Billing Guide/Aid

For Psychologists and Other Qualified Mental and Behavioral Health Practitioners

Notice and Disclaimer
The information contained in this document is intended to provide helpful and applicable information pertaining to the appropriate Current Procedural Terminology (CPT®) codes to use for billing purposes for the mental health practitioner. The billing code selected should both reflect the services provided and result in maximum reimbursement. CPT is published and copyrighted by the American Medical Association (AMA). No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for any data contained herein.

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Steps to Correct Coding and Billing
Healthcare practitioners who seek reimbursement for mental health services or use of our tests should follow the direction of billing and coding experts familiar with the policies of the third-party payer liable for reimbursement. It is the healthcare practitioner’s responsibility to document the medical necessity of any services rendered. There are
some key steps in completing an accurate claim form, whether the claim is filed via paper and pencil, or electronically. These steps are:

- Ensure the medical necessity of the service being provided.
- Use the correct diagnostic or therapeutic code.
- Select the right billing code to describe the service.
- Determine the correct units to bill based on time incurred/service provided.
- Clearly document all relevant information concerning the client, diagnosis, therapy provided, etc., within practitioner records.
- Resolve all coding and billing questions with third-party payers prior to claims submission.
- Submit all required information via paper or electronic claim forms.

Although determining and documenting all of the information necessary to submit a claim form is extensive, it also delivers excellent client/customer service, and is part of good business practices.

**General Patient Record Documentation Suggestions**

At a minimum, it is suggested that providing psychotherapy, diagnostic evaluations or assessments, or using psychological testing should be documented to include the following information, including time documentation where appropriate.

- Patient was in the office or at another facility (location of services).
- Medical necessity of test described or reason for further diagnosis. Medical necessity may also be established if a referring physician states suspicion of mental illness, saying, for example “the patient appears to be depressed, please evaluate.” In the case of a health and behavior assessment, the underlying medical condition that is linked to the particular mental health current status should be included.
- Patient exhibited symptoms that resulted in a suspicion of mental illness (e.g., anxiety, depression, somatization, nonspecific pain, loss of function), or in the case of a health and behavior assessment, provide descriptions of the physical ailments, as well as mental health complications resulting from such physical illnesses.
- Documentation of any physical condition that exists.
- Appropriate test selected, if used.
- Individual (or position title of individual) who administered the test.
- Length of time spent on face-to-face administration and interpretation and reporting the test (if modifier is used, include explanation for reduced services).
- Scoring of test (e.g., method used, time spent, etc.).
- Interpretation of test (if by computer, with summary by physician to be added).
- Time spent integrating the test interpretation and writing the comprehensive report based on the integrated data. Summarize tasks, which might include the practitioner’s interpretation of a test’s overall pattern of scores and the report in the context of:
  - Observed behavior symptoms
  - Purpose of evaluation
  - Legal context
  - Primary, secondary, or tertiary gain
• Medical diagnosis
• Medical history
• Behavioral history
• Social setting (work situation, living environment, social network)
• IQ and literacy
• Ethnicity and gender
• Clinical impressions
• Results of other psychological and/or medical tests
• Any known effects of prescribed or illegal drugs

• Treatment, including, if applicable, how test results could affect the prescribed treatment.
• Follow-up administration of test to measure efficacy of procedure.
• Outcomes.
• Recommendation for further testing.

Summary Description of Diagnostic International Classification of Diseases - 9th Revision, Clinical Modification (ICD-9-CM) and Procedure Billing Codes

Medicare Part B, as well as many private insurers, provides benefits for psychiatric services that are medically necessary for the diagnosis or treatment of an illness or injury. Medicare is a program run by the federal government under the umbrella of CMS. In addition, CMS works with states to run the Medicaid program. Coding and billing has evolved over the years, and in many respects, CMS now sets the “standards” in terms of correct coding for reimbursement purposes, although individual health insurance entities may occasionally deviate from Medicare practices. Physicians, psychiatrists, clinical psychologists, clinical social workers, clinical nurse specialists, nurse practitioners, and physician’s assistants are recognized by Medicare B to provide diagnostic and therapeutic treatment for mental, psychoneurotic, and personality disorders. Independent psychologists/non-clinical psychologists are recognized by Medicare Part B for diagnostic services only. Definitions of authorized mental healthcare providers (as defined by CMS) may be found at https://www.cms.gov/ContractorLearningResources/downloads/JA1013.pdf. Coverage is limited to those services that the mental health professional is legally authorized to perform under state law (or the state regulatory mechanism provided by state law) of the state in which such services are performed for the diagnosis and treatment of mental illnesses. Clinical psychologists may provide therapeutic and diagnostic services, while independent psychologists may only provide diagnostic services. Billing requires the use of both diagnostic codes, as well as procedure codes, which are further described below.

