



United Behavioral Health

## Medicare Coverage Summary: Outpatient Psychiatric and Psychological Services

**Document Number:** BH803HHMCOP0720

**Effective Date:** July, 2020

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### INTRODUCTION

*Medicare Coverage Summaries* are a set of objective and evidence-based behavioral health criteria used by medical necessity plans to standardize coverage determinations, promote evidence-based practices, and support members' recovery, resiliency, and wellbeing for Medicare behavioral health benefit plans managed by Optum®<sup>1</sup>.

### INSTRUCTIONS FOR USE

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

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

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

Optum may also use tools developed by third parties that are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

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<sup>1</sup> Optum is a brand used by United Behavioral Health and its affiliates.

Optum may develop clinical criteria or adopt externally-developed clinical criteria that supersede this guideline when required to do so by contract or regulation.

## OUTPATIENT PSYCHIATRIC AND PSYCHOLOGICAL SERVICES

Outpatient psychiatric and psychological services refer to Part A and Part B services in the fields of psychiatry, psychology, clinical social work, and psychiatric nursing services rendered in a hospital outpatient facility or by individual providers for the diagnosis and treatment of various mental disorders or diseases (L33632, 2019; L34353, 2019).

Outpatient psychiatric and psychological services refer to services provided by providers including physicians, and non-physicians, such as clinical psychologists, independent psychologist, nurse practitioners, clinical nurse specialists and physician assistants when the services performed are within the scope of their clinical practice/education and authorized under state law (L33632, 2019; L34353, 2019; L34616, 2019).

Psychiatric care includes the therapeutic services provided to a beneficiary for the treatment of mental, psychoneurotic, and personality disorders which are directed toward identifying specific behavior patterns, factors determining such behavior, and effective goal oriented therapies. For approved providers of mental health services, the state licensure or authorization must specify that the provider's scope of practice includes the provision of clinical psychotherapy for the treatment of mental illness. Psychiatrists are physicians (MDs and Dos) trained in mental health disorders and may provide all services described in this LCD. Coverage for all non-physician practitioners is limited to services which they are authorized to perform by the state in which they practice (L35101, 2019).

"Incident to" a physician's professional services means that services or supplies furnished as an integral, although incidental, part of a physician's personal professional services in the course of diagnostic or treatment of an illness or injury. The "incident to" provision may also apply to coverage for psychological services furnished "incident to" the professional services of certain non-physician practitioners including clinical psychologists, clinical social workers, nurse practitioners, and clinical nurse specialists (L34539, 2019).

"Incident to" services are defined as services or supplies furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness (A52403, 2019; L34539, 2019). This Medicare Coverage Summary is applicable to the following States/jurisdictions:

## APPLICABLE STATES

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

**CMS L33252/A57520 (All states & territories Part A Inpatient Services and Part B Outpatient Services apply)**

- Florida
- Puerto Rico
- Virgin Islands

**CMS L33632/A56937 (All states Part A Inpatient Services and Part B Outpatient Services apply)**

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

- Vermont
- Wisconsin

**CMS L34353/A57065 and L34539/A57054 (All states Part A Inpatient Services and Part B Outpatient Services apply)**

- Kentucky
- Ohio

**CMS L34616/A57480 (Part A Inpatient Services and Part B Outpatient Services vary, see each state)**

- Alabama (Part A Inpatient Services)
- Alaska (Part A Inpatient Services)
- Arizona (Part A Inpatient Services)
- Arkansas (Part A Inpatient Services)
- California (Part A Inpatient Services)
- Colorado (Part A Inpatient Services)
- Connecticut (Part A Inpatient Services)
- Delaware (Part A Inpatient Services)
- Florida (Part A Inpatient Services)
- Georgia (Part A Inpatient Services)
- Hawaii (Part A Inpatient Services)
- Idaho (Part A Inpatient Services)
- Illinois (Part A Inpatient Services)
- Indiana (Part A Inpatient Services **and** Part B Outpatient Services)
- Iowa (Part A Inpatient Services **and** Part B Outpatient Services)
- Kansas (Part A Inpatient Services **and** Part B Outpatient Services)
- Kentucky (Part A Inpatient Services)
- Louisiana (Part A Inpatient Services)
- Maine (Part A Inpatient Services)
- Massachusetts (Part A Inpatient Services)
- Michigan (Part A Inpatient Services **and** Part B Outpatient Services)
- Missouri (Part A Inpatient Services **and** Part B Outpatient Services)
- Mississippi (Part A Inpatient Services)
- Montana (Part A Inpatient Services)
- Nebraska (Part A Inpatient Services **and** Part B Outpatient Services)
- New Hampshire (Part A Inpatient Services)
- New Jersey (Part A Inpatient Services)
- New Mexico (Part A Inpatient Services)
- Nevada (Part A Inpatient Services)
- North Carolina (Part A Inpatient Services)
- North Dakota (Part A Inpatient Services)

- Ohio (Part A Inpatient Services)
- Oklahoma (Part A Inpatient Services)
- Oregon (Part A Inpatient Services)
- Pennsylvania (Part A Inpatient Services)
- Rhode Island (Part A Inpatient Services)
- South Carolina (Part A Inpatient Services)
- South Dakota (Part A Inpatient Services)
- Tennessee (Part A Inpatient Services)
- Texas (Part A Inpatient Services)
- Utah (Part A Inpatient Services)
- Vermont (Part A Inpatient Services)
- Virginia (Part A Inpatient Services)
- Washington (Part A Inpatient Services)
- West Virginia (Part A Inpatient Services)
- Wisconsin (Part A Inpatient Services)
- Wyoming (Part A Inpatient Services)

**CMS L35101/A57130 (All states Part A Inpatient Services and Part B Outpatient Services apply)**

- Arkansas
- Colorado
- Delaware
- District of Columbia
- Louisiana
- Maryland
- Mississippi
- New Jersey
- New Mexico
- Oklahoma
- Pennsylvania
- Texas

**COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY**

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

**Indications (CMS L33252/A57520)**

Psychiatric diagnostic evaluations will be considered medically necessary when the patient has a psychiatric illness and /or is demonstrating emotional or behavioral symptoms sufficient to cause inappropriate behavior patterns or maladaptive functioning in personal or social settings, which may be suggestive of a psychiatric illness. This examination may also be medically necessary when baseline functioning is altered by suspected illness or symptoms. It is appropriate for dementia, in patients who experience a sudden and rapid change in behavior.

