tr>
<td>307.80–307.81</td>
<td>Special symptoms or syndromes, not elsewhere classified (psychalgia)</td>
</tr>
<tr>
<td>307.89</td>
<td>Other, pain disorder related to psychological factors</td>
</tr>
<tr>
<td>307.9</td>
<td>Other and unspecified symptoms of syndromes, NEC</td>
</tr>
<tr>
<td>308.0–308.4</td>
<td>Acute reaction to stress</td>
</tr>
<tr>
<td>308.9</td>
<td>Acute reaction to stress</td>
</tr>
<tr>
<td>309.0–309.1</td>
<td>Adjustment reaction</td>
</tr>
<tr>
<td>309.21–309.24</td>
<td>Adjustment reaction with predominant disturbance of other emotions</td>
</tr>
<tr>
<td>309.28–309.29</td>
<td>Adjustment reaction with predominant disturbance of other emotions</td>
</tr>
<tr>
<td>309.3–309.4</td>
<td>Adjustment reaction</td>
</tr>
<tr>
<td>309.81–309.83</td>
<td>Adjustment reaction (other specified)</td>
</tr>
<tr>
<td>309.89</td>
<td>Adjustment reaction (other specified)</td>
</tr>
<tr>
<td>309.9</td>
<td>Adjustment reaction (unspecified)</td>
</tr>
<tr>
<td>310.0–310.2</td>
<td>Specific non-psychotic mental disorders due to organic brain damage</td>
</tr>
<tr>
<td>310.8–310.9</td>
<td>Specific non-psychotic mental disorders due to organic brain damage</td>
</tr>
<tr>
<td>311</td>
<td>Depressive disorder, not elsewhere classified</td>
</tr>
</tbody>
</table>
312.00–312.03 Undersocialized conduct disorder, aggressive type
312.10–312.13 Undersocialized conduct disorder, unaggressive type
312.20–312.23 Socialized conduct disorder
312.30–312.35 Disorders of impulse control, not elsewhere classified
312.39 Disorders of impulse control, not elsewhere classified
312.4 Mixed disturbance of conduct and emotions
312.81–312.82 Other specified disturbances of conduct, not elsewhere classified
312.89 Other specified disturbances of conduct, not elsewhere classified
312.9 Unspecified disturbance of conduct
313.0–313.1 Disturbance of emotions specific to childhood and adolescence
313.21–313.23 Sensitivity, shyness, and social withdrawal disorder
313.3 Relationship problems
313.81–313.83 Other or mixed emotional disturbances of childhood or adolescence
313.89 Other or mixed emotional disturbances of childhood or adolescence
313.9 Unspecified emotional disturbance of childhood or adolescence
314.00–314.01 Attention deficit disorder
314.1–314.2 Hyperkinetic syndrome of childhood
314.8–314.9 Hyperkinetic syndrome of childhood
315.4 Coordination disorder
315.5 Mixed developmental disorder
315.8 Other specified delays in development
316 Psychic factors associated with diseases classified elsewhere
317 Mild mental retardation
318.0 Moderate mental retardation
318.1–318.2 Other specified mental retardation
327.02 Insomnia due to mental disorder
327.15 Hypersomnia due to mental disorder
327.42–327.43 Organic parasomnia
331.0 Alzheimer's disease
331.2 Senile degeneration of brain
332.1 Secondary Parkinsonism
333.1 Essential and other specified forms of tremor
333.71–333.72 Acquired torsion dystonia
333.79 Other acquired torsion dystonia
333.82 Orofacial dyskinesia
333.85 Subacute dyskinesia due to drugs
333.90 Unspecified extrapyramidal disease and abnormal movement disorder
333.92 Neuroleptic malignant syndrome
333.99 Other unspecified extrapyramidal disease and abnormal movement disorder (neuroleptic-induced acute akathisia)
758.0 Down’s Syndrome
780.09 Alteration of consciousness, other
780.95 Excessive crying of child, adolescent, or adult
780.97 Altered mental status
784.3 Aphasia
784.60–784.61 Other symbolic dysfunction
995.20 Unspecified adverse effect of unspecified drug, medicinal and biological substance
995.50–995.55 Child maltreatment syndrome
995.59 Child maltreatment syndrome
995.80–995.85 Adult maltreatment
V11.0 – V11.4 Personal history of mental disorder
V11.8 – V11.9 Personal history of mental disorder

**Note:** Providers should continue to submit ICD-9-CM diagnosis codes without decimals on their claim forms and electronic claims.

