

Draft LCD for Psychological Services under the Incident to Provision (DL30715)

Draft

Please note: This is a Draft policy.

Draft LCDs are works in progress that are available on the Medicare Coverage Database site for public review. Draft LCDs are not necessarily a reflection of the current policies or practices of the contractor.

Future

Please note: This is a Future Draft LCD.

Contractor Information

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Contractor Name

Wisconsin Physicians Service Insurance Corporation

Contractor Number

00951, 00952, 00953, 00954, 05102, 05202, 05302, 05402

Contractor Type

Carrier, MAC B

LCD Information

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LCD ID Number

DL30715

LCD Title

Psychological Services under the Incident to Provision

Contractor's Determination Number

PSYCH-013

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CMS National Coverage Policy

Title XVIII of the Social Security Act section 1862 (a)(1)(A). This section allows coverage and payment of those services that are considered to be medically reasonable and necessary.

Title XVIII of the Social Security Act section 1862 (a)(7). This section excludes routine physical examinations and services

Title XVIII of the Social Security Act section 1833 (e). This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Title XVIII of the Social Security Act, Section 1833(e). This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Primary Geographic Jurisdiction**Oversight Region**

Region V

Projected Determination Effective Date

For services performed on or after 04/03/2010

Original Determination Ending Date**Revision Effective Date****Revision Ending Date****Indications and Limitations of Coverage and/or Medical Necessity**

Indications and Limitations of Coverage and/or Medical Necessity

The “incident to” provision also applies to coverage for psychological services furnished “incident to” the professional services of non-physician practitioners listed in this policy.

The training requirements and state licensure or authorization of individuals who perform psychological services are intended to ensure an adequate level of expertise in the cognitive skills required for the performance of diagnostic and therapeutic psychological services. Therefore, only the types of individuals listed later in this policy are considered qualified to perform medically necessary psychological services addressed in this policy. Delegation of diagnostic and therapeutic psychological services to personnel not performing within the scope of practice as authorized by state law, under the “incident to” provision, would bypass the safeguards afforded by professional credentialing and state licensure requirements. Such delegated services under the “incident to” provision would be inappropriate, unreasonable, and medically unnecessary, and therefore not covered by Medicare.

A. Only the following types of individuals, when they are performing within their scope of clinical practice as authorized under State law, are qualified to perform the indicated diagnostic and/or therapeutic psychological services under the “incident to” provision:

Doctorate or Masters level Psychologists: 90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90845, 90846, 90847, 90849, 90853, 90857, 90880, 90899

Doctorate or Masters level Social Workers: 90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90846, 90847, 90849, 90853, 90857, 90899

Clinical Nurse Specialists (CNSs)/Nurse Practitioner: 90801, 90802, 90804 -90815, 90846, 90847, 90849, 90853, 90857, 90880, 90899, (90862, if authorized by the state to prescribe medication)

Masters level Licensed Marriage and Family Therapist: 90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90846, 90847, 90849, 90853, 90857, 90899

Licensed Clinical Professional Counselors (LCPCs): 90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90846, 90847, 90849, 90853, 90857, 90899

PLEASE NOTE:: Doctorate or Masters level Psychologists, Doctorate or Masters level Social Workers, Clinical Nurse Specialists (CNSs), Nurse Practitioner, Masters level Licensed Marriage, Family Therapist and Licensed Clinical Professional Counselors (LCPCs), must meet both the educational and licensing criteria listed in section A and the provisions listed in sections B. and C.

B. Psychological services referenced in the above HCPCS codes may be delegated only to employees who qualify as one of the categories of individuals listed above. For example, a psychiatrist may hire a social worker to perform services “incident to,” but the services the social worker may perform must be limited to the services designated by the HCPCS codes listed above. Individuals who are performing services “incident to” a qualified Medicare practitioner are not required to be separately enrolled as an independent practitioner in Medicare. Also, it is not possible for the billing provider to hire and supervise a professional whose scope of practice is outside the provider’s own scope of practice as authorized under State law, or whose professional qualifications exceed those of the “supervising” provider. For example, a certified nurse midwife (CNMW) may not hire a psychologist and bill for that psychologists' services under the “incident to” provision, because a psychologist’s services are not integral to a CNMW personal professional services and are not regularly included in the CNMW’s bill. Even though sections 1861(s)(2)(L) and 1861(gg) of the Social Security Act authorize coverage for services furnished “incident to” a CNMW’s services, psychological services are not commonly furnished in CNMW’s offices nor within their scope of practice. Similarly even though section 1861(s)(2)(K)(iv) authorizes coverage for services furnished “incident to” a physician assistant’s services, a physician assistant would not be qualified to supervise psychological services performed by the types of individuals listed above.

C. Individuals who are not licensed or otherwise authorized by state law to provide psychological services may not provide psychological services under the “incident to” provision. This level of professional credentialing is necessary to appropriately furnish medically necessary services under the “incident to” provision. Psychological services furnished to Medicare beneficiaries under the “incident to” provision by individuals other than those listed above is not covered. (Note: the standards for professional credentialing are higher for these services billed to Medicare Part B than for similar services performed by other mental health professionals not under the “incident to” provision and billed to Medicare Part A. Under the “incident to” provision, services are performed in the place of the billing provider. In order for services performed and billed under the “incident to” provision to be commensurate with the services performed by the billing provider, and therefore medically necessary, this higher standard of professional credentialing is necessary.)