The psychiatric diagnostic evaluation is not considered to be medically reasonable and necessary:

- When it is rendered to a patient who has a medical/neurological condition such as dementia, delirium, or other psychiatric conditions, which have produced a severe enough cognitive defect to prevent effective communication and the ability to assess the patient; or
- When the patient has a previously established diagnosis of a neurological condition or dementia and is not amenable to the evaluation and therapy, unless there has been an acute and/or marked mental status change, a request for second opinion, or diagnostic clarification is necessary to rule out additional psychiatric or neurological processes, which may be treatable; or
- When a patient is referred with an organic diagnosis and a mental health diagnosis is established, the mental health diagnosis should be billed. Routine performance of additional psychiatric diagnostic evaluation of patients with chronic conditions is not considered medically necessary.

A psychiatric diagnostic evaluation can be conducted once, at the onset of an illness or suspected illness. The same provider may repeat it for the same patient if an extended hiatus in treatment occurs, if the patient requires admission to an inpatient status for a psychiatric illness, or for a significant change in mental status requiring further assessment. An extended hiatus is generally defined as approximately 6 months from the last time the patient was seen or treated for their psychiatric condition. A psychiatric diagnostic evaluation may also be utilized again if the patient has a previously established neurological disorder or dementia and there has been an acute and/or marked mental status change, or a second opinion or diagnostic clarification is necessary to rule out additional psychiatric or neurological processes, which may be treatable.

Psychotherapy will be considered medically necessary when the patient has a psychiatric illness and/or is demonstrating emotional or behavioral symptoms sufficient to cause inappropriate behavior or maladaptive functioning. Psychotherapy services must be performed by a person licensed by the state where practicing, and whose training and scope of practice allow that person to perform such services. Psychotherapy must be provided as an integral part of an active treatment plan for which it is directly related to the patient's identified condition/diagnoses. Some patients receive psychotherapy alone, and others receive psychotherapy along with medical evaluation and management services. These services involve a variety of responsibilities unique to the medical management of psychiatric patients such as medical diagnostic evaluation (i.e. evaluation of co-morbid medical conditions, drug interactions, and physical examinations), drug management when indicated, physician orders, interpretation of laboratory or other diagnostic studies and observations. The patient should be amenable to allowing insight-oriented therapy such as behavioral modification techniques, interpersonal psychotherapy techniques, supportive therapy, and cognitive/behavioral techniques to be effective.

Psychotherapy services are not considered to be medically reasonable and necessary when they are rendered to a patient who has a medical/neurological condition such as dementia, delirium or other psychiatric conditions, which have produced a severe enough cognitive deficit to prevent effective communication with interaction of sufficient quality to allow insight oriented therapy (i.e. behavioral modification techniques, interpersonal psychotherapy techniques, supportive therapy or cognitive/behavioral techniques). In these cases, evaluation and management or pharmacological codes should be used. Psychotherapy services are not considered to be medically reasonable and necessary when they primarily include the teaching of grooming skills, monitoring activities of daily living, recreational therapy (dance, art play), or social interaction.

Group therapy will be considered medically necessary when the patient has a psychiatric illness and/or is demonstrating emotional or behavioral symptoms sufficient to cause inappropriate behavior patterns or maladaptive functioning in personal or social settings. The issues presented and explored in the group setting should evolve towards a theme or a therapeutic goal. Group psychotherapy must be ordered by a provider as an integral part of an active treatment plan for which it is directly related to the patient's identified condition/diagnosis. This treatment plan must be adhered to and should be endorsed and monitored by the treating physician or physician of record. The specialized skills of a mental health care professional must be required.

Group psychotherapy services are not considered to be medically reasonable and necessary when they are rendered to a patient who has a medical/neurological condition such as dementia, delirium, or other psychiatric conditions, which have produced a severe enough cognitive deficit to prevent effective communication including interaction of sufficient quality with the therapist and members of the group. Other services such as music therapy, socialization, recreational activities/recreational therapy, art classes/art therapy, excursions, sensory stimulation, eating together, cognitive stimulation, or motion therapy are not considered to be medically reasonable and necessary.

Family psychotherapy will be considered medically reasonable and necessary only in clinically appropriate circumstances and when the primary purpose of such psychotherapy is the treatment/management of the patient's condition. Examples are as follows:

- When there is a need to observe and correct, through psychotherapeutic techniques, the patient's interaction with family members; and/or
- Where there is a need to assess the conflicts or impediments within the family, and assist, through psychotherapeutic techniques, the family members in the management of the patient.

Family psychotherapy must be ordered by a provider as an integral part of an active treatment plan for which it is directly related to the patient's identified condition/diagnosis.

Family psychotherapy must be conducted face to face by physicians (MD/DO), psychologists, or other mental health professionals licensed or authorized by state statutes and considered eligible for reimbursement.