Diagnostic Codes

When psychologists and other health care practitioners bill Medicare (or other third-party payers), they must use appropriate diagnostic and procedure codes on the claim form. The claim form is known as the Uniform Claim Form (UCF)-1500 (also called the CMS-1500 or HCFA-1500). Information on the form and how to complete it can be found at http://www.cms.gov/Transmittals/downloads/R1058CP.pdf. (The 1500 claim form is used for outpatient services, while form UB-04 is used for inpatient services.) Claims may also be filed electronically; a Web site providing information pertaining to electronic filing can be found at http://www.wpc-edi.com. An additional helpful Web site for information about CMS-1500 and a crosswalk to the electronic form can be found at http://www.cms.gov/MLNProducts/downloads/form_cms-1500_fact_sheet.pdf. The diagnostic code represents the reason why the patient is seeking services from the
qualified provider (i.e., depression), while the procedure code represents the service being provided (i.e., psychotherapy). For purposes of Medicare payment, practitioners must use a diagnostic code from the ICD-9. Conveniently, nearly all mental health ICD-9 codes crosswalk exactly to the *Diagnostic and Statistical Manual of Mental Disorders, 4th Ed.* (DSM-IV) diagnoses, and many psychologists, knowingly or not, list the DSM-IV diagnoses on their claim form. Use of a current version of the ICD-9 coding manual will ensure that there is no question about using the proper diagnostic code.

**CPT Codes**
CPT codes are used to represent services provided by psychologists and other healthcare professionals. For example, if a psychologist were to provide a 45-50 minute “insight-oriented” individual psychotherapy session in their private practice office, the CPT code for that service would be 90806. This code is put on the CMS 1500 claim form and tells the carrier or CMS (Medicare, Medicaid, or another third-party payer) what service was provided. The AMA, copyright holders for the CPT coding system, does not specifically restrict usage of certain codes; however, coverage of certain CPT codes is often restricted by insurance entities and by interpretation and application of CMS rules. Oftentimes, these coverage policies vary depending on the payer. For example, although Medicare will not cover Evaluation and Management (E&M) services provided by psychologists, occasionally other third-party insurance payers will reimburse for such services. Additionally, virtually no third-party will pay for any procedures, therapy, or treatment that is considered experimental. And, unless specifically authorized by state law, psychologists and other mental healthcare professionals may not prescribe or monitor pharmaceuticals, and use of any code pertaining to the monitoring, administering, or prescribing of drugs is prohibited. Finally, various states may have more restrictive or specific rules that apply to mental health claims, and the practitioner needs to be aware of the potential for further state constraints.

**CPT Codes Frequently Used by Psychologists**
Codes pertaining to mental health psychotherapy services are most frequently found in the Psychiatry section of the CPT manual. There are approximately 60 CPT codes that are appropriate for billing for qualified mental health providers, and these CPT codes generally fall under the sections of Psychiatry (mental health), Central Nervous System Assessment (testing), and Health & Behavior Assessment and Intervention Codes. In certain very limited situations, reimbursement may also be obtained for Biofeedback (CPT codes 90875-90876). Questions concerning coding should be directed to the third-party payer prior to claims submission. Further explanation and examples of common codes used by psychologists are found below. Note that generally speaking, E&M services are not covered for psychologists; codes containing E&M are not included in the information that follows.

**Outpatient/Inpatient Mental Health Billing Codes**
90801 – Psychiatric diagnostic interview examination includes a history, mental status, and a disposition, and may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. In certain circumstances, other informants will be seen in lieu of the individual. This billing code is a single untimed service, therefore, multiple units per date of service are not covered.

*Example:* A comprehensive evaluation of a 24-year-old male referred by his physician for depressive symptoms is performed in an outpatient mental health clinic by a clinical psychologist. The interview involved...
taking a patient history, evaluation of mental status by observation, as well as the completion of a brief self-report checklist of depressive symptoms completed by the client. This claim could be coded as 90801.

90802 – Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication.

90804, 90806, 90808 – Individual psychotherapy, in office — Face-to-face interactive interventions are focused and time-limited. Interventions are designed to improve functioning and increase independence. Interventions are relevant to the needs of the recipient and relate directly to the individualized goals and objectives specified in the recipient’s treatment plan. This service includes individual (child or adult), family, and group counseling. (90804 for appointments lasting 20-30 min., 90806 for appointments lasting 45-50 min., 90808 for appointments lasting 75-80 min.). Billing unit is time as specified for each code.

90810, 90812, 90814 – Interactive Psychotherapy — these codes typically involve providing services to children. It involves the use of physical aids and nonverbal communication to overcome barriers to therapeutic interaction between the clinician and an individual who has not yet developed, or has lost, either the expressive language communication skills to explain his or her symptoms and response to treatment, or the receptive communication skills to understand the clinician if he or she were to use ordinary adult language for communications. (90810 for appointments lasting 20-30 min., 90812 for appointments lasting 45-50 min., 90814 for appointments lasting 75-80 min.). Billing unit is time as specified for each code.

