

## Psychological Services

Eligible Medi-Cal recipients may receive psychological services when medically necessary. The information found in this section does not apply to specialty mental health services delivered by county Mental Health Plans (MHPs). For additional information regarding coverage of mental health services, refer to the *Specialty Mental Health Services* section of this manual. For additional help, refer to the *Psychological Services: Billing Examples* section of this manual.

### Eligibility

An adult recipient obtains eligibility for mental health services if the recipient is diagnosed with a mental health disorder as defined by the *Diagnostic and Statistical Manual of Mental Health Disorders* (DSM) resulting in mild to moderate distress or impairment of mental, emotional or behavioral functioning. A child recipient obtains eligibility for mental health services if the recipient is diagnosed with a mental health condition as defined by the *Diagnostic and Statistical Manual of Mental Health Disorders* (DSM) or as defined by the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (DC: 0-5) regardless of level of severity. Conditions that the DSM identifies as relational problems, that is, couples counseling or family counseling for relational problems are not covered. Adults and children are also eligible for central nervous system tests and assessments when medically necessary.

#### Exceptions:

Recipients under age 21 may receive up to five sessions of a combination of individual or family therapy before a mental health diagnosis is required.

Recipients under age 21 who have risk factors for mental health disorders as specified in the "Family Therapy" section below, are eligible for family therapy.

**Pregnancy and  
Postpartum-Related  
Services**

Policy for screening for depression in pregnant or postpartum recipients may be found in the *Evaluation and Management (E&M)* section of the appropriate Part 2 Manual.

Pregnant and postpartum women with one or more of the following risk factors for perinatal depression are also eligible for individual and group counseling: a history of depression, current depressive symptoms (that do not reach a diagnostic threshold), certain socioeconomic risk factors such as low income, adolescent or single parenthood, recent intimate partner violence, or mental health–related factors such as elevated anxiety symptoms or a history of significant negative life events. Up to a total of 20 individual counseling (CPT® codes 90832 and 90837) and/or group counseling (CPT code 90853) sessions are reimbursable when delivered during the prenatal period and/or during the 12 months following childbirth. Modifier 33 must be submitted on claims for counseling given to prevent perinatal depression.

For information about other pregnancy-related services, providers may refer to the *Pregnancy: Early Care and Diagnostic Services* section of the appropriate Part 2 manual.

**Mental Health Services  
Delivery Systems**

Eligible Medi-Cal recipients may receive Medi-Cal mental health services through all Medi-Cal delivery systems including, but not limited to, Managed Care and fee-for-service delivery systems. Recipients that meet medical criteria for specialty mental health services will receive mental health services via county MHPs.

**Mental Health Services**

Recipients who are eligible for Medi-Cal mental health services may receive the following:

- Individual and group mental health evaluation and treatment (psychotherapy) rendered by a psychologist, LCSW, LPCC or MFT
- Family therapy rendered by a psychologist, LCSW, LPCC, or MFT
- Psychological testing when clinically indicated to evaluate a mental health condition
- Development of cognitive skills to improve attention, memory and problem solving
- Outpatient services for the purposes of monitoring drug therapy
- Outpatient laboratory, drugs, supplies and supplements
- Psychiatric consultation
- Specialty mental health services provided by County Mental Health Plans

*Treatment Authorization Requests (TARs)* are not required for psychology services for Medi-Cal recipients that meet eligibility criteria for mental health services.

**Program Coverage**

Medi-Cal covers psychological services only when provided by persons who meet the appropriate requirements specified by the *California Code of Regulations*.

Marriage and family therapist interns, registered associate clinical social workers and psychology assistants may render psychotherapy services under a supervising clinician. The claim must list the intern, associate or assistant’s name in the *Additional Claim Information* field (Box 19) or in an attachment, along with the supervising clinician’s National Provider Identifier number as the “billing provider.”

Psychological services are not covered under the County Medical Services Program (CMSP).

**“Service” Defined**

“Service” means all care, treatment or procedures provided to a recipient by an individual practitioner on one occasion.

**Eligibility Requirements**

Providers should verify the recipient’s Medi-Cal eligibility for the month of service.

**Authorization**

A *Treatment Authorization Request* (TAR) is not required for psychological services. Psychological services are covered services when ordered by a primary care physician.

