Comments LCD Psychiatry and Psychology Services PSYCH-014

Comment:
One page 3 under the description of 90801, there is the phrase..."an evaluation of the patient's ability and capacity to respond to treatment on an initial plan of treatment." Our group feels that this statement applies to patients who are going to be seen for psychotherapy and it would make sense that those individuals would have the cognitive capacity to participate in therapy.

CPT code 90801, however, is used as the initial evaluation for a broader array of patients, even for those who will be receiving only medication management at future appointments. This could include people who have dementia or mental retardation as well as many individuals who do have the capacity to benefit from psychotherapy but that won't be the focus of their visits with the psychiatrist. In those cases it doesn't seem any more relevant to explicitly address their capacity than it would be for the internist to make mention of his/her patient's ability and capacity to respond to treatment with an antihypertensive agent. We would like to have the wording changed to "an evaluation...........treatment on an initial plan of treatment for those patient's who will be receiving subsequent psychotherapy".

Response:
The LCD states: "CPT code 90801 is described as the elicitation of a complete medical (including past, family, social) and psychiatric history, a mental status examination, establishment of an tentative initial diagnosis <u>for those patient's who will be receiving subsequent psychotherapy</u>, and an evaluation of the patient's ability and capacity to respond to treatment on an initial plan of treatment. Information may be obtained from the patient, healthcare providers, and/or family. There may be an overlapping of the medical and psychiatric history(s) depending on the problem."

Comment:
Page 4 on the table for interactive codes that support medical necessity. Our group wonders why only moderate MR and not mild or severe are listed. A related question has to do with the reimbursement for interactive codes. Some of our members would work with more Medicare recipients who require an ASL interpreter if the reimbursement were better. Medicare reimbursement doesn't adequately cover the cost of having the interpreter present and it is an expense the office can't adequately absorb with any regularity.

Response:
Mild mental retardation would need another mental health diagnosis. As the LCD states: "Severe and profound mental retardation is never covered for psychotherapy services. In such cases, rehabilitative, evaluation and management (E/M) CPT codes, or pharmacological management codes should be reported. The mental retardation ICD-9 codes are: 318.1 (Severe mental retardation) and 318.2 (Profound mental retardation)."
The capacity to meaningfully benefit from psychotherapy must be documented in the medical record. Psychotherapy services are not covered when documentation indicates that the beneficiary has a severe enough cognitive defect to prevent psychotherapy from being effective.

Comment:
The LCD states:
"For psychotherapy sessions lasting longer than 90 minutes, reimbursement will only be made if the report is supported by the medical record documenting the face-to-face time spent with the patient and the medical necessity for the extended time.

Time submitted for the viewing of films or other activities that are not face-to-face psychotherapy are not considered a provider service and are not separately payable. To establish medical necessity of the service, claims must be submitted with a covered diagnosis."

Our question specifically relates to the issue of only face-to-face services being covered. In some cases, especially involving very complex patients with extensive histories and difficult to diagnose and treat conditions, a psychiatrist may spend extensive time reviewing records. On some occasions this can take hours. Some of our members, particularly those who are sub specialized, must review these records in order to provide the needed level of service, but there is a limit to how much any one person can do on a complimentary basis. We would request that a CPT code be available and covered by WPS (even if it is only a one time code per member) to reimburse for this important service.

Response:
Medicare uses the CPT codes and definitions of code from the American Medical Association. The American Medical Association (AMA) owns and creates all CPT codes. Requests for additions or changes to these definitions and restrictions must be submitted to the AMA since CPT codes are their proprietary property.

Comment:
CPT codes 90846, 90847 and 90849-Family Psychotherapy. Are these codes to be used for both descriptions given in paragraph 1 and 2, i.e. the code can be used to gather background information and to treat the family unit's maladaptive behaviors that may be exacerbating the beneficiary's mental illness.

Response:
As the LCD states:
CPT codes 90846, 90847, 90849 are used to describe medically necessary treatment of the family unit when maladaptive behaviors of family members are exacerbating the beneficiary's mental illness in the treatment process of the patient.

CPT code 90846 is used when the patient is not present. CPT code 90847 is used when the patient is present. CPT code 90849 is intended for group therapy sessions for multiple families when similar dynamics are occurring due to a commonality of problems in the family members under treatment.

Comment:
Page 14 which includes the ICD-9 codes that support medical necessity. Narcolepsy and insomnia are the only two sleep disorders listed. We would request that the following additional sleep related disorders be added -sleepwalking, sleep terrors, bruxism, RLS, PLMS, nightmare disorder, REM sleep behavior disorders, obstructive sleep apnea, idiopathic hypersomnia and circadian rhythm sleep disorder. In addition we would ask that the diagnosis Intermittent Explosive Disorder be added (312.34).

Response:
You are correct. Sleep disorders are not psychiatric diagnosis's. However, since narcolepsy and insomnia were already in the previous LCD they will remain. Providers should use the psychiatric diagnosis that is causing them to see the patient.
The diagnosis Intermittent Explosive Disorder will be added (312.34).

Comment:
Coding and Billing Guidelines for PSYCH-014. Under III. Billing Guidelines letter C. "In the infrequent event that a patient has a separate and distinct individual psychotherapy and group therapy session in one day, modifier -59 should be appended to the CPT code....." There is a form of therapy called Dialectical Behavior Therapy used mostly for individuals with borderline personality disorder (a complex and difficult to treat disorder) wherein the therapy involves both weekly individual and weekly group therapy. Especially in more rural areas of the state, some patients must drive 60 or more miles to a facility which offers this important service. Sometimes it is cost and time prohibitive to travel that distance twice per week. Most clinics however are reluctant to provide the service on the same day because of reimbursement issues. While III C. seems to allow for it, it also suggests that it shouldn't be used much. However, when the program inherently involves both individual and group within a week's time, what difference does it make if they are offered on the same day (unless the psychotherapist feels it is contraindicated because it would be too much in one day)? Another scenario arises wherein the intention was for the group and the individual to occur on different days, but something happens in the group setting which necessitates an individual therapy session that same day. Our group would like to be reassured that billing could occur in these scenarios on the same day and both services would be fully reimbursed.

Response:
The LCD already states that "if a a patient has a separate and distinct individual psychotherapy and group therapy session in one day, modifier -59 should be appended to the CPT code**.**" The word will not be removed.

Comment:
The following are editorial comments on PSYCH-014-Page 10 under 96125 there is a typo (eg, ross) should be gross?

Response
No, the CPT code definition is (Ross Information Processing Assessment) not gross.

Comment:
Page 11 the second paragraph under Comments: there is a noun/verb disagreement "Self-administration or self-scored inventories such as.............(or similar test) is (should be are).

Response:
The policy now reads
Self-administration or self-scored inventories such as the Holmes and Rahe Social Readjustment Rating Scale or screening tests of cognitive function such as the Folstein Mini-Mental Exam (or similar test) is not separately reimbursable by Medicare and is included in the clinical interview or E/M service.