Local Coverage Determination (LCD)

Psychiatric Diagnostic Evaluation and Psychotherapy Services

L33252

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Contractor Information

Contractor Name	Contract Type	Contract Number	Jurisdiction	States
First Coast Service Options, Inc.	A and B MAC	09101 - MAC A	J - N	Florida
First Coast Service Options, Inc.	A and B MAC	09102 - MAC B	J - N	Florida
First Coast Service Options, Inc.	A and B MAC	09201 - MAC A	J - N	Puerto Rico Virgin Islands
First Coast Service Options, Inc.	A and B MAC	09202 - MAC B	J - N	Puerto Rico
First Coast Service Options, Inc.	A and B MAC	09302 - MAC B	J - N	Virgin Islands

LCD Information

Document Information

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L33252

LCD Title
Psychiatric Diagnostic Evaluation and Psychotherapy Services

Proposed LCD in Comment Period
N/A

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N/A

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Notice Period End Date
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CMS National Coverage Policy

This LCD supplements but does not replace, modify or supersede existing Medicare applicable National Coverage Determinations (NCDs) or payment policy rules and regulations for Psychiatric Diagnostic Evaluation and Psychotherapy Services. Federal statute and subsequent Medicare regulations regarding provision and payment for medical services are lengthy. They are not repeated in this LCD. Neither Medicare payment policy rules nor this LCD replace, modify or supersede applicable state statutes regarding medical practice or other health practice professions acts, definitions and/or scopes of practice. All providers who report services for Medicare payment must fully understand and follow all existing laws, regulations and rules for Medicare payment for Psychiatric Diagnostic Evaluation and Psychotherapy Services and must properly submit only valid claims for them. Please review and understand them and apply the medical necessity provisions in the policy within the context of the manual rules. Relevant CMS manual instructions and policies may be found in the following Internet-Only Manuals (IOMs) published on the CMS Web site.

Internet Only Manual (IOM) Citations:

- CMS IOM Publication 100-01, *Medicare General Information, Eligibility and Entitlement Manual*,
  - Chapter 3, Section 30 Outpatient Mental Health Treatment Limitation
- CMS IOM Publication 100-02, *Medicare Claims Processing Manual*,
  - Chapter 15, Section 40.4 Definition of Physician/Practitioner, Section 60 Services and Supplies Furnished Incident To a Physician's/NPP's Professional Service, and Section 160 Clinical Psychologist Services
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*,
  - Chapter 12, Section 120 Nurse Practitioner(NP) And Clinical Nurse Specialist (CNS) Services Payment Methodology, Section 120.2 Outpatient Mental Health Treatment Limitation, Section 120.3 NP and CNS Billing to the A/B MAC (b), Section 160 Independent Psychologist Services, Section 170 Clinical Psychologist Services, Section 210 Outpatient Mental Health Treatment Limitation, and Section 210.1 Application of the Limitation
- CMS IOM Publication 100-08, *Medicare Program Integrity Manual*,
  - Chapter 3, Section 3.3.2.6 Psychotherapy Notes
  - Chapter 13, Section 13.5.4 Reasonable and Necessary Provision in an LCD

Social Security Act (Title XVIII) Standard References:

- Title XVIII of the Social Security Act, Section 1862(a)(1)(A) states that no Medicare payment shall be made for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury.
- Title XVIII of the Social Security Act, Section 1862(a)(7). This section excludes routine physical examinations.
- Title XVIII of the Social Security Act, Section 1833(e) states that no payment shall be made to any provider for any claim that lacks the necessary information to process the claim.

Federal Register References:

- Code of Federal Regulations (CFR), Title 45, Volume 1, Subpart E Privacy of Individually Identifiable Health Information, Part 164.501 Definitions.

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

Covered Indications

This part of the LCD has been divided into seven (7) sections addressing the following services:

I. Psychiatric Diagnostic Evaluation and Psychiatric Diagnostic Evaluation with Medical Services
II. Psychotherapy
III. Group Psychotherapy
IV. Family Psychotherapy
V. Psychoanalysis
VI. Interactive Complexity Services
VII. Psychotherapy for Crisis

Section I: Psychiatric Diagnostic Evaluation and Psychiatric Diagnostic Evaluation with Medical Services

A. Psychiatric Diagnostic Evaluation
A psychiatric diagnostic evaluation is an integrated biopsychosocial assessment that includes the elicitation of a complete medical history (to include past, family, and social), psychiatric history, a complete mental status exam, establishment of a tentative diagnosis, and an evaluation of the patient's ability and willingness to participate in the proposed treatment plan. Information may be obtained from the patient, other physicians, other

clinicians or community providers, and/or family members or other sources. There may be overlapping of the medical and psychiatric history depending upon the problem(s).