**Place of Service Codes**

Psychologist, LCSWs, LPCCs and MFTs may only bill Place of Service codes for the following: office, home, outpatient hospital, community mental health center, comprehensive rehabilitation facility, state or local public health clinic, rural health clinic or other.

When using Place of Service code "99" (other), indicate the full name and address of the testing location in the *Additional Claim Information* field (Box 19) or on an attachment and leave the *Service Facility Location Information* field (Box 32) blank.

**Family Therapy**

Family therapy that is evidence-based or incorporates evidence-based components is reimbursable in an outpatient setting for adults with a mental health condition and for children under age 21 who meet at least one the following criteria:

- The child has a diagnosis of a mental health condition as defined by DSM or as defined by the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-5). If DC: 0-5 is used for the diagnosis, the corresponding ICD-10 code, which can be found at [www.zerotothree.org](http://www.zerotothree.org), must be entered on the claim form.
- The child under age 21 has a history of at least one of the risk factors below. Claims for family therapy for these children must be billed with ICD-10 code Z65.9:
  - Separation from a parent/guardian due to incarceration or immigration
  - Death of a parent/guardian
  - Foster home placement
  - A California Children's Services (CCS)-eligible condition
  - Food insecurity, housing instability
  - Exposure to domestic violence or other traumatic events
  - Maltreatment
  - Severe and persistent bullying
  - Experience of discrimination based on race, ethnicity, gender identity, sexual orientation, religion, learning differences or disability

- The child under age 21 has a parent/guardian with one of the risk factors below. Claims for family therapy for these children must be billed with ICD-10 code Z65.9:
  - A serious illness or disability
  - A history of incarceration
  - Depression or other mood disorder
  - PTSD or other anxiety disorder
  - Psychotic disorder under treatment
  - Substance use disorder
  - A history of intimate partner violence or interpersonal violence
  - Is a teen parent
- The medical provider suspects a mental health disorder and has referred the recipient under age 21 for evaluation. A specific diagnosis is not required for the first five sessions for recipients under age 21. Claims for these visits must be billed with ICD-10 code F99.

Some examples of evidence-based family therapy are:

- Child-Parent Psychotherapy (ages 0 – 5)
- Triple P Positive Parenting Program (ages 0 – 16)
- Parent Child Interactive Therapy (ages 2 – 12)

Family therapy must be composed of at least two family members. Mental health providers must bill for family therapy using the Medi-Cal ID of only one family member per therapy session for CPT codes 90846, 90847 and 99354. Mental health providers must bill for multiple-family group therapy using the Medi-Cal ID of only one family member per family.

#### Inpatient Family Therapy

Family therapy is reimbursable on an inpatient basis only for infants hospitalized in a neonatal intensive care unit. Claims for these therapy sessions must be billed with ICD-10 code P96.9.

#### Billing Newborn Infant Family Therapy with Mother's ID

Family therapy rendered to an infant who has not yet been assigned a Medi-Cal ID number may be billed with the mother's ID for the month of birth and the following month only.

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**Billing Codes**

Reimbursement of family therapy is limited to a maximum of 50 minutes when the patient is not present (CPT code 90846) or a maximum of 110 minutes when the patient is present (CPT code 90847 plus CPT code 99354).

When billing family therapy (CPT codes 90846, 90847, 90849 and 99354), providers should use the appropriate code, based on the following descriptions and direct patient care time frames:

<u>CPT Code</u>	<u>Description</u>
<u>90846</u>	<u>Family psychotherapy (without the patient present), 50 minutes</u>
<u>90847</u>	<u>Family psychotherapy (with patient present), 50 minutes</u>
<u>90849</u>	<u>Multiple-family group therapy</u>
<u>99354</u>	<u>Prolonged psychotherapy service requiring direct patient contact beyond the usual service; first hour</u>

CPT code 99354 is only reimbursable when billed on the same date of service as CPT code 90847

CPT codes 90846, 90847, 90849 and 90853 may not be billed on the same day for the same beneficiary.

**Group Therapy**

Group therapy is defined as counseling of at least two but not more than eight persons at any session. There is no restriction as to the number of Medi-Cal-eligible persons who must be included in the group's composition. For example, if there are five patients in the group, and only one is a Medi-Cal recipient, then Medi-Cal should be billed using CPT code 90853, once per session.