90816, 90818, 90821 – Individual psychotherapy, inpatient, – insight-oriented, behavior modifying and/or supportive in an inpatient facility. (90816 for appointments lasting 20-30 min., 90818 for appointments lasting 45-50 min., 90821 for appointments lasting 75-80 min.). Billing unit is time as specified for each code.

90823, 90826, 90828 – Individual psychotherapy, interactive, inpatient, – Involves physical aids and use of nonverbal communication. (90823 for appointments lasting 20-30 min., 90826 for appointments lasting 45-50 min., 90828 for appointments lasting 75-80 min.). Billing unit is time as specified for each code.

90845 – Psychoanalysis, utilizing methods of observation and analytical skills to review patient’s past experiences, motivations, and internal conflicts with goal of steering current behavior and emotions. Billing unit is CPT defined time.

90846 – Family psychotherapy (without the patient present). Psychotherapy directed toward an individual and family to address emotional, behavioral, or cognitive problems, which may be causative/exacerbating of the primary mental disorder or have been triggered by the stress related to coping with mental and physical illness, alcohol and drug abuse, and psychosocial dysfunction. Personal trauma, family conflicts, family dysfunction, self-concept responses to medication, and other life adjustments reflect a few of the many issues that may be addressed. Billing unit is 15 minutes.

90847 – Family psychotherapy (conjoint psychotherapy with patient present), same as 90846, but with patient present. Billing unit is 15 minutes.
90849 – Multiple family group psychotherapy. Therapy sessions for multiple families when similar dynamics are occurring due to a commonality of problems. Each family is treated as a unit and all services are billed under one admitted individual. Billing unit is 15 minutes.

90853 – Group psychotherapy (other than a multiple-family group). Psychotherapy administered in a group setting with a trained group leader in charge of individuals. Personal and group dynamics are discussed and explored in a therapeutic setting when similar dynamics are occurring due to a commonality of problems. Billing unit is 15 minutes.

90857 – Interactive group psychotherapy. Interactive psychotherapy, using play equipment, physical devices, language interpretation or other mechanisms of communication, in a group setting with a trained group leader in charge of individuals. Personal and group dynamics are discussed and explored in a therapeutic setting when similar dynamics are occurring due to a commonality of problems. Billing unit is 15 minutes.

96020 – Neurofunctional testing selection and administration during noninvasive imaging functional brain mapping, with test administered by a psychologist or physician, with review of test results and report. Note that CPT code 96020 should not be used in conjunction with 96101-96103, 96116, or 96120.

Possible ICD-9-CM codes to support the above CPT codes would generally fall within the range of mental disorder codes 290-319. Refer to your ICD-9-CM book to determine the most suitable code.

Central Nervous System Tests/Assessments
The patient file must indicate the presence and diagnosis of mental illness or signs of mental illness for which psychological testing is indicated as an aid in diagnosis and therapeutic planning. The patient file must show the tests performed, scoring and interpretation, as well as the time involved. Clearly establish the need for administering the test. For example:

- Because the patient showed indications of depression, anxiety or anger.
- Because the referring physician noted a suspicion of mental illness.
- Because the patient's symptoms are inconsistent with objective medical findings.

Note what the test results suggested. After reviewing the report, note the information you find most relevant for the patient. Examples follow:

- The patient reported depression symptoms.
- The patient reported a broad pattern of somatic complaints that are inconsistent with medical findings.
- The patient reported suicidal ideation.

Note the implications for treatment. For example:

- The patient was referred for further psychological evaluation.
• The patient was referred for chronic pain treatment.
• The patient was started on a trial of antidepressant medication.

Description of Psychological Testing Codes
96101 – Psychological Testing - Psychodiagnostic assessment of emotionality, intellectual abilities, personality, and psychopathology, (e.g., PAI, Minnesota Multiphasic Personality Inventory [MMPI], Rorschach, Wechsler Adult Intelligence Scale® [WAIS®]), hour of psychologist's or physician's time, both face-to-face time with the patient, and time interpreting test results and preparing the report.

96102 – Psychological Testing – Psychodiagnostic assessment of emotionality, intellectual abilities, personality, and psychopathology (e.g., PAI, MMPI, Rorschach, WAIS), with qualified health care professional interpretation and report, administered by a technician, per hour of technician time, face-to-face. Note that interpretation and reporting of test results by the psychologist are captured in the payment for technician time, and may not be reported additionally using code 96101.

96103 – Psychological Testing – Psychodiagnostic assessment of emotionality, intellectual abilities, personality, and psychopathology, (e.g., PAI, MMPI), administered by computer, with qualified health care professional interpretation and report. This is billed once regardless of the time spent. Note that interpretation and reporting of test results by the psychologist are captured in the payment for technician time, and may not be reported additionally using code 96101. Also, the computer code should ONLY be used when a computer is used to administer a test, NOT when a computer is used to score the test. Billing is based on units of service, and is not time-based.