Although the emphasis, types of details, and style of a psychiatric evaluation differ from the medical evaluation, the purpose is the same: to establish effective communication with interaction of sufficient quality between provider and patient to gather accurate data in order to formulate tentative diagnoses, determine necessity, and as appropriate, initiate an effective and comprehensive treatment plan.

Psychiatric diagnostic evaluations will be considered medically necessary when the patient has a psychiatric illness and /or is demonstrating emotional or behavioral symptoms sufficient to cause inappropriate behavior patterns or maladaptive functioning in personal or social settings, which may be suggestive of a psychiatric illness. This examination may also be medically necessary when baseline functioning is altered by suspected illness or symptoms. It is appropriate for dementia, in patients who experience a sudden and rapid change in behavior.

B. Psychiatric Diagnostic Evaluation with Medical Services

A psychiatric diagnostic evaluation with medical services is an integrated biopsychosocial and medical assessment, including history (to include past, family, and social), psychiatric history, a complete mental status exam, other physical examination elements as indicated, establishment of a tentative diagnosis, and an evaluation of the patient's ability and willingness to participate in the proposed treatment plan. The evaluation may include communication with family members or other sources, prescription of medications, and review and ordering of laboratory or other diagnostic studies.

Section II: Psychotherapy

Psychotherapy is the treatment of mental illness and behavior disturbances, in which the provider establishes a professional contact with the patient and through therapeutic communication and techniques, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, facilitate coping mechanisms and/or encourage personality growth and development.

Insight oriented, behavior modifying, and/or supportive psychotherapy refers to the development of insight or affective understanding, the use of behavior modification techniques, the use of supportive interactions, and the use of cognitive discussion of reality, or any combination of the above to provide therapeutic change.

Psychotherapy will be considered medically necessary when the patient has a psychiatric illness and/or is demonstrating emotional or behavioral symptoms sufficient to cause inappropriate behavior or maladaptive functioning. Psychotherapy services must be

performed by a person licensed by the state where practicing, and whose training and scope of practice allow that person to perform such services.

Psychotherapy must be provided as an integral part of an active treatment plan for which it is directly related to the patient's identified condition/diagnoses. Some patients receive psychotherapy alone, and others receive psychotherapy along with medical evaluation and management services. These services involve a variety of responsibilities unique to the medical management of psychiatric patients such as medical diagnostic evaluation (i.e. evaluation of co-morbid medical conditions, drug interactions, and physical examinations), drug management when indicated, physician orders, interpretation of laboratory or other diagnostic studies and observations. The patient should be amenable to allowing insight-oriented therapy such as behavioral modification techniques, interpersonal psychotherapy techniques, supportive therapy, and cognitive/behavioral techniques to be effective.

Some psychiatric patients receive a medical evaluation and management service on the same day as a psychotherapy service by the same physician or other qualified health care professional. These services to be medically necessary should be significantly different and separately identifiable.

Section III: Group Psychotherapy

Group Psychotherapy is a form of treatment administered in a group setting with a trained group leader in charge of several patients. Since it involves psychotherapy it must be led by a person, authorized by state statute to perform this service. This will usually mean a psychiatrist, clinical psychologist, licensed clinical social worker, certified nurse practitioner, or clinical nurse specialist. The group is a carefully selected group of patients meeting for a prescribed period of time during which common issues are presented and generally relate to and evolve towards a therapeutic goal. Personal and group dynamics are discussed and explored in a therapeutic setting allowing emotional outpouring, instruction, and support. Medical diagnostic evaluation and pharmacological management may continue by a physician when indicated. The group size should be of a size that can be considered therapeutically successful (i.e., maximum 12 people).

Group therapy will be considered medically necessary when the patient has a psychiatric illness and /or is demonstrating emotional or behavioral symptoms sufficient to cause inappropriate behavior patterns or maladaptive functioning in personal or social settings. The issues presented and explored in the group setting should evolve towards a theme or a therapeutic goal. Group psychotherapy must be ordered by a provider as an integral part of an active treatment plan for which it is directly related to the patient's identified condition/diagnosis. This treatment plan must be adhered to and should be endorsed and monitored by the treating physician or physician of record. The specialized skills of a mental health care professional must be required.