Family psychotherapy is considered to be medically reasonable and necessary when the patient has a psychiatric illness and/or is demonstrating emotional or behavioral symptoms sufficient to cause inappropriate behavior or maladaptive functioning.

In certain types of medical conditions, such as the unconscious or comatose patient, family psychotherapy would not be medically reasonable or necessary. Psychoanalysis is generally considered unsuitable for psychoses.

The medical record must document the indications for psychoanalysis, description of the transference, and that psychoanalytic techniques were used. The physician using this technique must be trained and credentialed in its use. Clinical nurse specialists (CNS) and nurse practitioners (NP) are not eligible for payment for psychoanalysis.

The psychoanalysis CPT code is not a time-related code, but the service is usually 45 to 50 minutes in duration. The code may be billed once for each daily session regardless of the time involved (A57520, 2019).

If a patient is unable to communicate by any means, the interactive complexity codes should not be billed. This service is used in conjunction with codes for diagnostic psychiatric evaluation, psychotherapy, psychotherapy when performed with an evaluation and management service, and group psychotherapy (A57520, 2019).

Any time that an interactive complexity service is reported, the medical record must clearly support the rationale for this approach. Otherwise stated, there must be an explanation of what specific communication factors complicated the delivery of a psychiatric procedure. The medical record must indicate that the person being evaluated has one of the following communication factors present during the visit:

- The need to manage maladaptive communication among participants (related to, e.g., high anxiety, high reactivity, repeated questions, or disagreement) that complicates delivery of care.
- Caregiver emotions or behaviors that interfere with implementation of the treatment plan.
- Evidence or disclosure of a sentinel event and mandated report to a third party (e.g., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.

- Use of play equipment, physical devices, interpreter, or translator to overcome barriers to diagnostic or therapeutic interaction with a patient who is not fluent in the same language or who has not developed or has lost expressive or receptive language skills to use or understand typical language.

Regarding psychotherapy for crisis, the presenting problem is typically life threatening or complex and requires immediate attention to a patient with high distress. The crisis codes are used to report the total duration of time face-to-face with the patient and/or family spent by the physician or other qualified health care professional providing psychotherapy for crisis, even if the time spent on that date is not continuous. For any given period of time spent providing psychotherapy for crisis state, the physician or other qualified health care professional must devote his or her full attention to the patient and, therefore, cannot provide service to any other patient during the same time period. The patient must be present for all or some of the service (A57520, 2019).

Patient progress may be small or not be measurable at each visit. However, a trend should be measurable presenting signs of progression or regression in changes relating to behavior, thought processes, or medication management. When services are performed in excess of established parameters, they may be subject to review for medical necessity.

There must be a reasonable expectation of improvement in the patient's disorder or condition, demonstrated by an improved level of functioning or maintenance of level of functioning where decline would otherwise be expected in the case of a disabling mental illness or condition or chronic mental disorder. When a patient reaches a point in his/her treatment where further improvement does not appear to be indicated and there is no reasonable expectation of improvement, the psychological services are no longer considered reasonable or medically necessary. The documentation must support that the patient's mental stability cannot be maintained without further psychotherapy treatment. The duration of a course of psychotherapy must be individualized for each patient.

Psychiatric and/or psychological services routinely performed to evaluate and/or treat an adjustment disorder associated with placement in a nursing home do not constitute medical necessity. It is not expected that every patient upon entry to a nursing home receives a psychiatric diagnostic evaluation and/or psychotherapy services. The routine use of these services is considered screening and is not medically reasonable and necessary for Medicare coverage. However, some individuals enter a nursing home at a time of physical and cognitive decline and may require these services to arrive at a diagnosis, plan of care, and/or treatment. Decisions to perform these services to individuals who have recently entered a nursing home need to be made judiciously, on a case-by-case basis, and the medical record documentation must clearly support the medical necessity for the performance of these services.

The medical record documentation for psychotherapy must be clear and concise. Statements such as "supportive psychotherapy given" are not adequate. A clear and detailed description of what the psychotherapy entailed and how it is addressing the presenting problem of the patient should be evident.

The patient must have the capacity to actively participate in all therapies prescribed, except for family therapy without the patient present.

Physicians/NPP's with a high utilization of these services per patient compared to their peers may be subject to review for medical necessity.

### **Indications (CMS L33632/A56937; L34353)**

*Psychiatry and psychology services* must meet the following criteria:

- **Individualized Treatment Plan.** The plan must state the type, amount, frequency, and duration of the services to be furnished and indicate the diagnoses and anticipated goals. (A plan is not required if only a few brief services will be furnished.)
- **Reasonable Expectation of Improvement.** Services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The treatment must, at a minimum, be designed to reduce or control the patient's psychiatric symptoms so as to prevent relapse or hospitalization, and improve or maintain the patient's level of functioning.

*It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness, although this may be appropriate for some patients. For many other psychiatric patients, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that if treatment services were withdrawn the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion would be met (A56937, 2019).*

*Some patients may undergo a course of treatment which increases their level of functioning, but then reach a point where further significant increase is not expected. When stability can be maintained without further treatment or with less intensive treatment, the psychological services are no longer medically necessary (A56937, 2019).*

- *Frequency and Duration of Services.* There are no specific limits on the length of time that services may be covered. There are many factors that affect the outcome of treatment; among them are the nature of the illness, prior history, the goals of treatment, and the patient's response. As long as the evidence shows that the patient continues to show improvement in accordance with his/her individualized treatment plan, and the frequency of services is within accepted norms of medical practice, coverage may be continued.

When a patient reaches a point in his/her treatment where further improvement does not appear to be indicated and there is no reasonable expectation of improvement, the outpatient psychiatric services are no longer considered reasonable or medically necessary.