Example: A patient comes in on Monday as scheduled for a clinical interview and psychological testing. The patient completes the clinical interview. Because of fatigue issues and unforeseen childcare problems, testing is broken into several appointments over the following days. The patient returns on Tuesday to complete 3 hours of computer-based psychological testing. Before testing, the provider spends 20 minutes face-to-face with the patient assessing whether there are current symptoms interfering with testing, answering patient questions about testing, and clarifying and expanding history and diagnostic information from the interview on the previous day. On Wednesday, the patient returns to complete 2 hours of technician-based testing. On Thursday, the patient completes 1 hour of psychological testing face-to-face with the provider (no significant clinician interaction beyond “Any problems that would interfere with testing today?”). On Friday, provider spends 2 hours interpreting testing and preparing report, then provider meets with patient for 30 minutes individually to review testing feedback (5-10 minutes) and spends 20-25 minutes discussing how the patient can use that information for insight and/or to improve coping or to better manage stressors, or how the patient can utilize the information to reduce conflict and/or help the patient cope with his difficulties.

Coding:
Monday 90801 - For clinical interview;
Tuesday 90804 and 96120 - For continuation of history and diagnostic information. Documentation must support the psychotherapy services provided;
Wednesday 96102- 2 units of service;
Thursday 96101- 1 unit of service;
Friday 90804 - For the patient-only encounter.

Neurobehavioral Status Exam
96116 – Neurobehavioral Status Exam: Clinical assessment of thinking, reasoning and judgment (e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of psychologist's or physician's time, both
face-to-face time with the patient and time interpreting test results and preparing the report.

**Neuropsychological Testing**

96118 – Neuropsychological Testing - (e.g., Halstead-Reitan, WCST), per hour of psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report.

96119 – Neuropsychological Testing - (e.g., Halstead-Reitan, WCST), with qualified health care professional interpretation and report, administered by a technician, per hour of technician time, face-to-face.

96120 – Neuropsychological Testing - (e.g., WCST- single test), administered by computer, with qualified health care professional interpretation and report. Billing is based on units of service and is not time-based.

**Example:** A 46-year-old man is referred by his neurologist due to post-concussion symptoms secondary to a motor vehicle accident. A series of individualized neuropsychological tests is administered by a computer for the purpose of making a medical diagnosis. The patient had previously met with the qualified health care professional who conducted a comprehensive clinical interview and review of the presenting complaints. The qualified health care professional now explains the computerized testing procedures as part of a more comprehensive test battery that also includes face-to-face testing. The computer test is explained to the patient, and a practice trial is administered to ensure adequate understanding of the test and response requirements. The computer test is administered under the supervision of the qualified health care professional who monitors performance to ensure continued engagement in the task.

Neuropsychological/neurocognitive assessments are defined as testing that is intended to diagnose and characterize the cognitive effects of medical disorders that impact directly or indirectly on the brain. Numerous neuropsychological tests produce a valid and reliable assessment of patients’ mental functions. Neuropsychological tests differ from psychological tests in that neuropsychological testing consists primarily of individually administered ability tests that comprehensively sample a patient's cognitive ability domains that are known to be sensitive to the functional integrity of the brain (e.g., abstraction, memory, attention, language, problem-solving, sensory and motor functions, constructional praxis). These tests are objective and quantitative and require the patient to directly demonstrate his or her level of confidence in a particular neurocognitive domain.

**Health and Behavioral Assessment Codes**

Health and Behavioral Assessment (HBA) codes are used to bill for services provided to clients who do not have a psychiatric diagnosis, but whose behavioral function impacts a health problem. In almost all of these cases, a physician will have diagnosed a patient’s physical health problem(s). These codes are then used to bill for behavioral, social, and psychophysiological services for the prevention, treatment, or management of physical health problems. Health and behavioral assessment codes cannot be used for psychotherapy services addressing the patient’s mental health diagnosis nor can they be billed out on the same day as a psychiatric code. Note that when billing a Medicare patient for these services, you will be reimbursed at a higher rate than psychotherapy because under other current federal regulations, the outpatient mental health treatment limitation does not apply (it only applies to services provided to patients identified by an ICD-9-CM code with a mental, psychoneurotic, or personality disordered diagnosis code between 290 and 319). The codes were created for use by nonphysician providers and
may be billed by advanced practice nurses (APNs), psychologists, social workers, and other healthcare providers. The services must be within the scope of practice for the provider. The HBA services are provided without meeting the requirements for the key components of an E&M service: obtaining a history, providing an examination, or making a medical decision.

96150 – Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient: Initial assessment to determine the biological, psychological, and social factors affecting the patient’s physical health and any treatment problems.

96151 – Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psycho-physiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient: Re-assessment.

96152 – Health and behavior intervention service provided to modify the psychological, behavioral, cognitive, and social factors affecting the patient’s physical health and well-being. Examples include increasing the patient’s awareness about his or her disease and using cognitive and behavioral approaches to initiate physician prescribed diet and exercise regimens. Each 15 minutes, face-to-face; individual.