Section IV: Family Psychotherapy

Family Psychotherapy is a specialized therapeutic technique for treating the identified patients' mental illness by intervening in a family system in such a way as to modify the family structure, dynamics, and interactions which exert influence on the patient's emotions and behaviors.

Family psychotherapy sessions may occur with or without the patient present. The process of family psychotherapy helps reveal a family's repetitious communication patterns that are sustaining and reflecting the identified patient's behavior. For the purposes of this policy, a family member is any individual who spends a significant amount of the time with the patient and provides psychological support to the patient, which may include but is not limited to a caregiver or significant other.

Family psychotherapy will be considered medically reasonable and necessary only in clinically appropriate circumstances and when the primary purpose of such psychotherapy is the treatment/management of the patient's condition. Examples are as follows:

- when there is a need to observe and correct, through psychotherapeutic techniques, the patient's interaction with family members; and/or
- where there is a need to assess the conflicts or impediments within the family, and assist, through psychotherapeutic techniques, the family members in the management of the patient.

Family psychotherapy is considered to be medically reasonable and necessary when the patient has a psychiatric illness and/or is demonstrating emotional or behavioral symptoms sufficient to cause inappropriate behavior or maladaptive functioning.

Section V: Psychoanalysis

Psychoanalysis is a treatment modality that uses psychoanalytic theories as the frame for formulation and understanding of the therapy process. These theories provide a focus on increasing self-understanding and deepening insight into emotional issues and conflicts which underlie presenting emotional difficulties. Typically therapists make use of exploration of unconscious thoughts and feelings which may relate to underlying emotional conflicts, interpretation of defensive processes which obstruct emotional awareness, and consideration of issues related to sense of self-esteem.

Psychoanalysis uses a special technique to gain insight into a patient's unconscious motivations and conflicts using the development and resolution of a therapeutic transference to achieve therapeutic effect. It is a different therapeutic modality than psychotherapy.

Section VI: Interactive Complexity Services

Interactive complexity refers to specific communication factors that complicate the delivery of a psychiatric procedure. Common factors include more difficult communication with discordant or emotional family members and engagement of young and verbally undeveloped or impaired patients.

The interactive complexity techniques are utilized primarily to evaluate children and/or adults who do not have the ability to interact through ordinary verbal communication. In the aforementioned instances, it involves the use of physical aids and nonverbal communication to overcome barriers to the therapeutic interaction between the clinician and the patient who has not yet developed or has lost either the expressive language communication skills to explain his/her symptoms and response to treatment or the receptive communication skills to understand the clinician if he/she were to use ordinary adult language for communication. An interactive technique may include the use of inanimate objects such as toys and dolls for a child, physical aids, and non-verbal communication to overcome barriers to therapeutic interaction, or an interpreter for a person who is deaf or in situations where the patient does not speak the same language as the provider of care.

Section VII: Psychotherapy for Crisis

Psychotherapy for crisis is an urgent assessment and history of a crisis state, a mental status exam, and a disposition. The treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma. The presenting problem is typically life threatening or complex and requires immediate attention to a patient with high distress.

Limitations

1.The psychiatric diagnostic evaluation is not considered to be medically reasonable and necessary:

- when it is rendered to a patient who has a medical/neurological condition such as dementia, delirium, or other psychiatric conditions, which have produced a severe enough cognitive defect to prevent effective communication and the ability to assess the patient; or
- when the patient has a previously established diagnosis of a neurological condition or dementia and is not amenable to the evaluation and therapy, unless there has been an acute and/or marked mental status change, a request for second opinion, or diagnostic clarification is necessary to rule out additional psychiatric or neurological processes, which may be treatable

2. For psychiatric diagnostic evaluation with medical services, routine performance of additional psychiatric diagnostic evaluation of patients with chronic conditions is not

considered medically necessary. A psychiatric diagnostic evaluation can be conducted once, at the onset of an illness or suspected illness. The same provider may repeat it for the same patient if an extended hiatus in treatment occurs, if the patient requires admission to an inpatient status for a psychiatric illness, or for a significant change in mental status requiring further assessment. An extended hiatus is generally defined as approximately 6 months from the last time the patient was seen or treated for their psychiatric condition. A psychiatric diagnostic evaluation may also be utilized again if the patient has a previously established neurological disorder or dementia and there has been an acute and/or marked mental status change, or a second opinion or diagnostic clarification is necessary to rule out additional psychiatric or neurological processes, which may be treatable.