Group therapy sessions of less than one and one-half hours are not reimbursable.

**Individual Therapy**

Individual therapy is limited to a maximum of one and one-half hours per day by the same provider.

When billing individual psychotherapy (CPT codes 90832, 90837, 90839 and 90840), providers should use the appropriate code, based on the following direct patient care time frames:

<u>CPT Code</u>	<u>Description</u>
90832	Psychotherapy, 30 minutes with patient
90837	Psychotherapy, 60 minutes with patient
90839	Psychotherapy for crisis; first 60 minutes
90840	Psychotherapy for crisis each additional 30 minutes

### **Case Conference**

Case conference allowances (CPT codes 99366 and 99368) are limited to conferences with persons immediately involved in the case or recovery of the client.

### **Central Nervous System Assessments/Tests**

Claims for central nervous system assessments/tests (CPT procedure codes 96105, 96110, 96112, 96113, 96116, 96121, 96130 – 96133, 96136 – 96139 and 96146) must include an itemization of the tests performed. Providers must list the tests performed either in the *Additional Claim Information* field (Box 19) or on an attachment.

Claims billed with CPT codes 96105, 96116 and 96121 must include an attachment specifying the amount of time spent completing each of the following:

- Administration of test(s)
- Interpretation of test results
- Preparation of the report

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Frequency Limitations/  
Additional Billing Instructions

Frequency limitations and additional billing instructions apply to the following central nervous system assessments/tests:

<u>CPT Code</u>	<u>Description</u>	<u>Frequency Limits</u>
96105	Assessment of aphasia, per hour.	Two episodes per year ( $\leq 3$ hours each), any provider. All hours for each episode must be billed on the last day of service.
96110*	Developmental screening, per standardized instrument	Two per year, any provider
96112	Developmental test administration; first hour	One per year, any provider
96113	each additional 30 minutes	One per year, any provider
96116	Neurobehavioral status exam; first hour	One per year, any provider
96121	each additional hour	One per year, any provider
96130	Psychological testing evaluation services; first hour	One per year, any provider
96131	each additional hour	Two per year, any provider

\* Refer to the *Preventive Services* section in the appropriate Part 2 manual for more information.



<u>CPT Code</u>	<u>Description</u>	<u>Frequency Limits</u>
96132 *	Neuropsychological testing evaluation services; first hour	One per year, any provider
96133 *	each additional hour	Two per year, any provider
96136 *	Psychological or neuropsychological test administration and scoring, two or more tests; first 30 minutes	One per year, any provider
96137 *	each additional 30 minutes	Nine per year, any provider
96138 *	Psychological or neuropsychological test administration and scoring by technician, two or more tests; first 30 minutes	One per year, any provider
96139 *	each additional 30 minutes	Nine per year, any provider
96146 *	Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only	One per year, any provider

\* Neuropsychological tests require medical necessity as explained in this section.

**Note:** A TAR override is allowed for CPT codes 96105, 96110, 96112, 96113, 96116, 96121 96130 – 96133, 96136 – 96139 and 96146.

Medical Necessity Criteria  
For Neuropsychological  
Testing

Neuropsychological testing (CPT codes 96132, 96133, 96136 – 96139 and 96146 [when billing for neuropsychological testing]) is considered medically necessary

- When there are mild deficits on standard mental status testing or clinical interview, and a neuropsychological assessment is needed to establish the presence of abnormalities or distinguish them from changes that may occur with normal aging, or the expected progression of other disease processes; or
- When neuropsychological data can be combined with clinical, laboratory and neuroimaging data to assist in establishing a clinical diagnosis in neurological or systemic conditions known to affect CNS functioning; or
- When there is a need to quantify cognitive or behavioral deficits related to CNS impairment, especially when the information will be useful in determining a prognosis or informing treatment planning by determining the rate of disease progression; or
- When there is a need for pre-surgical or treatment-related cognitive evaluation to determine whether it would be safe to proceed with a medical or surgical procedure that may affect brain function (for example, deep brain stimulation, resection of brain tumors or arteriovenous malformations, epilepsy surgery, stem cell transplant) or significantly alter a patient's functional status; or
- When there is a need to assess the potential impact of adverse effects of therapeutic substances that may cause cognitive impairment (for example, radiation, chemotherapy, antiepileptic medications), especially when this information is utilized to determine treatment planning; or
- When there is a need to monitor progression, recovery and response to changing treatments, in patients with CNS disorders, in order to establish the most effective plan of care; or
- When there is a need for objective measurement of patients' subjective complaints about memory, attention, or other cognitive dysfunction, which serves to inform treatment by differentiating psychogenic from neurogenic syndromes (for example, dementia vs. depression), and in some cases will result in initial detection of neurological disorders or systemic diseases affecting the brain; or
- When there is a need to establish a treatment plan by determining functional abilities/impairments in individuals with known or suspected CNS disorders; or