D. Medicare does not pay for routine screening tests. ICD-9-CM code V82.9 (special screening of other conditions, unspecified condition) should be used to indicate screening tests performed in the absence of a specific sign, symptom or complaint. Use of V82.9 will result in the denial of claims as non-covered screening services.

Coding Information



Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

CPT/HCPCS Codes

PSYCHIATRIC DIAGNOSTIC INTERVIEW
EXAMINATION

90802

INTERACTIVE PSYCHIATRIC DIAGNOSTIC
INTERVIEW EXAMINATION USING PLAY
EQUIPMENT, PHYSICAL DEVICES,
LANGUAGE INTERPRETER, OR OTHER
MECHANISMS OF COMMUNICATION

90804 - 90815

INDIVIDUAL PSYCHOTHERAPY, INSIGHT
ORIENTED, BEHAVIOR MODIFYING AND/OR
SUPPORTIVE, IN AN OFFICE OR OUTPATIENT
FACILITY, APPROXIMATELY 20 TO 30
MINUTES FACE-TO-FACE WITH THE PATIENT;
- INDIVIDUAL PSYCHOTHERAPY,
INTERACTIVE, USING PLAY EQUIPMENT,
PHYSICAL DEVICES, LANGUAGE
INTERPRETER, OR OTHER MECHANISMS OF
NON-VERBAL COMMUNICATION, IN AN
OFFICE OR OUTPATIENT FACILITY,
APPROXIMATELY 75 TO 80 MINUTES FACE-
TO-FACE WITH THE PATIENT; WITH MEDICAL
EVALUATION AND MANAGEMENT SERVICES

90845 - 90857

PSYCHOANALYSIS - INTERACTIVE GROUP
PSYCHOTHERAPY

90862

PHARMACOLOGIC MANAGEMENT,
INCLUDING PRESCRIPTION, USE, AND
REVIEW OF MEDICATION WITH NO MORE
THAN MINIMAL MEDICAL PSYCHOTHERAPY

90880

HYPNOTHERAPY

ICD-9 Codes that Support Medical Necessity

Mental, psychoneurotic and personality disorders

Note: ICD-9 codes must be coded to the highest level of specificity.

XX000

Not Applicable

Diagnoses that Support Medical Necessity

Diagnosis that Supports Medical Necessity

Mental, psychoneurotic and personality disorders.

ICD-9 Codes that DO NOT Support Medical Necessity

V70.1

GENERAL PSYCHIATRIC EXAMINATION
REQUESTED BY THE AUTHORITY

V70.2

GENERAL PSYCHIATRIC EXAMINATION
OTHER AND UNSPECIFIED

| | |
|-------|--|
| V79.0 | SCREENING FOR DEPRESSION |
| V79.1 | SCREENING FOR ALCOHOLISM |
| V79.2 | SCREENING FOR MENTAL RETARDATION |
| V79.3 | SCREENING FOR DEVELOPMENTAL HANDICAPS IN EARLY CHILDHOOD |
| V79.8 | SCREENING FOR OTHER SPECIFIED MENTAL DISORDERS AND DEVELOPMENTAL HANDICAPS |
| V79.9 | SCREENING FOR UNSPECIFIED MENTAL DISORDER AND DEVELOPMENTAL HANDICAP |
| V82.9 | SCREENING FOR UNSPECIFIED CONDITION |

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation

Diagnoses that DO NOT Support Medical Necessity

Any diagnosis that would indicate the service is performed for screening purposes.

General Information



Documentation Requirements

Documentation supporting the medical necessity of this item, such as ICD-9 codes, must be submitted with each claim. Claims submitted without such evidence will be denied as being not medically necessary.

In addition to ordinary standards of good clinical documentation, the legible identity of the individual rendering the service with his/her professional credentials and date of service must be included in the documentation of each service and available in the medical record.

Documentation must be submitted to Medicare upon request.

Appendices

Utilization Guidelines

NA

Sources of Information and Basis for Decision

Carrier Medical Directors,
Consultants
Medicare Benefit Policy Manual

This policy does not reflect the sole opinion of the contractor or the Contractor Medical Director(s). Although the final decision rests with the contractor, this policy was developed in cooperation with the Carrier Advisory Committee(s), which include representatives of various medical specialty societies.

* - An asterisk indicates a revision to that section of the policy.

Advisory Committee Meeting Notes

Wisconsin: 2/13/2010
Illinois: 1/13/2010
Michigan: 1/27/2010
Minnesota: 1/14/2010
J-5 MAC
(IA,KS, MO, NE) 2/19/2010

Start Date of Comment Period

02/19/2010

End Date of Comment Period

04/05/2010

Start Date of Notice Period**Revision History Number****Revision History Explanation****Reason for Change****Last Reviewed On Date**

11/20/2009

Related Documents

This LCD has no Related Documents.

LCD Attachments

Coding and Billing Guidelines (PDF - 41,213 bytes)

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All Versions



Updated on 12/11/2009 with effective dates 04/03/2010 - N/A