Psychiatric diagnostic procedures may be covered once, at the outset of an illness or suspected illness. It may be utilized again for the same patient if a new episode of illness occurs after a hiatus or on admission or readmission to an inpatient status due to complications of the underlying condition. Certain patients, especially children, may require more than one visit for the completion of the initial diagnostic evaluation. The medical record must support the reason for more than one diagnostic interview (A56937, 2019).

Interactive complexity may be reported with psychotherapy when at least one of the following is present:

- Maladaptive communication (e.g., high anxiety, high reactivity, repeated questions or disagreement)
- Emotional or behavioral conditions inhibiting implementation of treatment plan
- Mandated reporting/event exists (e.g., abuse or neglect) or
- Play equipment, devices, interpreter, or translator required due to inadequate language expression or different language spoken between patient and professional.

Interactive complexity may also be used in the evaluation of adult patients with organic mental deficits, or for those who are catatonic or mute.

The duration of a course of psychotherapy must be individualized for each patient. Prolonged treatment may be subject to medical necessity review. The provider must document the medical necessity for prolonged treatment.

The medical record must indicate the time spent in the psychotherapy encounter and the therapeutic maneuvers, such as behavior modification, supportive or interpretive interactions that were applied to produce a therapeutic change. Behavior modification is not a separate service, but is an adjunctive measure in psychotherapy. Additionally, a periodic summary of goals, progress toward goals, and an updated treatment plan must be included in the medical record. Prolonged periods of psychotherapy must be well-supported in the medical record describing the necessity for ongoing treatment (A56937, 2019).

Psychotherapy does not include teaching grooming skills, monitoring activities of daily living (ADL), recreational therapy (dance, art, play) or social interaction.



The medical record must document the indications for psychoanalysis, description of the transference, and the psychoanalytic techniques used. The physician or other healthcare professional using this technique must be trained by an accredited program of psychoanalysis. Psychoanalysis is not time defined, but the service is usually 45 to 50 minutes and is billed once for each daily session (A56937, 2019).

Family psychotherapy services are covered only where the primary purpose of such psychotherapy is the treatment of the patient's condition. Examples include:

- When there is a need to observe and correct, through psychotherapeutic techniques, the patient's interaction with family members.
- Where there is a need to assess the conflicts or impediments within the family, and assist, through psychotherapy, the family members in the management of the patient.

The term "family" may apply to traditional family members, live-in companions, or significant others involved in the care of the patient.

Multiple-family group psychotherapy is generally non-covered by Medicare. Such group therapy is usually directed to the effects of the patient's condition on the family and its purpose is to support the affected family members (L33632, 2019).

Group therapy, since it involves psychotherapy, must be led by a person who is licensed or otherwise authorized by the state in which he or she practices to perform this service. This will usually mean a psychiatrist, psychologist, clinical social worker, clinical nurse specialist, or other person authorized by the state to perform this service. Registered nurses with special training may also be considered eligible for coverage. For Medicare coverage, group therapy does not include: socialization, music therapy, recreational activities, art classes, excursions, sensory stimulation or eating together, cognitive stimulation, or motion therapy, etc.

The medical record should document the medical necessity of narcosynthesis (e.g., the patient had difficulty verbalizing their psychiatric problems without the aid of the drug). The record should also document the specific pharmacological agent, dosage administered, and whether the technique was effective or non-effective (A56937, 2019). Narcosynthesis is restricted to physicians (MD/DO) only (L34353, 2019).

Electroconvulsive Therapy is used primarily to treat major depressive disorder when antidepressant medication is contraindicated and for certain other clinical conditions.

When a psychiatrist performs both the ECT and the associated anesthesia, no separate payment is made for the anesthesia. Code 90870 is limited to use by physicians (MD/DO) only (L34353, 2019).

Hypnosis may be used for diagnostic or therapeutic purposes. Claims must be submitted with a covered diagnosis (A56937, 2019; L34353, 2019).

Individual psychophysiological therapy incorporating biofeedback training by any modality (face to face with patient), with psychotherapy (e.g., insight-oriented, behavior-modifying or supportive psychotherapy) is restricted. Medicare does not cover biofeedback for the treatment of psychosomatic disorders.

Testing when mental illness is not suspected would be a screening procedure not covered by Medicare. Each test performed must be medically necessary. Therefore, standardized batteries of tests are not acceptable unless each test in the battery is medically necessary.

Changes in mental illness may require psychological testing to determine new diagnoses or the need for changes in therapeutic measures. Repeat testing not required for diagnosis or continued treatment would be considered medically unnecessary. Nonspecific behaviors that do not indicate the presence of, or change in, a mental illness would not be an acceptable indication for testing. Psychological or psychiatric evaluations that can be accomplished through the clinical interview alone (e.g., response to medication) would not require psychological testing, and such testing might be considered as medically unnecessary. Adjustment reactions or dysphoria associated with moving to a nursing facility do not constitute medical necessity for psychological testing.

The formal evaluation of aphasia using a psychometric instrument such as the Boston Diagnostic Aphasia Examination is typically performed once during treatment and the medical necessity for such testing should be documented. Repeat testing should only be done if there is a significant change in the patient's aphasic condition (A56937, 2019).

Examples of problems that might lead to neuropsychological testing are:

- Detection of neurologic diseases based on quantitative assessment of neurocognitive abilities (e.g., mild head injury, anoxic injuries, AIDS dementia)
- Differential diagnosis between psychogenic and neurogenic syndromes
- Delineation of the neurocognitive effects of central nervous system disorders
- Neurocognitive monitoring of recovery or progression of central nervous system disorders; or
- Assessment of neurocognitive functions for the formulation of rehabilitation and/or management strategies among individuals with neuropsychiatric disorders.