**Diagnoses That Support Medical Necessity**

N/A

**ICD-9-CM Codes That DO NOT Support Medical Necessity**

N/A

**Diagnoses That DO NOT Support Medical Necessity**

All diagnoses not listed in the “ICD-9-CM Codes That Support Medical Necessity” section of this LCD.

**Documentation Requirements**

Documentation supporting the medical necessity should be legible, maintained in the patient’s medical record, and made available to Medicare upon request.

The total number of timed minutes must be documented in the patient’s medical record.

**Section I: Psychiatric Diagnostic Interview Examinations (90801, 90802)**

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, 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.
- Multiaxial diagnoses.

**Section II: 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.

Section III: 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.

Section IV: Pharmacologic Management of Psychiatric Illness (90862, M0064)

Patient records for pharmacologic management code 90862 should include or be able to be inferred by a trained professional, in legible form, all the following information in each note:
- Date and diagnosis.
- Current symptoms and problems.
- Problems, reactions and side effects, if any, to medications and/or ECT.
- Description of optional minimal psychotherapeutic intervention, if any.
- Reasons for medication adjustments/changes or continuation.

Section V: Other Psychiatric and Psychological Services (90865, 90870)

See the general requirements at the beginning of this section.

Appendices

N/A

Utilization Guidelines

- Allowed units outlined in the table below may be billed no more than once per provider, per discipline, per date of service, per patient. The codes allowed 0 units in the column for “Allowed Units” may not be billed under a plan of care indicated by the discipline in that column. Some codes may be billed by one discipline (e.g., PT) and not by others (e.g., OT or SLP). (See CMS Change Request 5253 for additional details.)

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Code Description</th>
<th>Timed/Untimed</th>
<th>Allowed Units</th>
<th>Physician/NPP Not Under a Therapy POC</th>
</tr>
</thead>
<tbody>
<tr>
<td>96110</td>
<td>Developmental test, lim</td>
<td>Untimed</td>
<td>1 1 1</td>
<td>1</td>
</tr>
<tr>
<td>96111</td>
<td>Developmental test, ext</td>
<td>Untimed</td>
<td>1 1 1</td>
<td>1</td>
</tr>
</tbody>
</table>

- Medicare will not cover more than three 90801 or 90802 (or a combination of both) per year, per beneficiary, same or different provider.
- Medicare will not cover more than one 90862 per day, per beneficiary.
- Medicare will not cover more than one M0064 per day, per beneficiary (whether the ECT provider is the beneficiary’s primary psychiatrist or not).

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.
Sources of Information and Basis for Decision

J4 (CO, NM, OK, TX) MAC Integration

TrailBlazer adopted the TrailBlazer LCD, "Psychiatric Codes," for the Jurisdiction 4 (J4) MAC transition, with inclusion of appropriate information from the Pinnacle and Noridian LCDs.

Full disclosure of information sources is found with original contractor LCDs.

Other Contractor Local Coverage Determinations

“Psychiatric Codes”, TrailBlazer LCD, (00900) L14210.

“Psychiatry/Psychology Services” Arkansas, BlueCross BlueShield (Pinnacle) LCD, (NM, OK) L19991 and L19992.

“Psychiatry and Psychological Services and ‘Incident To’ These Services” Noridian Administrative Services, LLC LCD, (CO) L21717 and L23870.


