OFFICIAL

NEW YORK STATE WORKERS' COMPENSATION

BEHAVIORAL HEALTH FEE SCHEDULE

Effective 4/1/2019
Revisions Effective 1/1/2020

Workers' Compensation Board

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New York Workers' Compensation Board Filing Notice

The Behavioral Health Fee Schedule was duly filed in the Office of the Department of State, and constitutes Sections 333.1 and 333.2 of Title 12 of the Official Compilation of Codes, Rules and Regulations of the State of New York.

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Revised Printing

This revised printing contains revisions effective January 1, 2020.

FOREWORD

The Workers' Compensation Board is pleased to present the updated version of the *New York State Workers' Compensation Behavioral Health Fee Schedule*.

The revised fee schedule is an essential tool for health care providers and those paying the cost of health care services under the New York State Workers' Compensation system. This schedule provides comprehensive billing guides, which will allow health care providers to appropriately describe their services and minimize disputes over reimbursement. Also, this schedule includes many new procedures and coding changes that have taken place since the previously published fee schedule.

This fee schedule could not have been produced without the assistance of many individuals. The spirit of cooperation between the provider and payer communities is very much appreciated. The excellence of this schedule is due, in large part, to the commitment of many people in the workers' compensation community. We are grateful for their efforts.

Except where noted, this fee schedule is effective for medical services rendered on or after April 1 2019, regardless of the date of accident. The fees established herein are payable to health care providers authorized or permitted to render care under the Workers' Compensation Law, Volunteer Firefighters' Benefit Law, and Volunteer Ambulance Workers' Benefit Law.

New York State Workers' Compensation Board

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Introduction and General Guidelines

The *Official New York State Workers' Compensation Behavioral Health Fee Schedule* shows behavioral health services and their relative value units. The services are listed by *Current Procedural Terminology* (CPT®) codes. The relative value unit set for each CPT service is based on comparative magnitude among various services and procedures. The relative value units within each section apply only to that section. CPT is a registered trademark of the American Medical Association (AMA).

The accompanying instructions and ground rules explain the application of these procedure descriptors and relative value units.

Because the Behavioral Health Fee Schedule is applicable to all of New York State, a large and diverse geographical area, the relative value units contained herein do not necessarily reflect the charges of any individual medical provider or the pattern of charges in any specific area of New York State.

A primary purpose of the schedule is to provide a precise description and coding of the services provided by authorized psychologists, psychiatric nurse practitioners, licensed clinical social workers, and physicians in the care of workers' compensation covered patients and ensure the proper payment for such services by assuring that they are specifically identifiable. The Behavioral Health Fee Schedule is for use by these medical providers delivering behavioral health services and treatment to injured workers covered under Workers' Compensation Law. Physicians and psychiatric nurse practitioners can use the full version of the *Official New York State Workers' Compensation Medical Fee Schedule* and the codes and conversion factors therein. Psychologists and licensed clinical social workers are to bill for services listed in this section of the fee schedule as appropriate.

An attempt has been made to adhere as closely as possible to the terminology and coding of the American Medical Association's *CPT 2018*.

To ensure uniformity of billing, when multiple services are rendered, each relative value unit is to be multiplied by the conversion factor separately, and then the products are to be added.

FORMAT

The *Official New York State Workers' Compensation Behavioral Health Fee Schedule* consists of one section, which uses the psychology conversion factor.

Introductory Information

The introductory ground rules that precede the data include definitions, references, prohibitions, and dire ctions for proper use. It cannot be emphasized too strongly that the introductory ground rules be read and understood before using the data in this schedule.

Regions

The Workers' Compensation Board has established four regions within New York State based on the difference in the cost of maintaining a practice in different localities of the state. The Board has defined each such region by use of the U.S. Postal Service ZIP codes for the state of New York, based upon the relative cost factors which are compatible to that region.

The fees payable for behavioral health services shall be determined by the region in which the services were rendered.

HOW TO INTERPRET THE FEE SCHEDULE DATA

The columns used in the Behavioral Health Fee Schedule vary by section throughout the schedule.

Icons

The following icons are included in the Behavioral Health Fee Schedule:

■ New and changed codes—Codes that are new, changed description, or changed value from June 1, 2012.

+ Add-on service—Add-on codes have been designated in the CPT book as being additional or supplemental procedures that are carried out in addition to the primary procedure.