Typically, psychological testing will require from four (4) to six (6) hours to perform, including administration, scoring and interpretation. Supporting documentation in the medical record must be present to justify greater than 8 hours per patient per evaluation. If the testing is done over several days, the testing time should be combined and reported all on the last date of service. If the testing time exceeds eight (8) hours, medical necessity for extended time should be documented. Medical records may be requested.

Severe and profound intellectual disabilities are never covered for psychotherapy services or psychoanalysis. In such cases, rehabilitative, evaluation and management (E/M) services should be reported.

Patients with dementia represent a very vulnerable population in which co-morbid psychiatric conditions are common. However, for such a patient to benefit from psychotherapy services requires that their dementia be mild (e.g., Mini Mental Status Examination score above 15) and that they retain their capacity to recall the therapeutic encounter from one session, individual or group, to another. This capacity to meaningfully benefit from psychotherapy must be documented in the medical record. Psychotherapy services are not covered when documentation indicates that dementia has produced a severe enough cognitive defect to prevent psychotherapy from being effective.

Any diagnostic or psychotherapeutic procedure rendered by a practitioner not practicing within the scope of his/her licensure or other State authorization will be denied.

The following services do not represent reasonable and necessary outpatient psychiatric services and/or coverage is excluded:

- Day care programs, which provide primarily social, recreational, or diversional activities, custodial or respite care;
- Programs attempting to enhance emotional wellness, e.g., day care programs;
- Services to a skilled nursing facility resident that should be expected to be provided by the nursing facility staff;
- Vocational training when services are related solely to specific employment opportunities, work skills, or work settings;
- Biofeedback training for psychosomatic conditions;
- Recovery meetings such as Alcoholics Anonymous, 12 Step, Al Anon, Narcotics Anonymous, due to their free availability in the community;
- Telephone calls to patients, collateral resources and agencies;
- Evaluation of records, reports, tests, and other data;
- Explanation of results to family, employers, or others;
- Preparation of reports for agencies, courts, schools, or insurance companies, etc. for medicolegal or informational purposes;

- Screening procedures provided routinely to patients without regard to the signs and symptoms of the patient's mental illness;
- Services to hospital inpatients;
- Meals, transportation;
- Supervision or administration of self-administered medications and supplying medications for home use.

Evaluations of the mental status that can be performed within the clinical interview, such as a list of questions concerning symptoms of depression or organic brain syndrome, corresponding to brief questionnaires such as the Folstein Mini Mental Status Examination or the Beck Depression Scale, should not be billed as psychological testing, but are considered included in the clinical interview.

Adjustment reactions or dysphoria associated with moving to a nursing facility do not constitute medical necessity for psychological testing. However, if a more serious mood disorder (e.g., major depression) is suspected upon admission to a nursing facility, psychological or neuropsychological testing may be indicated for differential diagnostic purposes and to develop appropriate treatment planning.

Routine testing of nursing home patients is considered screening and is not covered.

Each psychological test administered must be individually medically necessary. A standard battery of tests is only medically necessary if each individual test in the battery is medically necessary.

#### **Indications (CMS L34539)**

Coverage of services and supplies "incident to" the professional services of a physician in private practice is limited to situations in which there is direct physician supervision of auxiliary personnel.

For psychological services rendered under the "incident to" provision, the billing provider must first evaluate the patient personally and initiate the course of treatment. The appropriately trained therapists may then render psychological services to the patient under the billing provider's direct supervision.

#### **Indications (CMS L34616)**

The following information pertains to both psychiatric diagnostic evaluation; and psychiatric diagnostic evaluation with medical services:

- Cannot be reported with an E/M code on the same day by the same provider
- Cannot be reported with a psychotherapy service code on the same day
- May only be reported once per day
- May be reported more than once for a patient when separate evaluations are conducted with the patient and other informants (i.e., family members, guardians, significant others) on different days. This service is considered medically necessary once every 6 months per episode of illness. \*However, if reported more than once per episode of illness, documentation will be required for the establishment of medical necessity.
- In certain circumstances family members, guardians, or significant others may be seen in lieu of the patient.

Prolonged treatment must be well supported by the content of the medical documentation.

Family psychotherapy services are covered only where the primary purpose of such psychotherapy is the treatment of the patient's condition. Examples include:

- When there is a need to observe and correct, through psychotherapeutic techniques, the patient's interaction with family members and/or
- Where there is a need to assess the conflicts and impediments within the family, and assist, through psychotherapy, the family members in the management of the patient.

Psychotherapy does not include teaching grooming skills, monitoring activities of daily living (ADL), recreational therapy (dance, art, play) or social interaction. It also does not include oversight activities such as housing, or financial management.

Severe and profound mental retardation is never covered for psychotherapy services.

Psychotherapy services are not covered when documentation indicates that senile dementia has produced a severe enough cognitive defect to prevent psychotherapy from being effective.

Multiple-family group psychotherapy is for those situations where family dynamics are occurring due to a commonality of problems in the family members under treatment and would generally be non-covered by Medicare. Such group therapy is directed to the effects of the patient's condition on the family, and does not meet Medicare's standards of being part of the provider personal services to the patient.

Group therapy does not include socialization, music therapy, recreational activities, art classes, excursions, sensory stimulation or eating together, cognitive stimulation, or motion therapy.

Self-help groups or support groups without a qualified professional present are not covered. When covered the group size should be of a size that can be successfully led (e.g., maximum of 12 people).

The medical record must document the indications for psychoanalysis, description of the transference, and the psychoanalytic techniques used. The provider using this technique must be trained by an accredited program of psychoanalysis.