Start Date of Notice Period

12/20/2007

Revision History

<table>
<thead>
<tr>
<th>Number</th>
<th>Date</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>R4</td>
<td>01/01/11</td>
<td>Per CR 7121 (Annual HCPCS Update), description changed for the GA modifier in the article. Effective date: 01/01/2011. Use of LCD and related article made applicable to providers transitioning from WPS to TrailBlazer with addition of contractor number 04901. Effective date: dates of service on or after 10/18/2010.</td>
</tr>
<tr>
<td>R3</td>
<td>09/07/10</td>
<td>Per CR 7006 (Annual ICD-9-CM Diagnosis Coding Update), description changed for diagnosis code 307.0 in limited coverage for 90801, 90802, 96101, 96102, 96103, 96105, 96110, 96111, 96116, 96118, 96119, 96120, 96125, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, 90829, 90845, 90846, 90847, 90849, 90853, 90857, 90862, 90865, 90870, 90880, 90899 and M0064. Added code V11.4 to 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, 90829, 90845, 90846, 90847, 90849, 90853, 90857, 90862, 90865, 90870, 90880, 90899 and M0064. Effective date: 10/01/2010.</td>
</tr>
<tr>
<td>R2</td>
<td>02/12/10</td>
<td>Per CR 6686 (outpatient mental health treatment limitation), updated language in the “Outpatient Mental Health Treatment Limitation” section of the LCD describing the phase out of the limitation as set forth in Section 102 of MIPPA (2008). Added references to CMS publications for provider use. Effective date: 01/01/2010.</td>
</tr>
<tr>
<td>R1</td>
<td>10/01/09</td>
<td>Per CR 6520, Annual ICD-9-CM Diagnosis Coding Update, removed diagnosis code 784.5 (other speech disturbance) and replaced with new diagnosis codes 784.51 (dysarthria) and 784.59 (other speech disturbance) in the limited coverage for CPT codes 90801, 90802, 96101, 96102, 96103, 96105, 96110, 96111, 96116, 96118, 96119, 96120, 96125. Effective date: 10/01/2009.</td>
</tr>
<tr>
<td>N/A</td>
<td>06/13/08</td>
<td>LCD effective in TX Part B 06/13/2008</td>
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<tr>
<td>N/A</td>
<td>03/21/08</td>
<td>LCD effective in CO Part B 03/21/2008</td>
</tr>
<tr>
<td>N/A</td>
<td>03/01/08</td>
<td>LCD effective in NM Part B and OK Part B 03/01/2008</td>
</tr>
<tr>
<td>03/07/08</td>
<td>Per JSM 08163, clarified educational requirements for NPs and CNSs in the LCD. Effective for each state based upon cutover date.</td>
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</tr>
<tr>
<td>12/20/07</td>
<td>Consolidated LCD posted for notice effective: 12/20/2007</td>
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Psychiatric Codes – 4V-18B-R4

Contractor’s Determination Number

4V-18B

Contractor Name

TrailBlazer Health Enterprises

Contractor Number

04002 (04102, 04202, 04302, 04402).

Contractor Type

MAC – Part B.

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Primary Geographic Jurisdiction

• CO.
• NM.
• OK.
• TX:
  ◦ Indian Health Service.
  ◦ End Stage Renal Disease (ESRD) facilities.
  ◦ Skilled Nursing Facilities (SNFs).
  ◦ Rural Health Clinics (RHCs).
• Transitioned WPS legacy providers.

Oversight Region

• Region IV.
• Region VI.

Original Article Effective Date

03/01/2008
03/21/2008
06/13/2008

Article Revision Effective Date

01/01/2011

Article Ending Effective Date

N/A

Article Text

Abstract

Psychiatry and psychology are specialized disciplines involved with the diagnosis and treatment of various behavioral disorders. This policy is a statement that outlines the coverage of the professional services in the fields of psychiatry, psychology, clinical social work and psychiatric nursing for the management of patients with various mental health diseases.

In addition to the standard format elements required of all LCDs, this policy will be divided into the following sections:

I. Psychiatric Diagnostic Interview Examinations.
II. Psychological and Neuropsychological Testing.
III. Psychotherapy Services.

IV. Pharmacological Management of Psychiatric Illness.

V. Other Psychiatric and Psychological Services.

Sections I and II address diagnostic/assessment services, while Sections III, IV and V are directed at therapeutic services.

**Section I: Psychiatric Diagnostic Interview Examinations (90801, 90802)**

**Description:**

The psychiatric diagnostic interview (90801) includes assessment of the patient’s history, mental status and disposition in relation to a specific presenting problem or referral question. The examination may include communication with family or other sources, ordering and medical interpretation of laboratory tests and other medical diagnostic studies as appropriate. In certain circumstances, other informants may be seen in lieu of the patient.

An Evaluation and Management (E/M) service may be substituted for the initial interview procedure (for Doctors of Medicine (MDs) and Doctors of Osteopathic Medicine (DOs) only), including consultation codes (CPT 99241–99263), provided required elements of the E/M service billed are fulfilled.

Consultation services require, in addition to the interview and examination, a written opinion and/or advice. They do not include psychiatric treatment. However, **diagnostic and/or therapeutic services may be initiated on the same day as the consultation.**

The interactive psychiatric diagnostic interview examination (90802) includes the same components as code 90801, i.e., history, mental status and disposition. However, in the interactive examination, the provider uses inanimate objects such as toys and dolls for a child, adaptive communication apparatus for an adult with cognitive impairments, an interpreter for a deaf person or one who does not speak the dominant language of the culture, or other physical aids. It may also include the use of family members or other caretakers to assist in the examination.

