JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Provider Relations and Network Innovation Reimbursement Policy**	*Policy Number*	RPC.033
		Effective Date	11/07/2024
		Approval Date	11/06/2024
	Subject **Psychotherapy Services Billed with Evaluation and Management Codes**	*Supersedes Date*	10/20/2023
		Original Date	10/20/2023
		Page	1 of 7

This document applies to the following Participating Organizations:

EHP	Johns Hopkins Advantage MD	Priority Partners	US Family Health Plan

Keywords: E/M, Evaluation and Management, Psychotherapy

Table of Contents		Page Number

I. ABOUT OUR REIMBURSEMENT POLICIES

The most current version of the reimbursement policies can be found on www.hopkinsmedicine.org.

Johns Hopkins Health Plan LLC (JHHP) reimbursement policies serve as a guide to assist in accurate claim submissions and outline the basis for reimbursement of services covered by a member's JHHP benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a guarantee that you will be reimbursed. Services must meet prior authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence. Providers are expected to and must follow proper billing and submission guidelines. Providers are required to use industry standard, compliant codes on all claim submissions. Services must be billed with valid ICD-10 diagnosis codes, Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, place of service (POS) codes, and/or revenue codes as defined by the Centers for Medicare & Medicaid Services (CMS) and in the American Medical Association's (AMA's) "CPT Manual".

The codes billed should denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the patient's medical record and/or office notes and JHHP reserves the right to request the records. Issues related to inconsistent, missing, conflicting, or unclear documentation must be resolved by the provider submitting the claim. If a corrected claim is filed, it must comply with timely filing to be reprocessed through the claims system. Corrected claims are for administrative errors on the claim (i.e., misspelled name, CPT/HCPCS code transposed, wrong DOB, missing modifier, etc.). Intentionally changing the CPT/HCPCS or diagnosis code in order to get the claim paid, after the billed service was denied, is not a correction. The medical records must match the services billed. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

JHHP policies apply to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. JHHP reimbursement policies are developed based on nationally accepted industry standards, coding principles, and follows CMS guidelines and the CMS developed National Correct Coding Initiative (NCCI) program to

prevent inappropriate payment of services that should not be reported together. These policies may be superseded by mandates in provider or state contracts, or state, federal or CMS contracts and/or requirements. If appropriate, when coding/billing guidelines or current reimbursement policies are not followed, JHHP may:

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

JHHP reserves the right to modify policies at any time and publish new versions when necessary. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, JHHP strives to minimize these modifications. When there is an update, policies will be published on our website.

II. PURPOSE

To provide billing and reimbursement guidance for high-level evaluation and management (E/M) services and outpatient visit codes, that are billed with psychotherapy procedure codes, on the same date of service, performed by the same treating provider, for the same member, by participating and nonparticipating providers, when rendered within the provider's scope of practice, under state and federal law. JHHP will process claims for psychotherapy services reported on a CMS-1500, or the electronic equivalent, when billed in accordance with regulatory, state and federal guidance. Providers submitting claims to JHHP must ensure documentation in the patient's medical record always supports the level of service(s) reported, or payment can be denied.

III. POLICY STATMENT

Johns Hopkins Health Plan LLC (JHHP) follows CMS, State, and American Medical Association (AMA) Current Procedural Terminology (CPT) guidelines, and will reimburse covered, psychotherapy services rendered by network and non-network providers, when all billing requirements and coding guidelines are met, and in accordance with member plan benefits. JHHP has identified CPT codes and HCPCS codes that are not payable, not covered, or may be bundled (not separately reimbursed) which are applicable to this policy. Each line of business possesses its own unique contract and guidelines for benefit and payment purposes. As such, there could be various factors that may impact reimbursement, including but not limited to legislative mandates, provider contracts, member's benefit coverage, prior authorization requirements, including provisions addressing services rendered by non-participating providers, which may supplement, modify, or supersede this policy.