The medical record should document the medical necessity of narcosynthesis (e.g., the patient had difficulty verbalizing his/her psychiatric problems without the aid of the drug). Narcosynthesis is restricted to physicians (M.D., D.O.) only.

Hypnosis is an artificially induced alteration of consciousness in which the patient is in a state of increased suggestibility. To establish medical necessity of the service, claims must be submitted with a covered diagnosis. Hypnosis may be used for diagnostic or therapeutic purposes.

#### **Indications (CMS L35101/A57130)**

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 these codes.

An additional diagnostic evaluation service may be considered reasonable and necessary for the same patient if a new episode of illness occurs, an admission or a readmission to inpatient status due to complications of the underlying condition occurs, or when re-evaluation is required to address a new referral question. Certain patients, especially children and geriatric patients may require more than one visit for the completion of the initial diagnostic evaluation. The indication for the assessment should be based on medical necessity and supported in the medical record.

Interactive procedures may be necessary and considered reasonable and necessary for patients whose ability to communicate is impaired by expressive or receptive language impairment from various causes. These may include conductive or sensorineural hearing loss, deaf mutism, aphasia, language barrier, or lack of mental development (childhood).

Psychological and neuropsychological testing is used when mental illness is suspected, and clarification is essential for the diagnosis and the treatment plan. Testing conducted when no mental illness/disability is suspected would be considered screening and would not be covered by Medicare. Non-specific behaviors that do not suggest the possibility of mental illness or disability are not an acceptable indication for testing. Examples of problems that might require psychological or neuropsychological testing include:

- Assessment of mental functioning for individuals with suspected or known mental disorders for purposes of differential diagnosis or treatment planning.
- Assessment of patient strengths and disabilities for use in treatment planning or management when signs or symptoms of a mental disorder are present.
- Assessment of patient capacity for decision-making when impairment is suspected that would affect patient care or management.
- Differential diagnosis between psychogenic and neurogenic syndromes (e.g., depression versus dementia).
- Detection of neurologic disease based on quantitative assessment of neurocognitive abilities (e.g., mild head injury, anoxic injuries, Acquired Immune Deficiency Syndrome (AIDS) dementia).

- Delineation of the neurocognitive effects of central nervous system disorders.
- Neurocognitive monitoring of recovery or progression of central nervous system disorders.

When a psychiatric condition or the presence of dementia has already been diagnosed, there is value to the testing only if the information derived from the testing would be expected to have significant impact on the understanding and treatment of the patient. Examples include:

- Significant change in the patient's condition.
- The need to evaluate a patient's capacity to function in a given situation or environment.
- The need to specifically tailor therapeutic and or compensatory techniques to particular aspects of the patient's pattern of strengths and disabilities.

Adjustment reactions or dysphoria associated with moving to a nursing home do not automatically constitute medical necessity for testing. Testing of every patient upon entry to a nursing home would be considered a routine service and would not be covered by Medicare. However, some individuals enter a nursing home at a time of physical and cognitive decline, and may require psychological testing to arrive at a diagnosis and plan of care. Decisions to test individuals who have recently entered a nursing home need to be made judiciously, on a case-by-case basis. Medical necessity of such evaluations should be documented and maintained in the medical record.

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

Depending on the issues to be assessed, a typical test battery may require 7 to 10 hours to perform, including administration, scoring and interpretation.

A formal evaluation of aphasia with an instrument such as the Boston Diagnostic Aphasia Examination 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.

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

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

Psychotherapy will be considered medically necessary when the patient has a psychiatric illness or is demonstrating emotional or behavioral symptoms sufficient to cause inappropriate behavior or maladaptive functioning.

Psychotherapy services must be comprised of clinically recognized therapies that are pertinent to the patient's illness or condition. The type, frequency and duration of services must be medically necessary for the patient's condition under accepted practice standards.

There must be a reasonable expectation of improvement in the patient's disorder or condition, demonstrated by an improved level of functioning, or maintenance of level of functioning where decline would otherwise be expected in the case of a disabling mental illness or condition, or chronic mental disorders.

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

To benefit from psychotherapy, an individual must be cognitively intact to the degree that he/she can engage in a meaningful verbal interaction with the therapist.

For patients suffering from dementia, the type and degree of dementia must be taken into account in planning and evaluating effective psychotherapeutic interventions. If psychotherapy is provided to a patient with dementia, the patient's record should support that the patient's cognitive level of functioning was sufficient to permit the patient to participate meaningfully in the treatment.

The duration of psychotherapy must be individualized for every patient. The provider of service must document in the patient's record the medical necessity for continued (prolonged) treatments.

Group therapy is defined as psychotherapy administered in a group setting with a trained group leader in charge of several patients. The group should not exceed 10 participants and the sessions should be at least 45 to 60 minutes in duration. While a video or movie may be used as an adjunct to the sessions, this modality should not be used as a replacement for the therapist's active participation and the majority of the session should involve the interaction between the participants and the therapist leading the session. If group psychotherapy is provided to a patient with dementia, the patient's record should document that the patient's cognitive level of functioning was sufficient to permit the patient to participate meaningfully in the treatment.

Psychotherapy services are not considered reasonable and necessary when documentation indicates that dementia has produced a severe enough cognitive defect to prevent establishment of a relationship with the therapist, which allows insight-oriented, behavior-modifying or supportive therapy to be effective.

Psychotherapy services are never covered for severe and profound mental retardation. Severe mental retardation is defined as an IQ 20-34 and profound mental retardation is defined as an IQ under 20.

Psychotherapy codes should not be used when an E/M code would be more appropriate (A57130, 2019).