3. The medical record for psychiatric diagnostic evaluation with or without medical assessment should indicate the presence of a psychiatric illness and/or the demonstration of emotional or behavioral symptoms which may be suggestive of a psychiatric illness or are sufficient to significantly alter baseline functioning. The diagnostic evaluation should include:

- The reason for the evaluation/patient's chief complaint
- A referral source (if applicable)
- History of present illness, including length of existence of problems/symptoms/conditions
- Past history (psychiatric)
- Significant medical history and current medications
- Social history
- Family history
- Mental status exam
- Strengths/liabilities
- Multi-axis diagnosis or diagnostic impression list-including problem list
- Treatment plan (including methods of therapy, anticipated length of treatment to the extent possible, and a description of the planned measurable and objective goals related to expected changes in behavior or thought processes)

In circumstances where other informants (family or other sources) are interviewed in lieu of the patient, documentation must include the elements outlined previously, as well as the specific reason(s) for not evaluating the patient. Any notations where family members provided patient history should be included. This should be a rare occurrence.

4. Any time that an interactive complexity service is reported, the medical record must clearly support the rationale for this approach. Otherwise stated, there must be an explanation of what specific communication factors complicated the delivery of a psychiatric procedure. The medical record must indicate that the person being evaluated has one of the following communication factors present during the visit:

- The need to manage maladaptive communication among participants (related to, e.g., high anxiety, high reactivity, repeated questions, or disagreement) that complicates delivery of care.
- Caregiver emotions or behaviors that interfere with implementation of the treatment plan.
- Evidence or disclosure of a sentinel event and mandated report to a third party (e.g., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.
- Use of play equipment, physical devices, interpreter, or translator to overcome barriers to diagnostic or therapeutic interaction with a patient who is not fluent in the same language or who has not developed or has lost expressive or receptive language skills to use or understand typical language.

Additionally, the medical record must include adaptations utilized in the session to overcome the difficulty in communication and the rationale for employing these techniques justifying the interactive complexity of the service. The medical record must include treatment recommendations.

5. Psychotherapy/psychoanalysis services are not considered to be medically reasonable and necessary when they are rendered to a patient who has a medical/neurological condition such as dementia, delirium or other psychiatric conditions, which have produced a severe enough cognitive deficit to prevent effective communication with interaction of sufficient quality to allow insight oriented therapy (i.e. behavioral modification techniques, interpersonal psychotherapy techniques, supportive therapy or cognitive/behavioral techniques). In these cases, evaluation and management or pharmacological codes should be used.

6. Psychoanalysis is generally considered unsuitable for psychoses.

7. It is expected that the treatment plan for a patient receiving outpatient psychotherapy or psychoanalysis services, (i.e., measurable and objective treatment goals, descriptive documentation of therapeutic intervention, frequency of sessions, and estimated duration of treatment) will be updated on a periodic basis, generally at least every three months.

8. Psychotherapy services are not considered to be medically reasonable and necessary when they primarily include the teaching of grooming skills, monitoring activities of daily living, recreational therapy (dance, art play), or social interaction.

9. Group psychotherapy services are not considered to be medically reasonable and necessary when they are rendered to a patient who has a medical/neurological condition such as dementia, delirium, or other psychiatric conditions, which have produced a severe enough cognitive deficit to prevent effective communication including interaction of sufficient quality with the therapist and members of the group. Other services such as music

therapy, socialization, recreational activities/recreational therapy, art classes/art therapy, excursions, sensory stimulation, eating together, cognitive stimulation, or motion therapy are not considered to be medically reasonable and necessary.

10. In certain types of medical conditions, such as the unconscious or comatose patient, family psychotherapy would not be medically reasonable or necessary.

