Priority Health	BILLING POLICY No. 026
PSYCHIATRY AND PSYCHOLOGY SERVICES (INCLUDING PSYCHOLOGICAL AND NEUROPSYCHOLOGICAL TESTING)	
Date of origin: Aug. 2024	**Review dates: 2/2025, 12/2025, 01/2026**

APPLIES TO

- Commercial and Medicare
- For Medicaid, refer to the Medicaid manual for billing and coding guidelines

DEFINITION

Psychiatry and Psychology are specialized fields for the diagnosis and treatment of various mental health disorders and/or diseases.

Psychological and Neuropsychological testing are diagnostic procedures that must be used as an important tool in making specific diagnoses or prognoses to aid in treatment planning and to address questions regarding treatment goals, efficacy and patient disposition.

References to providers include physicians and non-physicians, such as clinical psychologists, independent psychologists, nurse practitioners, clinical nurse specialists and physician assistances when the services performed are within the scope of their state license and clinical practice/education.

MEDICAL POLICY

Neuropsychological and Psychological Testing (#91537)

POLICY SPECIFIC INFORMATION

Priority Health follows CMS specific guidelines. Consult specific LCD for additional information.
Various mental disorders and/or disease may be evaluated in the following methods (may not be an all-inclusive listing)

Psychiatric diagnostic evaluation (90791, 90792)

- Assessment including history, mental status and recommendations may include additional components where applicable
- Cannot be reported with an E/M service on the same day by same provider
- Allowed 1x per day
- May be reported more than 1x for a patient when separate evaluations are done with the patient and family members, guardians or significant others on different days. This service is only allowed 1x per every 6 months per episode of illness.

Interactive complexity (90785)

- Add-on code
- May be reported for increased work intensity of the psychotherapy service which could include (not an all-inclusive listing. See LCA for specific criteria)
    - Lack of ability to interact through normal communicative channels

    - Communication with emotionally charged family members
- **Doesn't** change the time spent for the psychotherapy service
- Documentation must support/describe increased work intensity
- Communication challenges may occur when:
    - Have other individuals legally accountable for their care such as minors or adults with guardians.
    - Adults accompanied by one or more family members or an interpreter
    - Engagement of third parties such as child welfare agencies, parole or probation officers/ educational institutions.

Psychotherapy (90832-90838)

- Time based codes, time must be documented
- For therapy sessions exceeding 90 minutes, documentation must include face to face time spent with patient and the medical necessity of the extended time

Family Psychotherapy (90846-90847)

- Time based codes, time must be documented
- Don't use for service performance of taking a family history or E/M counseling services. An E/M counseling service should be coded with the appropriate E/M code that supports the service documented
- Doesn't include supervision of therapy with caretakers or staff

Psychotherapy for Crisis (90839-90840)

- Time based codes, time must be documented
- CPT 90839 code description states first 60 minutes. However, CPT code lay description states must meet 74 mins before billing the add-on code for additional time.

Neurobehavioral Status Examination (96116, 96121)

- Includes test administration
- Scoring
- Interpretation and Report
- Time based code, time must be documented

Psychological Testing (96136 – 96139)
Developmental/behavioral screening and testing (96110, 96112, 96113, 96127)
Assessment of aphasia and cognitive performance testing (96105, 96125)

- Time based codes, time must be documented.
- If testing is performed over several days, all time should be combined with the total time reported on the last day of the service.
- 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 tests) is not separately reimbursable. These inventories/tests are included in the clinical interview or E/M service.

Documentation requirements
Psychological and Neuropsychological Testing

- Report must contain information to support medical necessity for testing being performed. This documentation should include (not limited to):
    - Medical history
    - Physical examination
    - Diagnostic testing and procedures
    - Suspected mental illness, neuropsychological abnormality or CNS disfunction

    - Clinical findings that determined the need for testing
    - Testing that was indicated
    - Time spent in testing and if initial testing or follow up testing
    - Any previous testing performed
    - Tests performed include scoring, interpretation and treatment recommendations.
- A minimum of 31 minutes must be provided to report a per hour code.

Psychiatry and Psychology Services

- The documentation should include the goals of therapy
- Methods for monitoring outcomes
- Reason why the chosen therapy is the appropriate treatment.
- Relevant medical history, physical examination and results of diagnostic tests or procedures
- Patient's capacity to participate, benefit from treatment. Including expectations for improvement of health status or function of the patient
- Estimated number of sessions should be specified
- A minimum of 31 minutes must be provided to report a per hour code

Modifiers

Priority Health follows standard coding rules and guidelines. Modifiers should only be applied if appropriate and supported by documentation.

REFERENCES

- LCD - Psychiatry and Psychology Services (L34616) (CMS)
- Article - Billing and Coding: Psychiatry and Psychology Services (A57480) (CMS)
- LCD - Psychological and Neuropsychological Testing (L34646) (CMS)
- Article - Billing and Coding: Psychological and Neuropsychological Testing (A57481) (CMS)

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Feb. 13, 2025	Added "Disclaimer" section
Dec. 22, 2025	Wording clarifications
Jan. 23, 2026	Reviewed no updates