

CHAMPVA POLICY MANUAL

CHAPTER: 2
SECTION: 18.3
TITLE: PSYCHOTHERAPY

AUTHORITY: 38 CFR 17.270(a) and 38 CFR 17.272(a)

RELATED AUTHORITY: 32 CFR 199.4(c)(3)(ix), and 199.4(g)(1)

I. EFFECTIVE DATE

November 13, 1984

II. PROCEDURE CODE(S)

A. CPT codes: 90801-90802, 90804-90857, 90862, and 90887

B. HCPCS code(s): M0064

III. 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 mental disorder (DSM IV) that coexists with an alcohol and other drug abuse disorder is a covered benefit.

IV. POLICY CONSIDERATIONS

A. Maximum duration of psychotherapy sessions.

1. Inpatient or outpatient individual psychotherapy (90806, 90807, 90818 and 90819) approximately 45 to 50 minutes, or (90804, 90805, 90816 and 90817) approximately 20 to 30 minutes.

2. Inpatient or outpatient group, conjoint or family psychotherapy: 90 minutes.

a. 90846 - family medical psychotherapy (without the patient present),

b. 90847 - family medical psychotherapy (conjoint psychotherapy),

c. 90849 - multiple family group medical psychotherapy,

d. 90853 - group psychotherapy (other than of a multiple-family group), and

e. 90857 - interactive group psychotherapy.

3. Crisis intervention.

90808, 90809, 90821 and 90822 - individual medical psychotherapy, approximately 75 to 80 minutes.

4. Cross-walk of 1998 CPT psychotherapy codes:

<u>Old Codes</u>	<u>New Codes</u>
90842	90808, 90809, 90821, 90822
90843	90804, 90805, 90816, 90817
90844	90806, 90807, 90818, 90819

B. Minimum duration of psychotherapy sessions. Individual psychotherapy sessions of less than 20 minutes or group, family or marital sessions of less than 45 minutes may be paid or denied based upon medical necessity. If the claim meets all other program requirements at first-level review, and is other than psychotropic pharmacologic management billed as psychotherapy, cost sharing may be allowed. Claims for psychotherapy sessions involving lesser amounts of time shall count as one full outpatient session.

C. 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. Inpatient psychotherapy. More than seven sessions per calendar week (Sunday through Saturday) of any type of psychotherapy requires certification of the overall treatment plan by the Mental Health Contractor for necessity and appropriateness.

4. Outpatient psychotherapy preauthorization requirements.
 - a. More than 23 sessions per fiscal year requires preauthorization from the mental health contractor.
 - b. More than 2 sessions per calendar week (Sunday through Saturday) of any type of psychotherapy requires preauthorization from the mental health contractor. Preauthorization is required in this case regardless of whether the beneficiary has met or exceeded the 23 sessions per fiscal year. For example, if a beneficiary has had 10 psychotherapy sessions, but the physician wants to increase weekly sessions from two to three, the provider must obtain preauthorization from the mental health contractor.
 - c. The preauthorization requirement is applicable to all providers except VA medical providers under the CITI Program. CITI facilities are not required to obtain preauthorization.
5. Psychotropic pharmacologic management visits do not count towards the 23 self-referred psychotherapy sessions.
6. 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.
7. Collateral visits (CPT 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.
8. Psychoanalysis (CPT 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 Director, Health Administration Center (or designee).
9. 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.
10. 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.

11. 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.

12. Physical examination. A physical examination is an essential component of the work-up 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.

13. This policy does not preclude the attending psychiatrist from billing for other relevant and medically necessary care THAT IS concurrent with performance of, and billing for, the code 90801 and 90802.

V. EXCLUSIONS

A. Charges for outpatient psychotherapy are not covered when the patient is receiving treatment on an inpatient basis. Claims for outpatient psychotherapy must be denied for the entire period during which the beneficiary is an inpatient.

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

C. Counseling services that are not medically necessary in the treatment of a diagnosed medical condition. For example, educational counseling, vocational counseling, nutrition counseling, and marriage counseling are not covered benefits.

END OF POLICY