**Section II: Psychological and Neuropsychological Testing**

**Description:**

Psychological testing refers to the administration, scoring and interpretation of standardized measures of mental functioning. Psychological tests compare an individual’s responses to a set of clearly defined test items to those of an established reference group.

The general psychological testing codes (96101, 96102 and 96103) include the use of a wide range of reliable and valid, standardized, projective and objective measures for the assessment of personality, psychopathology, affect, behavior, intelligence, abilities and disabilities, etc.

Specialized testing codes, such as 96105 (assessment of aphasia), 96110 and 96111 (developmental testing), 96116 (neurobehavioral status exam), 96118, 96119 and 96120 (neuropsychological testing), and 96125 (cognitive performance testing) can be used when the techniques of testing are limited to or focused on those areas described in the CPT definitions of each of these procedures.

Neuropsychological testing (96118, 96119 and 96120) is a specialty area of psychological testing consisting primarily of individually administered ability tests that comprehensively sample ability domains 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 that patients directly demonstrate a level of competence in a particular cognitive domain.

**Section III: Psychotherapy Services**

**Description:**

Individual psychotherapy (90804, 90805, 90806, 90807, 90808, 90809, 90816, 90817, 90818, 90819, 90821 and 90822) includes insight-oriented, behavior-modifying and/or supportive psychotherapy and is a process in which the therapist establishes a professional relationship with the patient and through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and/or encourage personality growth and development or support current level of functioning.

Interactive psychotherapy services (90810, 90811, 90812, 90813, 90814, 90815, 90823, 90824,
90826, 90827, 90828 and 90829 use physical aids and non-verbal communication to overcome barriers to therapeutic interaction between the practitioner and the patient who has lost or has not yet developed either the expressive language communication skills to explain his symptoms and response to treatment or the receptive language communication skills to understand the therapist if he were to use ordinary adult language for communication. Interactive psychotherapy codes are also utilized when language translation is required to communicate with a patient who does not speak the dominant language of the culture where the therapy takes place. Play therapy, utilizing toys and concrete materials to facilitate communication with children, is also considered a form of interactive psychotherapy. It may also include the use of family members or other caretakers including staff members of group homes and community residences to assist in the treatment of the patient.

Group therapy (90853 and 90857) is administered in a group setting with a trained therapist leading the session. Personal and group dynamics are discussed and explored in a therapeutic setting allowing emotional catharsis, instruction and support. An attempt is made to create a cohesive group. It is expected that no more than eight to 10 individuals participate in the group session to ensure adequate therapeutic attention to each member.

Each session typically involves a meeting with a group of patients for a prescribed period of time during which common issues are presented that generally relate to and evolve toward a theme or therapeutic goal. During group therapy, the members discuss issues that are affecting their behavior, thought processes, etc. Patients can verbalize their feelings and the therapist usually acts as a facilitator.

Family therapy (90846, 90847 and 90849) is a specialized therapeutic technique for treating the identified patient's mental illness by intervening in a family system in such a way as to modify the family structure, dynamics and interactions that exert influence on the patient's emotions and behavior.

Family sessions are conducted face-to-face with family members, with or without the identified patient present. Sessions may be organized strategically, for therapeutic purposes, with different family members or sets of family members in the treatment room separately at different points during the session.

Psychoanalysis (90845) is a technique of intensive psychotherapy focusing primarily on increasing the patient's insight into unconscious processes, motivations and conflicts. The analyst utilizes techniques of free association, analysis of transference, dream interpretation and exploration of personal history to bring into awareness and help the patient work through problematic personality dynamics.

Psychotherapy (90880) is a technique of psychotherapy utilizing trance, an induced alteration of consciousness in which the patient is in a state of increased suggestibility.

**Section IV: Pharmacologic Management of Psychiatric Illness (90862, M0064)**

**Description:**
Pharmacotherapy (90862) involves the management of prescription medicines, observation of response to medication, and/or dosage regulation. This management may also include evaluation of the effects of Electroconvulsive Therapy (ECT). The effects and side effects of the drugs may be evaluated, the medications may be modified or renewed, and some psychotherapy, usually supportive, may be rendered but is not required.