Psychotherapy services are not considered reasonable and necessary when they primarily include teaching grooming skills, monitoring activities of daily living, recreational therapy (dance, art, play) or social interaction.

Family therapy will be considered medically reasonable and necessary only for treatment of the Medicare beneficiary's mental illness and not the family member's problems. Family therapy is appropriate when intervention in the family interactions would be expected to improve or stabilize the patient's emotional/behavioral disturbance. Family therapy is commonly the major treatment, especially for children and for the elderly. Where both husband and wife are covered by Medicare, such therapy may be the most effective treatment for both individuals.

Family psychotherapy without the patient present does not represent routine consultation with staff about the patient's progress and treatment. Facility staff members are not considered caregivers for purposes of this policy; however, caretakers in group-living facilities may be considered caregivers for the purpose of this policy.

Family therapy sessions with a patient whose emotional disturbance would be unaffected by changes in the patterns of family interaction (i.e., a comatose patient) would not be considered reasonable and necessary. Similarly, an emotional disturbance in a family member, which does not impact on the Medicare patient's status, would not be covered by that patient's Medicare benefits.

Narcosynthesis is indicated for patients who have difficulty verbalizing psychiatric problems without the aid of the drug.

## CLINICAL BEST PRACTICES

A psychiatric diagnostic evaluation is an integrated biopsychosocial assessment that includes the elicitation of a complete medical history (to include past, family, and social), psychiatric history, a complete mental status exam, establishment of a tentative diagnosis, and an evaluation of the patient's ability and willingness to participate in the proposed treatment plan. Information must be obtained from the patient, other physicians, other clinicians or community providers, and/or family members or other sources. There may be overlapping of the medical and psychiatric history depending on the problem(s). Although the emphasis, types of details, and style of a psychiatric evaluation differ from the medical evaluation, the purpose is the same: to establish effective communication with interaction of sufficient quality between provider and patient to gather accurate data in order to formulate tentative diagnoses, determine necessity, and as appropriate, initiate an effective and comprehensive treatment plan (L33252, 2019).

A psychiatric diagnostic evaluation with medical services is an integrated biopsychosocial and medical assessment, including history (to include past, family, and social), psychiatric history, a complete mental status exam, other physical examination elements as indicated, establishment of a tentative diagnosis, and an evaluation of the patient's ability and willingness to participate in the proposed treatment plan. The evaluation may include communication with family members or other sources, prescription of medications, and review and ordering of laboratory or other diagnostic studies (L33252, 2019).

The medical record for psychiatric diagnostic evaluation with or without medical assessment should indicate the presence of a psychiatric illness and/or the demonstration of emotional or behavioral symptoms which may be suggestive of a psychiatric illness or are sufficient to significantly alter baseline functioning. The diagnostic evaluation should include (L33252, 2019):

- The reason for the evaluation/patient's chief complaint
- A referral source (if applicable)
- History of present illness, including length of existence of problems/symptoms/conditions
- Past history (psychiatric)
- Significant medical history and current medications
- Social history
- Family history
- Mental status exam
- Strengths/liabilities
- Multi-axis diagnosis or diagnostic impression list-including problem list
- Treatment plan (including methods of therapy, anticipated length of treatment to the extent possible, and a description of the planned measurable and objective goals related to expected changes in behavior or thought processes)

Psychiatric diagnostic procedure codes require the elicitation of a complete medical (including past, family, social) and psychiatric history, a mental status examination, establishment of an initial diagnosis, an evaluation of the patient's ability and capacity to respond to treatment, and an initial plan of treatment. Information may be obtained from not only the patient, but also other physicians, healthcare providers, and/or family if the patient is unable to provide a complete history (L33632, 2019).

A psychiatric diagnostic evaluation is an integrated assessment that includes history, mental status, and recommendations. It may include communicating with the family and ordering further diagnostic studies. A psychiatric diagnostic evaluation with medical services includes a psychiatric diagnostic evaluation and a medical assessment. It may require a physical exam, communication with the family, prescription medications and ordering laboratory and other diagnostic studies. A psychiatric diagnostic evaluation with medical services also includes physical examination results (L34616, 2019).

Psychotherapy is the treatment of mental illness and behavior disturbances, in which the provider establishes a professional contact with the patient and through therapeutic communication and techniques, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, facilitate coping mechanisms and/or encourage personality growth and development. Insight oriented, behavior modifying, and/or supportive psychotherapy refers to the development of insight or affective understanding, the use of behavior modification techniques, the use of supportive interactions, and the use of cognitive discussion of reality, or any combination of the above to provide therapeutic change (L33252, 2019; L34616, 2019).

Psychotherapy is the treatment for mental illness and behavioral disturbances in which the physician or other qualified health care professional through definitive therapeutic communication attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage personality growth and development (L33632, 2019).

Group Psychotherapy is a form of treatment administered in a group setting with a trained group leader in charge of several patients. Since it involves psychotherapy it must be led by a person, authorized by state statute to perform this service. This will usually mean a psychiatrist, clinical psychologist, licensed clinical social worker, certified nurse practitioner, or clinical nurse specialist. The group is a carefully selected group of patients meeting for a prescribed period of time during which common issues are presented and generally relate to and evolve towards a therapeutic goal. Personal and group dynamics are discussed and explored in a therapeutic setting allowing emotional outpouring, instruction, and support. Medical diagnostic evaluation and pharmacological management may continue by a physician when indicated. The group size should be of a size that can be considered therapeutically successful (i.e., maximum 12 people) (L33252, 2019).

Group Psychotherapy is psychotherapy administered in a group setting with a trained therapist simultaneously providing therapy to several patients. Personal and group dynamics are discussed and explored in a therapeutic setting allowing emotional catharsis, instruction, insight and support (L34616, 2019).

