CHAPTER 7
SECTION 3.13

PSYCHOTHERAPY

ISSUE DATE: December 5, 1984
AUTHORITY: 32 CFR 199.4(c)(3)(ix)

I. CPT[1] PROCEDURE CODE RANGE

90804 - 90857

II. POLICY

A. Benefits are available for inpatient and outpatient psychotherapy that is medically or psychologically necessary to treat a covered mental disorder.

B. Individual psychotherapy for patients with a mental disorder (DSM IV) that coexists with an alcohol and other drug abuse disorder is a covered benefit.

C. Charges for outpatient psychotherapy are not covered when the patient is an inpatient in an institution. Claims for outpatient psychotherapy must be denied for the entire period during which the beneficiary is an inpatient in the institution.

D. Employees of institutional providers are not authorized to bill for services rendered as part of that employment. Such services billed by the employee must be denied.

III. POLICY CONSIDERATIONS

A. Maximum duration of psychotherapy sessions:

1. Inpatient or outpatient individual psychotherapy (CPT[1] procedure codes 90806, 90807, 90818, 90819) approximately 45 to 50 minutes; or (CPT[1] procedure codes 90804, 90805, 90816, 90817) approximately 20 to 30 minutes.

2. Inpatient or outpatient group, conjoint or family psychotherapy: 90 minutes (CPT[1] procedure codes):

90846 - FAMILY PSYTX W/O PATIENT
90847 - FAMILY PSYTX W/ PATIENT
90849 - MULTIPLE FAMILY GROUP PSYTX
90853 - GROUP PSYCHOTHERAPY

[1]

3. Crisis intervention (CPT[2] procedure codes):

90808 - PSYTX, OFFICE, 75-80 MIN
90809 - PSYTX, OFF, 75-80, W/E&M
90821 - PSYTX, HOSP, 75-80 MIN
90822 - PSYTX, HOSP, 75-80 MIN W/E&M

B. Frequency of psychotherapy sessions.

NOTE: Beginning October 1, 1993, the mental health benefit year is changed from a calendar year to fiscal year. A patient is not automatically entitled to a designated number of sessions, and review can be more frequent when determined necessary.

1. The frequency limitations on outpatient psychotherapy apply to any psychotherapy performed on an outpatient basis, whether by an individual professional provider or by staff members of an institutional provider.

2. Treatment sessions may not be combined, i.e., 30 minutes on one day added to 20 minutes on another day and counted as one session, to allow reimbursement and circumvent the frequency limitation criteria.

3. Multiple sessions the same day: If the multiple sessions are of the same type--two individual psychotherapy sessions or two group therapy sessions--payment may be made only if the circumstances represent crisis intervention and only according to the restrictions applicable to crisis intervention. A collateral session not involving the identified patient on the same day the patient receives a therapy session does not require review.

4. Collateral visits (CPT[2] procedure code 90887). Collateral visits are payable when medically or psychologically necessary for treatment of the identified patient. A collateral visit is considered to be a psychotherapy session for purposes of reviewing the duration or frequency of psychotherapy.

5. Psychoanalysis (CPT[2] procedure code 90845). Psychoanalysis is covered when provided by a graduate or candidate of a psychoanalytic training institution recognized by the American Psychoanalytic Association and when preauthorized by the contractor.

6. Play therapy. Play therapy is a form of individual psychotherapy which is utilized in the diagnosis and treatment of children with psychiatric disorders. Play therapy is a benefit, subject to the regular points of review and frequency limitations applicable to individual psychotherapy.

7. Marathon therapy. Marathon therapy is a form of group therapy in which the therapy sessions last for an extended period of time, usually one or more days. Marathon therapy is not covered since it is not medically necessary or appropriate.

8. Inpatient psychotherapy and medical care. The allowable charge for inpatient psychotherapy includes medical management of the patient. A separate charge for hospital visits rendered by the provider on the same day as he/she is rendering psychotherapy is not covered. Payment is authorized only for medically necessary hospital visits billed on a day that psychotherapy was not rendered. If the provider who is primarily responsible for treatment of the mental disorder is not a physician, charges for medical management services by a physician are coverable, but only if the physician is rendering services that the non-physician provider is prohibited from providing. Concurrent inpatient care by providers of the same or different disciplines is covered only if second or third level review determines that the patient's condition requires the skills of multiple providers.

9. Physical examination. A physical examination is an essential component of the workup of the psychiatric patient, and for all admissions should be performed either by the attending psychiatrist or by another physician. The examination may lead to confirmation of a known psychiatric diagnosis or consideration of other unsuspected psychiatric or medical illness. When not performed by the attending psychiatrist, payment may be made to another physician for performance of the initial physical examination. Any additional concurrent care provided by a physician other than the attending psychiatrist may be covered only if it meets the criteria under inpatient concurrent care.

IV. EFFECTIVE DATE November 13, 1984.

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