Example: A patient recently diagnosed with diabetes and struggling with diet and exercise suggested by the physician may be counseled using cognitive and behavioral approaches to increase awareness of the disease and strengthen compliance with recommended diet and exercise changes.

96153 – Health and behavior intervention service provided to a group. An example is a smoking cessation program that includes educational information, cognitive-behavioral treatment, and social support. Group sessions typically last for 90 minutes and involve 8 to 10 patients. Each 15 minutes, face-to-face; group (2 or more patients).

96154 – Health and behavior intervention service provided to a family with the patient present. For example, a clinician could use relaxation techniques with both a diabetic child and his or her parents to reduce the child’s fear of receiving injections and the parents’ tension when administering the injections. Each 15 minutes, face-to-face; family (with patient present).

96155 – Health and behavioral intervention service provided to a family without the patient present. An example would be working with parents and siblings to shape a diabetic child’s behavior, such as praising successful diabetes management behaviors, and ignoring disruptive behaviors.

Practitioners often ask why these codes would be used. HBA codes were created for assessing cognitive, emotional, social, and behavioral factors that affect acute or chronic health problems or diseases, maintenance of health, or recovery from illness. As such they are distinguished from mental health diagnoses, and can be most effectively used when evaluating an individual who suffers from physical or medical conditions which impact social or behavioral functioning.
Rehabilitation Services
97532, 97533 – Cognitive rehabilitation performed to retrain the brain to recognize symbols and how the symbols are used; neuropsychological rehabilitation treats mental and/or nervous conditions by cognitive training.

Case Management Services
Billing for medical team conferences may be permissible under certain circumstances. Below are codes that may be used for conferences that capture face-to-face participation by a minimum of three qualified health care professionals from different specialties, with and without the presence of the patient, family members, or caregivers. Note that each team participant must provide direct care to the patient and be involved in development, coordination, and implementation of services needed by the patient. No more than one person from each specialty may report using the CPT codes below at the same encounter, nor should the code(s) be used when their participation is part of a facility where the service is part of the facility services. The health care professional involved in these conferences (and billing for same) should have performed an evaluation of the patient within the past 60 days.

99366 – Medical team conference with interdisciplinary team, face-to-face with patient and/or family, 30 minutes or more, participation by non-physician qualified health care professional.

99368 – Medical team conference with interdisciplinary team, patient and/or family not present, 30 minutes of more, participation by non-physician qualified health care professional.
**Abbreviations and Definitions**

**Medicaid** – The state- and federally-funded Title XIX program under which medical care is provided to persons eligible for the Categorically Needy Program or Medically Needy Program.

**Medicare** – Health insurance for people age 65 or older, under age 65 with certain disabilities, or any age with end-stage renal disease (ESRD).

**National Drug Code (NDC)** – The standard code set for drugs obtained from pharmacies.

**National Provider Identifier (NPI)** – A federal system for uniquely identifying all providers of healthcare services, supplies, and equipment.

**Evaluation and Management** – CPT codes (99201-99499); E&M codes are used to report services to new and established patients in the office or other outpatient facility. **Additionally**, any therapeutic services that are billed by CPs under CPT psychotherapy codes that include medical evaluation and management services are **not covered**. Psychologists cannot bill E&M codes when treating Medicare beneficiaries because CMS currently restricts the use of these codes. CMS has taken the position that E&M codes involve services unique to medical management, such as medical diagnostic evaluation, drug management, and interpreting laboratory or other medical diagnostic studies. Psychologists treating patients with private insurance may be able to bill for E&M services because not all insurers impose the same restrictions as Medicare. Psychologists should check with the private carrier to determine its policy on E&M services. Therapeutic services that are billed by CPs under CPT psychotherapy codes that include medical evaluation and management services are **not** covered.

**CPT Codes** – CPT is an acronym for Current Procedure Technology. The CPT coding system is maintained by the AMA and a revised edition of the CPT book is published each fall. New CPT codes become effective on January 1st of the following year. The revisions in each new edition are prepared by the CPT Editorial Panel. The CPT Editorial Board is composed of 17 members, 15 are physicians in various specialties, representing physicians in practice as well as those representing the insurance industry, as well as two representatives from other health care disciplines.

**Outpatient Mental Health Treatment Limitation** – By law, Medicare payment for outpatient mental health therapeutic services is limited to 62.5 percent of covered expenses incurred in any calendar year in connection with the treatment of a mental, psychoneurotic, or personality disorder for an individual who is not an inpatient of a hospital at the time the expenses are incurred. This limitation is being phased out and will be completely eliminated by the end of 2014. Brief office visits for the purpose of monitoring or changing drug prescriptions are **NOT** subject to this limitation. Certain diagnostic services are also not subject to the limitation. Tests and evaluations performed to establish or confirm the patient's diagnosis are not subject to the limitation. Diagnostic services include psychiatric or psychological tests and interpretations, diagnostic consultations and initial evaluations. However, follow-up diagnostic services done to evaluate the progress of a course of treatment are subject to the limitation. Below is the scheduled phase-out of this reimbursement limitation.