Family Psychotherapy is a specialized therapeutic technique for treating the identified patients' mental illness by intervening in a family system in such a way as to modify the family structure, dynamics, and interactions which exert influence on the patient's emotions and behaviors (L33252, 2019).

Family psychotherapy sessions may occur with or without the patient present. The process of family psychotherapy helps reveal a family's repetitious communication patterns that are sustaining and reflecting the identified patient's behavior. For the purposes of this policy, a family member is any individual who spends a significant amount of the time with the patient and provides psychological support to the patient, which may include but is not limited to a caregiver or significant other (L33252, 2019).

Psychoanalysis is a treatment modality that uses psychoanalytic theories as the frame for formulation and understanding of the therapy process. These theories provide a focus on increasing self-understanding and deepening insight into emotional issues and conflicts which underlie presenting emotional difficulties. Typically, therapists make use of exploration of unconscious thoughts and feelings which may relate to underlying emotional conflicts, interpretation of defensive processes which obstruct emotional awareness, and consideration of issues related to sense of self-esteem (L33252, 2019).

Psychoanalysis uses a special technique to gain insight into a patient's unconscious motivations and conflicts using the development and resolution of a therapeutic transference to achieve therapeutic effect. It is a different therapeutic modality than psychotherapy (L33252, 2019; L34616, 2019).

Interactive complexity refers to specific communication factors that complicate the delivery of a psychiatric procedure. Common factors include more difficult communication with discordant or emotional family members and engagement of young and verbally undeveloped or impaired patients (L33252, 2019).

The interactive complexity techniques are utilized primarily to evaluate children and/or adults who do not have the ability to interact through ordinary verbal communication. In the aforementioned instances, it involves the use of physical aids and nonverbal communication to overcome barriers to the therapeutic interaction between the clinician and the patient who has not yet developed or has lost either the expressive language communication skills to explain his/her symptoms and response to treatment or the receptive communication skills to understand the clinician if he/she were to use ordinary adult language for communication. An interactive technique may include the use of inanimate objects such as toys and dolls for a child, physical aids, and non-verbal communication to overcome barriers to therapeutic interaction, or an interpreter for a person who is deaf or in situations where the patient does not speak the same language as the provider of care (L33252, 2019).



Interactive complexity refers to specific communication factors that complicate the delivery of a psychiatric procedure. Common factors include more difficult communication with discordant or emotional family members and engagement of young and verbally undeveloped or impaired patients. Interactive complexity is used principally to evaluate children and also adults who do not have the ability to interact through ordinary verbal communication. The healthcare provider uses inanimate objects, such as toys and dolls for a child, physical aids and non-verbal communication to overcome barriers to therapeutic interaction, or an interpreter for a person who is deaf or one who does not speak the same language as the healthcare provider. Interactive complexity may also be used in the evaluation of adult patients with organic mental deficits, or for those who are catatonic or mute (L33632, 2019).

Interactive complexity refers to communication difficulties during the psychiatric procedure. The medical record for interactive complexity reported with the psychiatric procedures must indicate that the person being evaluated does not have the ability to interact through normal verbal communicative channels, include adaptations utilized in the session and the rationale for employing these interactive techniques, and recommendations for future care. (L34616, 2019).

Psychotherapy for crisis is an urgent assessment and history of a crisis state, a mental status exam, and a disposition. The treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma. The presenting problem is typically life threatening or complex and requires immediate attention to a patient with high distress (L33252, 2019; L33632, 2019).

Narcosynthesis is 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 (L33632, 2019; L34616, 2019).

Electroconvulsive therapy (ECT), is the application of electric current to the brain, through scalp electrodes to produce a seizure (L33632, 2019). ECT) is used in the treatment of depression and related disorders and other severe psychiatric conditions. When a psychiatrist administers the anesthesia for an ECT procedure, the anesthesia service is considered part of the ECT procedure (L35101, 2019).

Psychological testing includes the administration, interpretation, and scoring of tests for evaluation of intellectual strengths, psychopathology, psychodynamics, mental health risks, insight, motivation, and other factors influencing treatment and prognosis (L33632, 2019).

Neuropsychological testing is intended to diagnose and characterize the neurocognitive effects of medical disorders that impinge directly or indirectly on the brain. The content of neuropsychological testing procedures differs from that of psychological testing in that neuropsychological testing consists primarily of individually administered ability tests that comprehensively sample cognitive and performance domains that are known to be sensitive to the functional integrity of the brain (e.g., abstraction, memory and learning, attention, language, problem solving, sensorimotor functions, constructional praxis, etc.). These procedures are objective and quantitative in nature and require the patient to directly demonstrate his/her level of competence in a particular cognitive domain. Neuropsychological testing does not rely on self-report questionnaires such as the Minnesota Multiphasic Personality Inventory 2 (MMPI-2), rating scales such as the Hamilton Depression Rating Scale, or projective techniques such as the Rorschach or Thematic Apperception Test (TAT) when questions of how brain damage or degenerative disease processes (e.g. right hemisphere CVA) may be affecting emotional expression or how significant emotional distress or mood impairment might be affecting cognitive function (e.g. question of presence of "pseudodementia") arise (L33632, 2019).

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#### HISTORY/REVISION INFORMATION

Date	Action/Description
April, 2014	• Version 1
August, 2015	• Version 2
September, 2016	• Version 3
April, 2017	• Version 4
January, 2018	• Version 5
May, 2019	• Version 6
August, 2019	• Updates per CMS LCDs and to clarify Part A and Part B services
October, 2019	• Updates to add LCD titles to page 1
July, 2020	• Version 7; Annual Review and Update