- When there is a need to determine whether a member can comprehend and participate effectively in complex treatment regimens (for example, surgeries to modify facial appearance, hearing, or tongue debulking in craniofacial or Down syndrome patients; transplant or bariatric surgeries in patients with diminished capacity), and to determine functional capacity for health care decision making, work, independent living, managing financial affairs, etc.; or
- When there is a need to design, administer, and/or monitor outcomes of cognitive rehabilitation procedures, such as compensatory memory training for brain-injured patients; or
- When there is a need to establish treatment planning through identification and assessment of neurocognitive conditions that are due to other systemic diseases (for example, hepatic encephalopathy; anoxic/hypoxic injury associated with cardiac procedures); or
- Assessment of neurocognitive functions in order to establish rehabilitation and/or management strategies for individuals with neuropsychiatric disorders; or
- When there is a need to diagnose cognitive or functional deficits in children and adolescents based on an inability to develop expected knowledge, skills or abilities as required to adapt to new or changing cognitive, social, emotional or physical demands.

Neuropsychological testing is not considered medically necessary when:

- The patient is not neurologically and cognitively able to participate in a meaningful way with the requirements necessary to successfully perform the tests; or
- Used as screening tests given to the individual or general populations; or
- Used as a screening test for Alzheimer's dementia; or
- Administered for educational or vocational purposes that do not inform medical management; or
- Performed when abnormalities of brain function are not suspected; or
- Used for self-administered or self-scored inventories, or screening tests of cognitive function such as AIMS, or Folstein Mini Mental Status Exam (MMSE); or
- Repeated when not required for medical decision making, (for example, to make a diagnosis, or to start or continue rehabilitative or pharmacological therapy); or

- Administered when the patient has a substance abuse background and any one of the following apply:
  - the member has ongoing substance abuse such that test results would be inaccurate, or
  - the member is currently intoxicated; or
- The member has been diagnosed previously with brain dysfunction, and there is no expectation that the testing would impact the member's medical management.

Test Scoring/Written  
Test Report

The appropriate test scoring or written test report procedure code must be billed on the same claim as the test administration. Claims with a test score or written report code billed without a test administration code will be denied.

When billing Place of Service code "99" (other), the full name and address of the testing location must be documented in the *Additional Claim Information* field (Box 19) or on an attachment or the claim will be denied.

**Cognitive Skills Development**

When billing for cognitive skills development providers should use HCPCS code G0515 (development of cognitive skills to improve attention, memory, problem solving [includes compensatory training], direct [one-on-one] patient contact, each 15 minutes). The frequency limit is two units (30 minutes) per day, any provider.

**Medicare/Medi-Cal  
Crossovers**

If Medicare denies payment because the following requirements are not met, payment will also be denied by Medi-Cal.

Requirements

Medicare covers both psychotherapy and central nervous system assessments/tests. Claims for testing and therapy must first be submitted to Medicare before billing Medi-Cal for Medicare-eligible recipients. When billing Medi-Cal, providers must submit an *Explanation of Medicare Benefits (EOMB)/Medicare Remittance Notice (MRN)* with the claim for services rendered to a Medicare/Medi-Cal recipient.

Diagnostic Testing Covered  
by Medicare When Ordered  
by a Physician

Diagnostic testing performed by a psychologist practicing independently of an institution, agency or physician's practice is covered by Medicare only when the service is ordered by a physician. When submitting a claim, Medicare requires the psychologist to include a copy of the report sent to the physician who ordered the testing and the name and address of the referring physician.