**Section V: Other Psychiatric and Psychological Services (90865, 90870)**

**Description:**
Narcosynthesis (90865) refers to 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 requisite infusion of medication reserves this code for MD and DO use only.

Electroconvulsive Therapy (ECT) (90870) involves the application of electric current to the brain through scalp electrodes to produce a single seizure. The potential for respiratory and cardiac compromise reserves this code for MD and DO use only.

**Part B Program Instructions:**

**Reasons for Denial**
- Code 90862 will be denied as not covered if billed on the same day as E/M codes by the same provider.
- Services performed by any practitioner other than those listed as covered for that procedure will be denied.
- Claims that are not supported by required documentation, in legible form, may be denied.
- Claims for psychotherapy services for patients with severe or profound mental retardation will be denied as not medically necessary.
- Claims for both anesthesia services and ECT administered by the same provider on the same day will be denied.
- Higher amounts of units are billed than those allowed by Medicare (see table in "Utilization Guidelines" section
of related LCD).

- It is not enough to link the procedure code to a correct, payable ICD-9-CM diagnosis code. The diagnosis or clinical suspicion must be present for the procedure to be paid.
- All other indications not listed in the “Indications and Limitations of Coverage” section of the related LCD.
- Service(s) rendered is not consistent with accepted standards of medical practice.
- The medical record does not verify that the service described by the CPT/HCPCS code was provided.
- The service does not follow the guidelines of the related LCD.
- The service is considered:
  - Investigational.
  - For routine screening.
  - A program exclusion.
  - Otherwise not covered.
  - Never medically necessary.

**Coding Guidelines**

- Refer to the Correct Coding Initiative (CCI) for correct coding guidelines and specific applicable code combinations prior to billing Medicare. Provisions of this LCD do not take precedence over CCI edits.
- When coding diagnoses, include the primary diagnosis or condition (e.g., depression) as well as secondary diagnoses or conditions (e.g., Alzheimer’s disease) that most closely reflect the medical necessity of the billed service.
- Reimbursement for CPT codes 90885 and 90887 is bundled into that of other services. These codes should not be billed separately.
- Clinical social workers cannot be paid under Medicare Part B for services in inpatient hospitals, partial hospitalization settings or skilled nursing homes.
- One time-based code should reflect the time spent to provide the service. Use of multiple time-based codes, in aggregate, is not appropriate.
- Medicare does not authorize payment for psychological and neuropsychological testing when performed on an "incident to" basis (Pub 100-2, Ch. 15, Sect. 80.2).
- Medicare will expect raw testing data demonstrating methodology of testing and identification of who administered the test (e.g., physician, technologist) be maintained in the patient’s medical record when using the newly added CPT codes 96101, 96102, 96103, 96118, 96119, 96120 and 96125.
- Diagnosis(es) must be present on any claim submitted and coded to the highest level of specificity for that date of service.
- To report these services, use the appropriate HCPCS or CPT code(s).
- All coverage criteria must be met before Medicare can reimburse this service.
- When billing for this service in a non-covered situation (e.g., does not meet indications of the related LCD), use the appropriate modifier (see below). To bill the patient for services that are not covered (investigational/experimental or not reasonable and necessary) will generally require an Advance Beneficiary Notice (ABN) be obtained before the service is rendered.
  - Modifiers:
    - GA: Waiver of liability statement issued as required by payer policy, individual case. (Use for patients who do not meet the covered indications and limitations of this LCD and for whom an ABN is on file.) (ABN does not have to be submitted but must be made available upon request.)
    - GZ: Waiver of liability statement is not on file. (Use for patients who do not meet the covered indications and limitations of this LCD and who did not sign an ABN.)
    - GY: Item or service is statutorily excluded or does not meet the definition of any Medicare benefit.
- Bill Type and Revenue Codes below DO NOT apply to Part B.

**Section I: Psychiatric Diagnostic Interview Examinations (90801, 90802)**

1. Codes 90801 and 90802 may be billed by MDs, DOs, Clinical Psychologists (CPs), Clinical Social Workers (CSWs), Clinical Nurse Specialists (CNSs), Physician Assistants (PAs), and Nurse Practitioners (NPs), meeting state requirements for psychiatric services.

2. Medicare would not expect to be billed for CPT code 90801 or 90802 (or a combination of both) more than three times per year.