*Providers are responsible to review the **"EXCEPTIONS & EXCLUSIONS" Sections** below for specific plan guidance, as some guidelines in this policy may not be applicable to all health plans/products.*

IV. BILLING GUIDELINES and PAYMENT METHODOLOGY

1. CMS-1500 claim submissions may not span dates. Submit each date of service on a separate line.
2. Multiple units of the same service code/modifier on the same day must be submitted on ONE claim line.
3. E/M services performed on the same day as a psychotherapy service (same physician or other qualified health care professional) must be significant and separately identifiable in order to bill both psychotherapy and Evaluation and Management (E/M) service.
4. Exact start and end times of the visit must be documented in the medical record along with the date of service.
5. For a given E/M encounter, the selection of the appropriate level of E/M service should be determined according to the code definitions in the AMA's CPT book and any applicable documentation guidelines.
   - Refer to the JHHP Evaluation and Management (E/M) policy, for additional guidance.
6. For approved providers of mental health services, the state licensure or authorization must specify that the provider's scope of practice includes the provision of clinical psychotherapy for the treatment of mental illness.

7. Providers are responsible for determining if a CPT/HCPCS code requires preauthorization. Each line of business possesses its own unique contract and guidelines which, for benefit and payment purposes, should be consulted first to know what benefits are available for coverage.
8. Consistent with CMS and CPT guidance, time spent on history, examination and medical decision making when used for the E/M service is **not** psychotherapy time.
9. CPT codes 90832-90838 include all psychotherapy provided to a patient with family members as informants, if present, for a single date of service.
10. Family psychotherapy (e.g., CPT codes 90846, 90847) focused on the patient addressing interactions between the patient and family members may be reported separately with psychotherapy (CPT codes 90832-90838) on the same date of service if performed as a separate and distinct service during a separate time interval.
11. Medical Doctors (MDs), Doctors of Osteopath (DOs), qualified Clinical Nurse Specialists (CNS), Psychiatric Nurse Practitioners (PNPs), Clinical Nurse Specialists (CNS) and Physician Assistants (PA) are the only providers that may render psychotherapy codes that include an E/M component (CPT codes 90833, 90836, 90838).
12. Appropriate documentation, in the patient's record, must support all codes billed.
    i. JHHP may conduct medical record documentation reviews on a randomly selected sample of practitioners or on providers who render services outside their regular scope of practice or assigned specialty.
    ii. Refer to the JHHP resources and guidelines for all of our health plans for additional information for Medical Record Standards Documentation.

V. INAPPRORIATE USE OF PSYCHOTHERAPY CODES

1. When a high-level E/M code is reported on the same date of service with a Psychotherapy code, the claim may be pended for further review. Documentation of both services provided must be well-supported by the content of the medical record or the claim will be denied.
2. Do not report psychotherapy codes for any session lasting less than 16 minutes.
3. In accordance with CMS, mental health services under the "Incident to" provision, a billing provider may not hire and supervise a professional whose scope of practice is outside the hiring provider's own scope of practice as authorized under State law, or whose professional qualifications exceed those of the supervising provider.
4. Psychotherapy add-on codes must be reported in conjunction with an appropriate code and can never be reported alone.
5. Psychotherapy services should not be reported for Activities of Daily Living (ADL) training or socialization activities.
6. CPT 90832, 90833, 90834, 90836, 90837 and 90838 should not be reported with a unit of service greater than one (except in place of service 52). Services will be denied when reporting more than one unit of service (expect in POS 52).
7. Clinical Nurse Specialists (CNS) may not render psychoanalysis (CPT code 90845) services.

VI. PSYCHOTHERAPY NOTES

1. Documentation must clearly identify the person performing the service (including but not limited to: title, education background, credentials).
2. The Privacy Rule in 45 CFR §164.501 defines psychotherapy notes as notes recorded by a mental health professional that document or analyze the contents of a counseling session and that are separated from the rest of a medical record.
3. The definition of psychotherapy notes expressly excludes: Medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of diagnosis, functional status, treatment plan, symptoms, prognosis, progress, and progress to date.
4. In accordance with CMS, JHHP requires that the medical record must indicate the exact start and stop time of the visit and length of time the provider spent in the psychotherapy encounter with the patient.

VII. EXCEPTIONS and EXCLUSIONS

1. Some state laws do not require certain services to be covered in all contracts; therefore, providers will need to contact the appropriate provider service department to verify the member's benefits.
2. **PPMCO**: Behavioral health services are reimbursed in accordance to the Code of Maryland Regulations (COMAR) and Maryland Medicaid. Under certain circumstances, some behavioral health (BH) services are under the responsibility of Maryland Medicaid. Please consult the authoritative guidance found in the MDH Manuals and transmittals to obtain additional specific information on policy, benefits, and coverage not addressed in this reimbursement policy.

