BlueCross BlueShield of Minnesota

# REIMBURSEMENT POLICY

## Psychotherapy Professional Services

Active

**Policy Number:** Behavioral Health - 001
**Policy Title:** Psychotherapy Professional Services
**Section:** Behavioral Health
**Effective Date:** 09/04/17

## Description

This policy includes general psychotherapy coding for behavioral health providers who bill on a professional claim format (837P).

## Definitions

Psychotherapy is a variety of treatment techniques in which a physician or other qualified health care provider helps a patient with a mental illness or behavioral disturbance identify and alleviate any emotional disruptions, maladaptive behavioral patterns, and contributing/exacerbating factors. This treatment also involves encouraging personality growth and development through coping techniques and problem-solving skills.

The codes in this policy are specific to the psychotherapy CPT codes 90791-90792, 90832-90863, 90845-90846, 90882, 90885, 90887, 90889, 90899 and the Evaluation and Management (E/M) visit codes 99201-99215.

## Policy Statement

### Providers Who Should Use this Section

Psychiatrists, Ph.D. level psychologists (LP-PhD), master's level

psychologists (LP-MA), licensed independent clinical social workers (LICSW), certified nurse specialists in psychiatry (CNS-Psych), licensed marriage and family therapists (LMFT), licensed professional clinical counselor (LPCC) and psychiatric mental health nurse practitioners (PMHNP).

Behavioral health practitioners working as a clinical trainee should bill under the licensed supervising practitioner's individual provider number and with the U7 modifier attached to the procedure codes submitted on the claim.

Psychotherapy services will be considered as out of scope of practice for practitioners not listed above.

### Psychiatric interviews/evaluations 90791, 90792

90791 includes the assessment of the patient's psychosocial history, current mental status, review, and ordering of diagnostic studies followed by appropriate treatment recommendations.

90792 is reported if additional medical services such as physical examination and prescription of pharmaceuticals are provided in addition to the diagnostic evaluation. Interviews and communication with family members or other sources are included in these codes.

**Psychotherapy 90832-90834, 90836-90838**

- Time conventions are consistent with CPT convention (more than 50 percent of stated time must be spent in order to report the code).
- Psychotherapy time may include face-to-face time with family members as long as the patient is present for part of the session.
- Add-on codes 90833, 90836, 90838.
  - To report both an E/M code and a psychotherapy add on code, 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.
  - Time may not be used as the basis of the E/M code selection.

**Interactive complexity code 90785**

- Add-on code to the code for a primary psychiatric service.
- May be reported, as appropriate, with 90791, 90792, 90832, 90833, 90834, 90836, 90853, 90837, 99201-99255, 99304-99337, and 99341-99350
- One of the following must exist during the session in order to report 90785:
  - Maladaptive communication (for example, high anxiety, high reactivity, repeated questions, or disagreement).
  - Emotional or behavioral conditions inhibiting implementation of treatment plan.
  - Mandated reporting/event exists (for example, abuse or neglect).
  - Play equipment, devices, interpreter or translator required due to inadequate language expression or different language spoken between patient and professional.

**Crisis psychotherapy 90839, 90840**

- Used when psychotherapy services are provided to a patient who presents in high distress with complex or life-threatening circumstances that require urgent and immediate attention.
- 90839 is a stand-alone code not to be reported with psychotherapy or psychiatric diagnostic evaluation codes, the interactive complexity code, or any other psychiatry section code.
  - Report 90839 for the first 30-74 minutes of psychotherapy on a given date.
  - Psychotherapy for crisis of less than 30 minutes total should be reported with 90832 or 90833.
  - Report 90839 only once per date even if time spent is not continuous on that date.
- 90840 is an add-on code that should be reported for each additional 30 minutes of service beyond the first 74 minutes.

**Family Therapy 90846, 90847**

**90846**

- This code is billed for family therapy when the patient is not present. There may be specific contract exclusions for some self-insured groups.
- This code should be billed under the specific patient, not under the subscriber.
- Bill one unit per session regardless of total time.
- This code must be billed with a behavioral health diagnosis.

**90847**

- This code is billed for family therapy when the patient is present. There may be specific contract exclusions for some self-insured groups.
- This code should be billed under the specific patient, not under the subscriber.
- Bill one unit per session regardless of total time.
- This code must be billed with a behavioral health diagnosis.

**Medication/Pharmacologic Management 90863**

Pharmacologic or medication management is considered a component of E/M services. Providers who can report E/M services would **not** use the medication/pharmacologic codes (including MDs and advanced nurse practitioners). The code 90863 was created to be used by providers who cannot report E/M services (such as psychologists or social workers). It is to be used to report pharmacologic management when it is provided with psychotherapy. Note that because enrolled practitioners are eligible to submit E/M services, code 90863 should never be reported.

If medication/pharmacologic management (90863) is billed on the same day as an E/M code, the medication/pharmacologic management code will deny as incidental to the E/M code.

Medication/pharmacologic management is compatible with a behavioral health diagnosis.

This service is eligible when billed in the office or skilled nursing facility. It is not an eligible service when billed with an inpatient place of service. A medication management visit billed on the same day as an inpatient visit will deny as incidental to the inpatient visit.

