


<b>MEDICAL POLICY</b>	<b>Extended Outpatient Psychotherapy (Medicare Only)</b>
<b>Effective Date: 1/1/2023</b>	Medical Policy Number: 370
 1/1/2023	Medical Policy Committee Approved Date: 12/2022
Medical Officer                      Date	

**See Policy CPT/HCPCS CODE section below for any prior authorization requirements**

**SCOPE:**

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayn Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

**APPLIES TO:**

Medicare Only

**MEDICARE POLICY CRITERIA**

The following Centers for Medicare & Medicaid Service (CMS) guidelines should be utilized for medical necessity coverage determinations. Click the link provided in the table below to access applicable medical necessity criteria. All listed guidelines apply.

Service	Medicare Guidelines
<i>Extended Outpatient Psychotherapy</i>	<p>Company medical policy for <a href="#">Extended Outpatient Psychotherapy (All Lines of Business Except Medicare)</a></p> <p>I. These services may be considered <b>medically necessary</b> for Medicare when the Company medical policy criteria are met.</p> <p>II. These services are considered <b>not medically necessary</b> for Medicare Plan members when the Company medical policy criteria are <b>not</b> met. <i>See Policy Guidelines below.</i></p>

**POLICY GUIDELINES**

Medicare and Medical Necessity

Only medically reasonable and necessary services or items which treat illness or injury are eligible for Medicare coverage, as outlined in *Title XVIII of the Social Security Act, §1862(a)(1)(A)*.

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The Company policy for *PHA Medicare Medical Policy Development and Application* (MP50) provides details regarding Medicare’s definition of medical necessity and the hierarchy of Medicare references and resources during the development of medical policies, as well as the Plan’s use of evidence-based processes for policy development. In the absence of Medicare coverage policies (e.g., manual, national coverage determination [NCD], local coverage determination [LCD], article [LCA], etc.) which addresses the medical necessity of a given health care service, Medicare regulatory guidelines do allow Medicare Advantage Organizations (MAOs) to make their own coverage determinations, as long as the MAO applies an objective, evidence-based process, based on authoritative evidence. (*Medicare Managed Care Manual, Ch. 4, §90.5*)

**CPT/HCPCS CODES**

Medicare Only	
No Prior Authorization Required	
90837	Psychotherapy, 60 minutes with patient
90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to code for primary procedure)
90839	Psychotherapy for crisis; first 60 minutes
90840	Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary procedure)

**INSTRUCTIONS FOR USE**

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

**REGULATORY STATUS**

Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.