- **January 1, 2010 – December 31, 2011**, the limitation percentage is 68.75% (of which Medicare pays 55% and the patient pays 45%);
- **January 1, 2012 – December 31, 2012**, the limitation percentage is 75% (of which Medicare pays 60% and the patient pays 40%);
• **January 1, 2013 – December 31, 2013**, the limitation percentage is 81.25% (of which Medicare pays 65% and the patient pays 35%); and,
• **January 1, 2014 – onward**, the limitation percentage is 100%, at which time Medicare pays 80% and the patient pays 20%.

**ICD-9-CM** – The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is based on the World Health Organization's International Classification of Diseases, Ninth Revision (ICD-9). ICD-9-CM is the official system of assigning codes to diagnoses and procedures. ICD-10-CM has been released and is mandated for use beginning October 1, 2013.

**HCPCS** – HCPCS (often pronounced “hickpicks”) stands for the Healthcare Common Procedure Coding System. It was established in 1978 as a way to standardize identification of medical services, supplies, and equipment.

There are two sets of codes. The first, or Level I, code set is a five-digit numeric code that contains the physician’s CPT maintained by the AMA. The CPT is composed of descriptive terms and identifying codes used primarily for billing for services provided by physicians and other healthcare professionals. The second code set, or Level II, is a code set for medical services not included in Level I, such as durable medical equipment, prosthetics, orthotics, and supplies. These codes are alpha-numeric in that they begin with a single letter, such as an AE or AK in the case of durable medical equipment, followed by four numbers.

**CMS** – Centers for Medicare and Medicaid Services, the federal agency that runs the Medicare program. In addition, CMS works with the states to run the Medicaid program. CMS works to make sure that the beneficiaries in these programs are able to get high quality health care.

**UCF-1500** – The uniform professional claim form also may be known as CMS-1500 or HCFA-1500.

**MODIFIER CODES** – Modifier codes are used to document a procedure or service that has been altered in some way due to a specific circumstance, however, its definition or code has not been charged. Below are some common code modifiers:

- **22** – Increased Procedural Services. When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier 22 to the usual procedure number.

- **52** – Reduced Services. Under certain circumstances, a service or procedure is partially reduced or eliminated at the provider’s discretion. Under these circumstances, the service provided can be identified by its usual procedure number and the addition of modifier 52.

- **59** – Distinct Procedural Service. Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Under these circumstances, the service provided can be identified by its usual procedure number and the addition of modifier 59. Note that another modifier cannot be used with 59.
Frequently Asked Questions
(Used with the permission of Magellan Health Services)

Where can I find HCPCS codes?

What modifiers are valid when billed with Healthcare Common Procedure Coding System (HCPCS) code 96116?
Effective January 1, 2008, the following modifiers are valid when billed with HCPCS code 96116:
• GT – Via interactive audio and video telecommunications system
• GQ – Via asynchronous telecommunications system

Are structured interview tools considered psychological testing (96101) or are they considered a diagnostic assessment (90801)?
If an instrument has specific instructions, items, and a specific group comparison or reference sample, it is considered a psychological test. However, most structured interview instruments lack normative data and, therefore, would not meet the criteria of a test. If the instrument/interview contains normative data, is accompanied by specific instructions, and contains comparison groups and other psychometric properties, it can be used as a psychological test.

If a technician explains the purpose of a computerized test and helps the client start taking the test, but does not stay in the same room—though he or she may occasionally come in to answer questions or to check on the client—may the psychologist bill the test as technician-administered?
If the technician spent a reportable amount of time with the client, this time may be billed as 96102/96119. Keep in mind that only the time the technician spent with the client may be billed—not the entire time the client spent taking the test. Also remember, for any computerized test, only the computer-administered code or the technician-administered code may be used, not both.

If the technician sat in the room with the client for the entire test, could that time be billed? If there was a justifiable reason why the technician needed to be in the same room, then this time may be billed. Justifiable reasons include that the technician's presence is a requirement of testing, behavioral observation is required, or it was necessary to supervise the client. Again, with this scenario either the computer-administered code or the technician-administered code may be used, but not both.

When the psychologist stays in the room with the client during the administration of a test for a justifiable reason such as assisting the client with the use of a computer, may the psychologist perform some other billable activity, such as writing a report, and bill for each service?
The psychologist should bill for only one service, and generally it should be the activity that takes the majority of the time.

How are partial hours billed? For example, if a testing battery takes four hours and 45 minutes, how many hours are billed?
When using the technician or psychologist billing code, partial hours are billed based on "rounding." If the hourly fraction is between one and 30 minutes, the time is rounded and billed to the previous hour. If the hourly fraction is between 31 and 59 minutes, the time should be
rounded and billed to the next hour. In this example, for four hours and 45 minutes of psychologist or technician-administered testing, the psychologist should bill for five hours.