11. The documentation for psychoanalysis or psychotherapy services including group and family psychotherapy should include on a periodic basis the patient's capacity to participate and benefit from psychotherapy/psychoanalysis. Such periodic documentation should include the estimated duration of treatment in terms of number of sessions required and the target symptoms, measurable and objective goals of therapy related to changes in behavior, thought processes and/or medications, methods of monitoring outcome, and why the chosen therapy is an appropriate modality either in lieu of or in addition to another form of psychiatric treatment. For an acute problem, there should be documentation that the treatment is expected to improve the mental health status or function of the patient. For chronic problems, there must be documentation indicating that stabilization of mental health status or function is expected. Documentation will reflect adjustments in the treatment plan that reveals the dynamics of treatment.

12. If psychotherapy services are performed incident-to, all incident-to rules must be met, and the person providing the psychotherapy service must be licensed in the state to perform psychotherapy.

13. For psychotherapy and psychoanalysis services, the medical record documentation maintained by the provider must indicate the medical necessity of each psychotherapy/psychoanalysis session and include the following:

- The presence of a psychiatric illness and/or the demonstration of emotional or behavioral symptoms sufficient to alter baseline functioning; and
- A detailed summary of the session, including descriptive documentation of therapeutic interventions such as examples of attempted behavior modification, supportive interaction, and discussion of reality; and
- The degree of patient participation and interaction with the therapist, the reaction of the patient to the therapy session, documentation toward goal-oriented outcomes and the changes or lack of changes in patient symptoms and/or behavior as a result of the therapy session.
- The rationale for any departure from the plan or extension of therapy should be documented in the medical record. The therapist must document patient/therapist interaction in addition to an assessment of the patient's problem(s).
- Additionally, for psychoanalysis, the medical record must document the indications for psychoanalysis, description of the transference, and that psychoanalytic techniques

were used. The physician using this technique must be trained and credentialed in its use. CNS's and NP's are not eligible for payment for psychoanalysis.

The medical record documentation for psychotherapy must be clear and concise. Statements such as "supportive psychotherapy given" are not adequate. A clear and detailed description of what the psychotherapy entailed and how it is addressing the presenting problem of the patient should be evident.

14. For family psychotherapy services (with or without the patient present), the medical record documentation maintained by the provider must indicate the medical necessity of each family psychotherapy session and include the following:

- The presence of a psychiatric illness and/or the demonstration of emotional or behavioral symptoms sufficient to alter baseline functioning; and
- The summary of themes addressed in the family psychotherapy session, including descriptive documentation of therapeutic interventions such as examples of attempted behavior modification, supportive interaction, and discussion of reality; and
- The degree of patient participation and interaction with the family members and leader, the reaction of the patient to the group, the group's reaction to the patient and the changes or lack of changes in patient symptoms and/or behavior as a result of the family psychotherapy session.
- Family psychotherapy must be ordered by a provider as an integral part of an active treatment plan for which it is directly related to the patient's identified condition/diagnosis.
- Family psychotherapy must be conducted face to face by physicians (MD/DO), psychologists, or other mental health professionals licensed or authorized by state statutes and considered eligible for reimbursement.

15. It is the provider's responsibility not to submit privileged information. This information should be kept apart from the clinical note in a separate section of the patient's medical record. Please refer to the Health Insurance Portability and Accountability Act (HIPPA) Privacy Rule and 45 CFR Section 164.501 for additional guidance regarding privileged information.

16. Patient progress may be small or not be measurable at each visit. However, a trend should be measurable presenting signs of progression or regression in changes relating to behavior, thought processes, or medication management. When services are performed in excess of established parameters, they may be subject to review for medical necessity.

17. There must be a reasonable expectation of improvement in the patient's disorder or condition, demonstrated by an improved level of functioning or maintenance of level of functioning where decline would otherwise be expected in the case of a disabling mental illness or condition or chronic mental disorder. When a patient reaches a point in his/her

treatment where further improvement does not appear to be indicated and there is no reasonable expectation of improvement, the psychological services are no longer considered reasonable or medically necessary. The documentation must support that the patient's mental stability cannot be maintained without further psychotherapy treatment. The duration of a course of psychotherapy must be individualized for each patient.

18. Psychiatric and/or psychological services routinely performed to evaluate and/or treat an adjustment disorder associated with placement in a nursing home do not constitute medical necessity. It is not expected that every patient upon entry to a nursing home receives a psychiatric diagnostic evaluation and/or psychotherapy services. The routine use of these services is considered screening and is not medically reasonable and necessary for Medicare coverage. However, some individuals enter a nursing home at a time of physical and cognitive decline and may require these services to arrive at a diagnosis, plan of care, and/or treatment. Decisions to perform these services to individuals who have recently entered a nursing home need to be made judiciously, on a case-by-case basis, and the medical record documentation must clearly support the medical necessity for the performance of these services.