    - All mental health providers must first enroll with Maryland Medicaid to receive a Medicaid provider number and then must register with Optum Maryland.
    - JHHP requires all providers (i.e., ordering, referring, rendering, servicing, billing) delivering services to Maryland Medicaid members to have an active enrollment status in the electronic Provider Revalidation and Enrollment Portal (ePREP) on the date of service.
    - Providers are solely responsible for ensuring their information in the ePREP portal is valid and active.
3. **USFHP:** JHHP will process and reimburse claims in accordance with TRICARE guidance. Please consult the authoritative guidance found in the TRICARE Manuals to obtain additional specific information on policy, benefits, and coverage not addressed in this reimbursement policy.

VIII. CODES, TERMS and DEFINITIONS

Definition of Terms

Term	Definition
Clinical Staff Member	A person (e.g., nurse, phlebotomist, or other health professional) who works under the supervision of a physician or other qualified health care professional, and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specific professional service, but does not individually report that professional service.
Evaluation and Management (E/M) Services	Per the CPT manual, E/M services (CPT 99202-99499) guidelines have sections that are common to all E/M categories and sections that are category specific. These guidelines are to be used by the reporting physician or other qualified healthcare professional to select the appropriate level of service. The E/M section of the CPT® manual is divided into broad categories and further divided into sub-categories of E/M services.

Office Visit	A physician's ambulatory practice (office) may be in a location other than in a hospital, nursing home, other extended care facility, patient's home, industrial clinic, college clinic, or family planning clinic. An office visit is any direct personal exchange between an ambulatory patient and a physician or members of their staff for the purpose of seeking care and rendering health services.
Outpatient	An outpatient is a person who has **not** been admitted by the provider as an inpatient and is not lodged in the provider facility while receiving its services. Where a provider uses the category "day patient;" i.e., an individual who receives the facility's services during the day and is not expected to be lodged in the facility at midnight, the individual is classified as an outpatient.
Physician or Other Qualified Health Care Professional (OQHCP)	A Physician or Other Qualified Health Care Professional is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.
Psychotherapy	The treatment of mental illness and behavioral disturbances in which the physician or other qualified health care professional, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.
Same Group Physician and/or Other Qualified Health Care Professional	All physicians and/or other qualified health care professionals of the same group who report with the same Federal Tax Identification Number (TIN). Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician.

Psychotherapy Service Codes: The following timed psychotherapy codes apply in all settings (e.g., office, outpatient, inpatient, etc.). Select the code that most closely matches the actual time spent.

Code	Definition
90832	Psychotherapy, 30 minutes with patient (16 to 37 minutes).
90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (16 to 37 minutes).

90834	Psychotherapy, 45 minutes with patient (38 to 52 minutes).
90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (38 to 52 minutes).
90837	Psychotherapy, 60 minutes with patient (53 minutes or longer).
90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (53 minutes or longer

E/M Service Codes

CPT Code	Definition
99202-99499	Please refer to the AMA CPT book for all E/M CPT descriptors located in the Evaluation and Management section (99202-99499), there are many code categories. Each category may have specific guidelines, or the codes may include specific details.

Modifiers

Modifier	Definition
25	Significant, separately identifiable Evaluation and Management (E/M) by the same physician or other qualified health care professional on the same day of the procedure or other service. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported.

IX. REFERENCES

This policy has been developed through consideration of the following:

- CMS Regulations & Guidance
- COMAR- Maryland Department of Health- Maryland Medicaid Administration
- CPT® Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association
- JHHP E&M Resources
- Medicare Benefit Policy Manual- Chapter 15
- Medicare Claims Processing Manual- Chapter 12
- MLN 1986542- Medicare Mental Health
- NCCI for Medicaid | CMS
- NCCI for Medicare | CMS
- TRICARE Reimbursement Manual

X. APPROVALS

Date	Review/Revision	Reason for Modification	Approved By
11/06/2024	Revision	Update policy language and guidance	Reimbursement Policy Committee (RPC)
8/09/23	New	N/A	Reimbursement, Authorization and Coding Committee (RAC)