In the special situation in which the total billable time for any testing code is between one and 30 minutes, the psychologist may bill for 30 minutes by adding the -52 modifier to the relevant CPT code. For 31 to 59 minutes, the psychologist should bill for one hour.

**Is time spent scoring reimbursable?**
A psychologist may request reimbursement for his or her time spent scoring or directly inputting information into a computerized scoring program. A technician may be reimbursed for time spent scoring only if completed while face-to-face with the client and there is a valid reason why the test needs to be scored in this fashion. Billing for computerized scoring (96103 or 96120) is not permitted unless the test itself is computer-administered. If this is the case, the computer code may only be billed once.

**A software program that scores a test also provides a report. The psychologist pays the software company for each report generated. May the psychologist bill for the cost of the report?**
No. The psychologist code is based on the time the psychologist spends administering and interpreting the tests and report writing. CPT codes 96101 and 96118 may not be used to bill for anything other than the time the psychologist personally spends on these activities.

**Are assessment tools that have their own device for testing considered computer-administered?**
If the assessment tool does not require the presence of a technician or psychologist to administer and it functions similarly to a personal computer (e.g., it is electronic, uses a microprocessor, has automated scoring, etc.), then it is billed as computer-administered.

**When should the neuropsychological test codes be used and when should the general psychological test codes be used?**
On any test battery only codes 96101, 96102, and/or 96103 (general psychological testing) or codes 96118, 96119, and/or 96120 (neuropsychological testing) may be used. Whether to bill for general psychological testing or neuropsychological testing depends on the focus of the testing. Generally speaking, for testing to be considered neuropsychological in focus, its goal should be to determine the extent of cognitive impairment due to a known or suspected medical/neurological disorder or brain injury or aimed at differentiating between a psychiatric condition and a medical/neurological condition.

**Does a psychologist use 96101 or 96118 when testing for Attention Deficit Hyperactivity Disorder (ADHD)?**
Although many psychiatric conditions such as ADHD may impact cognitive functioning, assessing for the presence of a psychiatric disorder in itself would not normally be billed as neuropsychological testing. Additionally, testing for ADHD is often NOT covered by third-party payers.

**How does a psychologist bill for a session spent discussing the test results with a client?**
If the conversation focuses on how the results impact treatment, the psychologist should bill using 90806. If the session focuses exclusively on providing the client with an interpretation of the results, then it is billed as 96101 or 96118. This example is more likely to occur with neuropsychological testing than general psychological testing.

**On the American Psychological Association (APA) Web site regarding the revised CPT codes for psychological testing it states, “When testing is administered by a technician or a computer, the time that the psychologist spends interpreting and reporting on the individual tests is included in the technician and computer code payment.” Is this generally the position of most third-party payers?**
Yes, but verify this with the insurance company. If a psychologist is just interpreting and reporting the information of a psychological test without integrating data from other sources, the time spent on interpreting and reporting is already included in the payment under the technician or computer code and cannot be billed separately. This might occur if the psychologist is asked by a treating provider to test for the presence or absence of a particular diagnosis through psychological testing and report back on the findings. However, when interpretations from individual tests are integrated with interpretations from other tests, clinical interview information, behavioral observations, and/or previous client records, the time spent on this portion of the work is billable.

**Where can I find answers to other commonly asked questions regarding billing for psychological testing?**

The APA Practice Directorate continuously updates common questions regarding billing on their Web site. Visit [http://www.apapractice.org/apo/toolkit.html](http://www.apapractice.org/apo/toolkit.html), then click on the different links to Q&A regarding billing for the various codes. Note that APA membership may be required for access to certain portions of the APA Web site. Additional answers regarding psychological testing can be found on the Centers for Medicaid and Medicare Services Web site at [http://questions.cms.hhs.gov](http://questions.cms.hhs.gov).

**From CMS:**
The following are additional questions and answers regarding psychological testing posted on the Centers for Medicaid and Medicare Services Web site at [http://questions.cms.hhs.gov](http://questions.cms.hhs.gov).

**Who is authorized by Medicare to bill for CPT code 96125 (that was added under CPT effective January 1, 2008)?**

CPT code 96125 (standardized cognitive performance testing [e.g., Ross Information Processing Assessment] per hour of a qualified health care professional’s time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report) is designated under Medicare as an "always therapy" code. Physical therapists (PTs), occupational therapists (OTs), and speech language pathologists (SLPs) may bill this code for patients only when the patient is under a therapy plan of care. (Please note that CPT Changes: An Insider’s View 2008 suggests that when testing like that performed under 96125 is performed by a physician or a psychologist, a code from the 96101-96103 or 96118-96120 series should be reported.)

**Do CPT codes for psychological and neuropsychological tests include tests performed by technicians and computers?**

Yes. Effective January 1, 2006, CPT codes for psychological and neuropsychological tests include tests performed by technicians and computers (CPT codes 96102, 96103, 96119, and 96120) in addition to tests performed by physicians, clinical psychologists, independently practicing psychologists, and other qualified non-physician practitioners. The payment amounts for tests performed by a technician or a computer are adjusted depending on whether the service was performed in a facility or non-facility setting.