**Section II: Psychological and Neuropsychological Testing**

1. Codes 96102, 96103, 96105, 96110, 96111, 96119, 96120 and 96125 may be billed by MDs, DOs, PAs, NPs, CNSs, psychologists and CPs. No modifier is required for these services.

2. Codes 96105, 96110 and 96111 may be billed by Physical Therapists (PTs), Occupational Therapists (OTs) and Speech-Language Pathologists (SLPs) when performed under the general supervision of a physician or a CP.

3. Codes 96101, 96116 and 96118 may be billed by MDs, DOs, psychologists and CPs. No modifier is required for
these services.

4. Psychological/neuropsychological testing codes should not be reported by the treating physician for **only reading** the results of the testing. The reading of the report is included in the office or floor time in the hospital and would be included in the evaluation and management service for that day.

5. Psychological test code 96101 should not be billed for the same test or service performed under code 96102 or 96103. Neuropsychological test code 96118 should not be billed for the same test or service performed under code 96119 or 96120.

6. Codes 96101, 96105, 96116, 96118 and 96125 are time-based codes and should be billed with units of service that reflect the total hours spent administering, interpreting, and reporting the test. If the performance, interpretation and reporting of the testing spans more than one day, then the entire service should be reported on one line of coding and billed for the date of the final report.

7. Codes 96102 and 96119 are time-based codes and should be billed with units of service that reflect the total hours spent **face to face with the patient administering the test**. For example, if a technician spends two hours administering a psychological test and the psychiatrist performs the interpretation and report, the psychiatrist should bill two units for code 96102 for the date the test was administered.

8. Codes 96103, 96110, 96111 and 96120 are **not** time-based codes and cannot be multiple serviced. They should be billed for the date the test was administered.

9. Non-physician practitioners (NPPs), such as NPs, CNSs and PAs, who personally perform diagnostic psychological and neuropsychological tests, are excluded from having to perform these tests under the general supervision of a physician or CP (Pub 100-2, Ch. 15, Sect. 80.2).

10. Independently Practicing Psychologists (IPPs) may bill for psychological and neuropsychological tests when the test is ordered by a physician (Pub 100-2, Ch. 15, Sect. 80.2).

11. Brief screening measures such as the Folstein Mini-Mental Status Exam or use of other mental status exams in isolation should not be reported separately as psychological or neuropsychological testing, since they are typically part of a more general clinical exam or interview.

12. Regular assessment of a patient’s progress during therapy, which uses items from the formal examinations, is considered part of the treatment and should not be reported with code 96105.

13. 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). These procedures are intended for psychological testing and should be reported under code 96110.

14. A brief clinical interview done on the same day as psychological testing may be included in testing time as a test mode and documented in the records.

15. Effective January 1, 2008, CPT code 96116 will be added to the approved list for telehealth services. Bill 96116 with modifier “GT” for telehealth services via interactive audio and video telecommunications system. Bill 96116 with modifier “GQ” for telehealth services via asynchronous telecommunications system.

**Section III: Psychotherapy Services**

1. Psychiatrists, CPs, NPs, PAs and CSWs may bill codes 90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90816, 90818, 90821, 90823, 90826, 90828, 90845, 90846, 90847, 90853, 90857 and 90880.

2. CNSs may bill codes 90801, 90802, 90804–90829, 90846, 90847, 90853 and 90857.

3. Psychiatric nurse practitioners may bill for CPT codes 90801, 90802, 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 and 90857 if they are trained and authorized to perform these psychiatric services.

4. Codes for psychotherapy with E/M services (90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90826 and 90827) should be used when psychotherapy is performed and there is an appropriate level of E/M service that is medically necessary and separately performed. For example, the E/M service could involve medical diagnostic evaluation, drug management, physician orders and/or interpretation of laboratory tests or other diagnostic studies and observations.

5. The Correct Coding Initiative (CCI) precludes billing psychotherapy services on the same day by the same provider as E/M codes. A complete list of CCI restrictions can be obtained from National Technical Information Service (NTIS).
6. Similar services on the same day are not permitted to multiple providers in the same specialty for the same diagnosis. Medicare will not accept psychotherapy procedure codes 90804–90829 billed on the same day of service as an E/M service, by the same provider. Interactive psychotherapy codes 90810–90815 and 90823–90829 should not be billed on the same dates of service as regular psychotherapy codes 90804–90809 or 90816–90822. Code 90857 should not be billed on the same date of service as 90853.