19. The patient must have the capacity to actively participate in all therapies prescribed, except for family therapy without the patient present.

20. Physicians/NPP's with a high utilization of these services per patient compared to their peers may be subject to review for medical necessity.

As published in the CMS IOM Publication 100-08, *Medicare Program Integrity Manual*, Chapter 13, Section 13.5.4, an item or service may be covered by a contractor LCD if it is reasonable and necessary under the Social Security Act Section 1862 (a)(1)(A). Contractors shall determine and describe the circumstances under which the item or service is considered reasonable and necessary.

Summary of Evidence

N/A

Analysis of Evidence (Rationale for Determination)

N/A

General Information

Associated Information

Documentation Requirements

Please refer to the Local Coverage Article: Billing and Coding: Psychiatric Diagnostic Evaluation and Psychotherapy Services (A57520) for documentation requirements that apply to the reasonable and necessary provisions outlined in this LCD.

Utilization Guidelines

Please refer to the Local Coverage Article: Billing and Coding: Psychiatric Diagnostic Evaluation and Psychotherapy Services (A57520) for utilization guidelines that apply to the reasonable and necessary provisions outlined in this LCD.

Sources of Information

First Coast Service Options, Inc. Reference LCD number - L33128

CPT Changes 2013: An Insider's View, pages 232-244.

CPT 2013, Professional Edition, pages 483-487.

CPT 2014, Professional Edition, pages 527-530.

HCPCS Level II 2013 Book, Professional Edition

LCDs and policies from other Medicare contractors

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Revision History Information

Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
07/01/2020	R10	Revision Number: 7 Publication: June 2020 Connection LCR A/B2020-043 Explanation of Revision: Based on a CMS directive, the LCD was revised to remove language in the "Limitations" section regarding multiple family group psychotherapy. The effective date of this revision is based on date of service.	• Other (Revision based on CMS directive)
01/08/2019	R9	Revision Number : 6 Publication: October 2019 Connection LCR A/B2019-069 Explanation of Revision: Based on Change Request (CR) 10901, the LCD was revised to remove all billing and coding and all language not related to reasonable and necessary provisions ("Bill Type Codes," "Revenue Codes," "CPT/HCPCS Codes," "ICD-10 Codes that Support Medical Necessity," "Documentation	• Other (Revision based on CR 10901)

Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
		Requirements” and “Utilization Guidelines” sections of the LCD) and place them into a newly created billing and coding article. During the process of moving the ICD-10-CM diagnosis codes to the billing and coding article, the ICD-10-CM diagnosis code ranges were broken out and listed individually. In addition, the Social Security Act, Code of Federal Regulations, and IOM reference sections were updated. The effective date of this revision is for claims processed on or after January 08, 2019, for dates of service on or after October 03, 2018. At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination and therefore not all the fields included on the LCD are applicable as noted in this LCD.	

Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
10/01/2018	R8	Revision Number: 5 Publication: September 2018 Connection LCR A/B2018-074 Explanation of Revision: Based on CR 10847 (Annual 2019 ICD-10-CM Update), the LCD was revised. Added ICD-10-CM diagnosis codes F12.93 and F53.0-F53.1. Deleted ICD-10-CM diagnosis code F53. In addition, the LCD was revised to indicate that diagnosis codes were added and descriptors revised within existing diagnosis code ranges. The effective date of this revision is based on date of service. 10/01/2018: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination and therefore not all the fields included on the LCD are applicable as noted in this LCD.	• Revisions Due To ICD-10-CM Code Changes

Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
10/01/2017	R7	**Revision Number: 4** Publication: September 2017 Connection LCR A/B2017-038 **Explanation of Revision:** Based on CR 10153 (Annual 2018 ICD-10-CM Update) the LCD was revised. Descriptor revised for ICD-10-CM diagnosis code F41.0. Added ICD-10-CM diagnosis code F12.11. The effective date of this revision is based on date of service. 10/01/2017: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination and therefore not all the fields included on the LCD are applicable as noted in this policy.	• Revisions Due To ICD-10-CM Code Changes
01/01/2017	R6	Revision Number: 3 Publication: December 2016 Connection LCR A/B2017-001	• Revisions Due To CPT/HCPCS Code Changes

Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
		Explanation of Revision: Annual 2017 HCPCS Update. Descriptors revised for CPT codes 90832, 90833, 90834, 90836, 90837, 90838, 90846, and 90847. Additionally, this LCD was revised in the “Indications and Limitations of Coverage and/or Medical Necessity” and “Documentation Guidelines” sections to reflect descriptor changes for the following CPT/HCPCS codes: 90832-90838. The effective date of this revision is based on date of service.	
10/01/2016	R5	Revision Number: 2 Publication: October 2016 Connection LCR A/B2016-097 Explanation of Revision: Based on CR 9677 (Annual 2017 ICD-10-CM Update) the LCD was revised. Revised ICD-10-CM diagnosis code range F32.0-F32.8 to read F32.0-F32.89, F34.0-F34.8 to read F34.0-F34.89, F42-F43.8 to read F42.2-F43.8, and F50.00-F50.8 to read F50.00-F50.89. Deleted diagnosis	• Revisions Due To ICD-10-CM Code Changes

Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
		codes F32.8, F34.8, F42.2, and F50.8. The effective date of this revision is based on date of service.	
06/28/2016	R4	Revision Number: 1 Publication: N/A LCR A/B2016-074 Explanation of Revision: This LCD was revised based on a recommendation from the provider community to add ICD-10-CM diagnosis code Z01.818 to the "ICD-10 Codes that Support Medical Necessity" sections of the LCD. The effective date of this revision is for claims processed on or after 6/28/2016.	• Request for Coverage by a Practitioner (Part B) • Request for Coverage by a Provider (Part A)
10/01/2015	R3	08/11/2015 - - The language and/or ICD-10-CM diagnoses were updated to be consistent with the current ICD-9-CM LCD's language and coding.	• Provider Education/Guidance
10/01/2015	R2	3/13/2015: The language and/or ICD-10-CM diagnoses were updated to be consistent with the	• Revisions Due To CPT/HCPCS Code Changes

Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
		current ICD-9-CM LCD's language and coding.	
10/01/2015	R1	05/29/2014 – The language and/or ICD-10-CM diagnoses were updated to be consistent with current LCD language and ICD-9-CM coding.	• Provider Education/Guidance • Revisions Due To ICD-10-CM Code Changes

Associated Documents

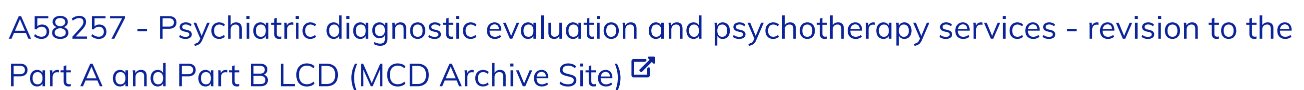
Attachments

N/A

Related Local Coverage Documents

Articles

A57520 - Billing and Coding: Psychiatric Diagnostic Evaluation and Psychotherapy Services

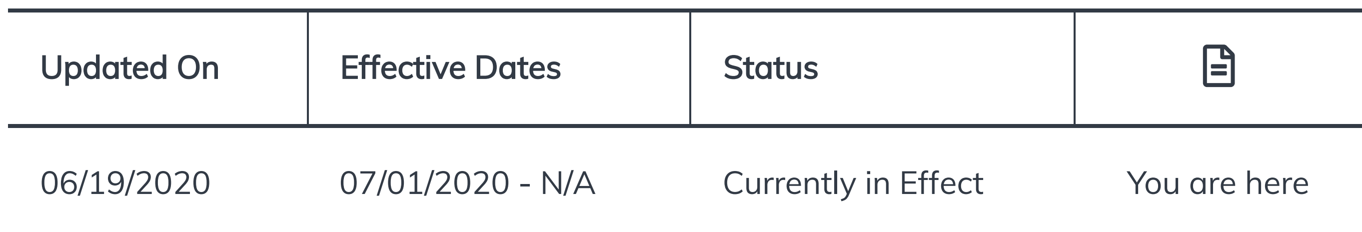

A58257 - Psychiatric diagnostic evaluation and psychotherapy services - revision to the Part A and Part B LCD (MCD Archive Site)

Related National Coverage Documents

NCDs

N/A

Public Versions



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Keywords

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