**What are the supervision requirements for diagnostic psychological and neuropsychological tests?**

Under the diagnostic test provision as authorized under Medicare law at section 1861(s)(3) of the Social Security Act and interpreted under regulations at 42 CFR 410.32, all diagnostic tests are assigned a certain level of supervision. Generally, regulations governing the provision of diagnostic tests require a physician to provide the appropriate level of supervision for such tests. That is, the physician must either provide general, direct, or personal supervision. However, for diagnostic psychological and neuropsychological tests (96101-96120), there is a regulatory exception at 42 CFR 410.32(b) (2) (iii) that allows either a clinical psychologist or a physician to provide the required general supervision for diagnostic psychological and neuropsychological tests. Moreover, non-physician practitioners such as nurse practitioners or clinical nurse specialists under 42 CFR 410.32(b) (2) (B) (v), and physician assistants under 42 CFR 410.32(b) (3) who personally perform diagnostic psychological and neuropsychological tests are excluded
from the supervision requirements for diagnostic tests. However, they must meet the collaboration and physician supervision practice requirements under their respective benefits.

Can more than one CPT code for psychological or neuropsychological testing be billed on the same date of service for the same patient?
Yes. If several different, clinically appropriate tests are administered on the same date to the same patient (whether by a physician/psychologist, technician, or by computer), then the appropriate testing codes for psychological testing or neuropsychological testing can be billed together. More than one code can also be billed when several distinct tests are administered to the same patient on the same date of service via technician (96102/96119) or computer (96103/96120), and the physician/psychologist needs to integrate the separate interpretations and written reports for each of these tests into a comprehensive report.

Can more than one CPT code for psychological or neuropsychological testing be billed together on the same date of service for the same patient if all of the testing is administered by a technician and/or computer?
Yes. The technician-administered code (96102/96119) is billed based on the number of hours that the technician spends face-to-face with the patient. The computer-administered testing code (96103/96120) is billed once, regardless of the time spent completing the tests. Note, however, that when testing is administered by a technician or a computer, the time that the physician/psychologist spends interpreting and reporting the results of each individual test is already included in each of these codes.

Are expenses for diagnostic psychological and neuropsychological tests subject to the payment limitation for outpatient mental health treatment services?
In most cases, expenses for diagnostic psychological and neuropsychological tests are not subject to the payment limitation on certain outpatient mental health treatment services. The outpatient mental health treatment limitation is the payment limitation on treatment services for mental, psychoneurotic, and personality disorders as authorized under section 1833(c) of the Social Security Act. However, the limitation does apply to diagnostic psychological and neuropsychological tests when these tests are performed to evaluate a patient’s progress during treatment rather than to establish or confirm the patient’s diagnosis. (See section 210.1, chapter 12 of the Medicare Claims Processing Manual, Pub.100-04).

Can more than one CPT code for psychological or neuropsychological testing be billed together for services rendered to the same patient but on different dates?
The physician/psychologist is expected to bill for the work he/she performed on the date of service. If all of the testing is conducted by a physician/psychologist, then the professional code should be billed for the time spent on test administration, interpretation, and report preparation, as well as integration of previously interpreted test results into a comprehensive report (96101 or 96118). Only the appropriate technician-administered or computer-administered codes can be billed on the actual date of service if a physician/psychologist interprets and writes a report on individual tests administered by a technician (96102 or 96119) or computer (96103 or 96120). The interpretation and reporting of the individual test results by the physician/psychologist, which may sometimes occur on a different date than the testing date, are already captured in the payment for the technician and computer-administered codes.

Should I bill the CPT code for computer-administered psychological (96103) or neuropsychological testing (96120) if my patient takes a paper-and-pencil test and I use a computer to score it?
The computer codes (96103 and 96120) can only be billed when a computer is used to administer tests. The codes cannot be billed if the computer is used only to score tests. For paper-and-pencil tests, the physician/psychologist should bill appropriately for any other service provided.
Additional Resources

*CPT Professional Edition manual.* The new codes are published each year in the *CPT Professional Edition* manual, which is available from the AMA at 1.800.621.8335.

*CPT Information Services (CPTIS).* This is a service offered by AMA. AMA members receive complimentary subscription to CPTIS, while for others, this is a fee-for-service resource. The Coding Helpline is 1.800.634.6922.

*2006 Testing Toolkit.* The APA Practice Organization has published a toolkit that contains information and materials to help you learn about the proper use of the psychological CPT testing codes and payment for these codes. The toolkit can be found at [http://www.apapractice.org/apo/toolkit.html#](http://www.apapractice.org/apo/toolkit.html#). APA membership may be required to access certain of these resources.

*CSM – 1500 Information*  

*UB-04 Information*  

*Centers for Medicare & Medicaid Services.* Web site that serves as resource for all Medicare & Medicaid regulations  