**Section IV: Pharmacologic Management of Psychiatric Illness (90862, M0064)**

1. Code 90862 should not be used to report the actual administration of medications, or for observation of the patient taking oral medication – services which are not covered under Medicare. Code 90862 includes prescribing medication, monitoring the effect of medication and its side effects and adjusting the dosage. Medicare would not expect to see code 90862 billed at a frequency of more than once per day.

2. When billing for a low level of drug monitoring, i.e., dosage adjustment or medication renewal in places of service other than office, report the minimal E/M code that is appropriate for that place of service.

3. Do not report code 90862 on the same day as E/M services.

4. If the primary purpose of the encounter is medication management, report code 90862 and do not bill individual psychotherapy services. M0064 should be used for the lesser level of drug monitoring such as simple dosage adjustment.

5. Do not report codes 90862 and M0064 on the same day as codes 90801, 90804–90829, 90845, 90847, 90849 or 90853 by the same provider.

6. Do not bill code 90846 (family psychotherapy without the patient present) with code 90862 when the service rendered is routine consultation with staff about the patient's progress and treatment.

7. Code M0064 may be billed for evaluation and management of the effects of ECT on patients. This code should be billed once per day, by one provider only, whether the provider of ECT is the patient's primary psychiatrist or not.

**Section V: Other Psychiatric and Psychological Services (90865, 90870)**

See the general requirements at the beginning of this section.

**Bill Type Codes**

N/A

**Revenue Codes**

N/A

**CPT/HCPCS Codes**

*Note:* Providers are reminded to refer to the long descriptors of the CPT codes in their CPT books. The American Medical Association (AMA) and the Centers for Medicare & Medicaid Services (CMS) require the use of short CPT descriptors in policies published on the Web.

90801© Psy dx interview
90802© Intac psy dx interview
90804© Psytx, office, 20–30 min
90805© Psytx, off, 20–30 min w/e&m
90806© Psytx, office, 45–50 min
90807© Psytx, office, 45–50 min w/e&m
90808© Psytx, office, 75–80 min
90809© Psytx, office, 75–80 min w/e&m
90810© Intac psytx, off, 20–30 min
90811© Intac psytx, off, 20–30 min w/e&m
90812© Intac psytx, off, 45–50 min
90813© Intac psytx, off, 45–50 min w/e&m
90814© Intac psytx, off, 75–80 min
90815© Intac psytx, off, 75–80 min w/e&m
90816© Psytx, hosp, 20–30 min
90817© Psytx, hosp, 20–30 min w/e&m
90818© Psytx, hosp, 45–50 min
90819© Psytx, hosp, 45–50 min w/e&m
90821© Psytx, hosp, 75–80 min
90822© Psytx, hosp, 75–80 min w/e&m
90823© Intac psytx, hosp, 20–30 min
90824© Intac psytx, hosp, 20–30 min w/e&m
90826© Intac psytx, hosp, 45–50 min
90827© Intac psytx, hosp, 45–50 min w/e&m
90828© Intac psytx, hosp, 75–80 min
90829© Intac psytx, hosp, 75–80 min w/e&m
90845© Psychoanalysis
90846© Family psytx w/o patient
90847© Family psytx w/ patient
90849© Multiple family group psytx
90853© Group psychotherapy
90857© Intac group psytx
90862© Medication management
90865© Narcosynthesis
90870© Electroconvulsive therapy
90880© Hypnotherapy
90889© Preparation of report
90899© Psychiatric service/therapy
96101© Psycho testing by psych/phys
96102© Psycho testing by technician
96103© Psycho testing admin by comp
96105© Assessment of aphasia
96110© Developmental test, lim
96111© Developmental test, extend
96116© Neurobehavioral status exam

Note: Must be accomplished by psychologist or physician (see CPT code long description).

96118© Neuropsych tst by psych/phys
96119© Neuropsych testing by tech
96120© Neuropsych tst admin w/comp
96125© Cognitive test by hc pro
M0064 Brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental psychoneurotic and personality disorders
Other Comments
The following organizations are recognized national certifying bodies for NPs and CNSs at the advanced practice level:
- American Academy of Nurse Practitioners.
- American Nurses Credentialing Center.

Note: For a complete list of national certifying bodies, refer to the Medicare Benefit Policy Manual – Pub. 100-02, Chapter 15, Section 200.

Comment Summary
[N/A]

Additional Information
[No additional information has been specified for this record]

Comments
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