Medication/pharmacologic management rendered in the outpatient clinic setting should only be billed on an 837P professional claim form. If billed on a facility claim, it will be denied.

**Behavioral Health Evaluation & Management (E&M) Office Calls 99201-99215**

Procedure codes 99201-99205 (for new patients) and procedure codes 99211-99215 (for established patients) can be billed by an MD, nurse practitioner, clinical nurse specialist, clinical nurse specialist in psychiatry, psychiatric mental health nurse practitioner or a physician assistant.

**Service Summary:**

| Type of Service | CPT | Report with 90785 |
|---|---|---|
| Diagnostic evaluation | 90791 (no medical)<br>90792 (with medical) | When appropriate |
| Psychotherapy 30 min. | 90832 | When appropriate |
| Psychotherapy 45 min. | 90834 | When appropriate |
| Psychotherapy 60 min. | 90837 | When appropriate |
| E/M plus psychotherapy add- on | E/M (select using key components, not time) and one of:<br>+90833 – 30 min.<br>+90836 – 45 min.<br>+90838 – 60 min. | When appropriate |
| Psychotherapy for crisis | 90839, +90840 | No |
| Family psychotherapy | 90846, 90847, 90849 | No |
| Group psychotherapy | 90853 | When appropriate |
| E/M (pharmacologic management is part of an E/M service) | E/M | No |
| Pharmacologic Management (**only** for specialties **not** eligible to submit E/M) | 90863 | No |

**Units**

One or more units should be submitted based on the time designation within the HCPCS code narrative. If there is **no** time designation, the service is considered 'per session' and only **one** unit should be submitted regardless of actual time spent.

**Timed Unit Reporting**

When a procedure/service indicates time, more than half of the designated time must be spent performing the service in order for a unit to be billed. In the case of a 30 minute service, at least 16 minutes of the service must be performed.

**Coding Restrictions**

| Code | Restriction |
|---|---|
| 90845 | Psychoanalysis is generally excluded in subscriber contracts. If it were to be covered, it must be provided by an MD (psychiatrist). |

| | |
|---|---|
| 90846 | Family psychotherapy without the patient present may be excluded in some subscribers' contracts. It is only compatible with a behavioral health diagnosis. |
| 90882 | Environmental intervention for medical management purposes is not covered because it is included in the practitioner's basic service. |
| 90885 | Psychiatric evaluation of hospital records - not covered because it is included in the practitioner's basic service. |
| 90887 | Interpretation or explanation of exam results is not covered because reimbursement is included in the compensation for the practitioner's basic service billed with the testing code. |
| 90889 | Preparation of report is a contract exclusion and is not covered. |
| 90899 | Unlisted psychiatric service or procedure codes **must** be submitted with a specific narrative description detailing exactly what the charge is for along with documentation of time. Unlisted codes may be subject to denial if there is an existing definitive code describing the service. |

## Documentation Submission

Documentation must identify and describe the procedures performed, including total time of the service and participants for family or group services. If a denial is appealed, this documentation must be submitted with the appeal.

## Coverage

Eligible psychotherapy services will be subject to the Blue Cross fee schedule amount and any coding edits.

E/M services will not be accumulated towards any dollar or visit maximums.

Subscribers who receive an E/M service billed with a behavioral health diagnosis by a non-behavioral health practitioner within their designated primary care clinic will have services reimbursed according to their behavioral health contract benefit.

Behavioral health E/M services provided outside the subscriber's participating provider network will be subject to the subscriber's nonparticipating provider benefit limitations.

### Groups that Carve Out Behavioral Health Benefits

Some self-insured groups contract with another carrier to manage their behavioral health

benefits. This means that their behavioral health claims should be filed with the designated third party behavioral health carrier for processing. This carrier's information should be obtained from the patient.

E/M services (codes 99201-99215) including medication/pharmacologic management services (included as part of the E/M) billed with a behavioral health diagnosis for carve out self- insured group subscribers should be billed to Blue Cross as long as the practitioner is a non-behavioral health practitioner or a multispecialty clinic. If one of these services is denied, Blue Cross should be contacted for it to be reprocessed. These services will be paid at the behavioral health benefit but will not accumulate towards patients' behavioral health benefit maximums. Any other behavioral health treatment for carve out self-insured group subscribers that is billed to Blue Cross will be denied.

**Provider Networks**

Subscribers are required to utilize a participating network provider for their highest level of benefits. To find a participating network provider, subscribers are encouraged to call Blue Cross so that a provider best suited to meet their treatment needs can be found in a convenient location within their assigned network.

**The following applies to all claim submissions.**

All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in the Provider Policy and Procedure Manual sections, Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be paid according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

## Coding

The following codes are included below for informational purposes only, and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement.

| | |
|---|---|
| **CPT / HCPCS Modifier**: | U7 |
| **ICD Diagnosis**: | N/A |
| **ICD Procedure**: | N/A |
| **HCPCS**: | 90785, 90791-90792, 90832-90863, 99201-99215, 99304-99337 |
| **Deleted Codes**: | N/A |

## Policy History

**Initial Committee Approval Date**: May 19, 2015

**Code Update**: January 1, 2017

**Policy Review Date**: June 9, 2016
August 2, 2017
March 23, 2020

**Cross Reference:**