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⦸ Modifier 51 exempt service—Modifier 51 exempt codes have not been identified as add-on services but are exempt from modifier 51 when performed in conjunction with other services.

⑤ Optum360 identified modifier 51 exempt service—Additional modifier 51 exempt codes identified by Optum360 based upon CPT language are exempt from modifier 51 when performed in conjunction with other services.

® Altered CPT codes—Services listed have been altered from the official CPT code description.

∞ State-specific codes—Where a CPT code does not currently exist to describe a service there may be a state-specific code number assigned to describe the service. RVU's are state assigned or gap filled.

Code

The Code column lists the American Medical Association's (AMA) CPT code. *CPT 2018* is used by arrangement with the AMA. Any altered CPT codes are identified with the registered trademark symbol (®). State-specific codes are identified with the infinity symbol (∞).

Description

This manual lists full 2018 CPT code descriptions.

Relative Value

The Relative Value column lists the relative value units used to calculate the fee amount for a service. Except as otherwise provided in this schedule, the maximum fee amount is calculated by multiplying the relative value units by the applicable conversion factor. Conversion factors are listed later in this chapter.

Relative values are used to calculate fees using the following formula:

Relative Value
x Applicable Conversion Factor
= Fee

For example, the fee for code 96110, performed by a psychologist in Region I or Region II, would be calculated as follows:

17.00 (Relative Value)
x $7.94 (Psychology Conversion Factor for Region I and Region II)
= $134.98

BR

Some services do not have a relative value unit because they are too variable or new. These by report services are identified with a "BR."

Postal ZIP Codes by Region

Postal ZIP codes included in each region:

Region I

From	*Thru*	*From*	*Thru*
12007	12099	13601	13699
12106	12177	13730	13797
12184	12199	13801	13865
12401	12498	14001	14098
12701	12792	14101	14174
12801	12887	14301	14305
12901	12998	14410	14489
13020	13094	14501	14592
13101	13176	14701	14788
13301	13368	14801	14898
13401	13439	14901	14925
13450	13495		

Region II

From	*Thru*	*From*	*Thru*
12179	12183	13440	13449
12201	12288	13501	13599
12301	12345	13901	13905
12501	12594	14201	14280
12601	12614	14601	14694
13201	13290		

Region III

From	*Thru*	*From*	*Thru*
06390	06390	10801	10805
10501	10598	10901	10998
10601	10650	11901	11980
10701	10710		

Region IV

From	*Thru*	*From*	*Thru*
00501	00501	11101	11120
00544	00544	11201	11256
10001	10099	11301	11390
10100	10199	11401	11499
10200	10299	11501	11599
10301	10314	11601	11697
10401	10499	11701	11798
11001	11096	11801	11854

Numerical List of Postal ZIP Codes

From	*Thru*	*Region*	*From*	*Thru*	*Region*
00501	00501	IV	12401	12498	I
00544	00544	IV	12501	12594	II
06390	06390	III	12601	12614	II
10001	10099	IV	12701	12792	I
10100	10199	IV	12801	12887	I
10200	10299	IV	12901	12998	I
10301	10314	IV	13020	13094	I

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From	Thru	Region	From	Thru	Region
10401	10499	IV	13101	13176	I
10501	10598	III	13201	13290	II
10601	10650	III	13301	13368	I
10701	10710	III	13401	13439	I
10801	10805	III	13440	13449	II
10901	10998	III	13450	13495	I
11001	11096	IV	13501	13599	II
11101	11120	IV	13601	13699	I
11201	11256	IV	13730	13797	I
11301	11390	IV	13801	13865	I
11401	11499	IV	13901	13905	II
11501	11599	IV	14001	14098	I
11601	11697	IV	14101	14174	I
11701	11798	IV	14201	14280	II
11801	11854	IV	14301	14305	I
11901	11980	III	14410	14489	I
12007	12099	I	14501	14592	I
12106	12177	I	14601	14694	II
12179	12183	II	14701	14788	I
12184	12199	I	14801	14898	I
12201	12288	II	14901	14925	I
12301	12345	II			

Conversion Factors

Regional conversion factors for services rendered on or after April 1, 2019.

Section	Region I	Region II	Region III	Region IV
Psychology	$7.94	$7.94	$9.08	$9.86

Physicians and psychiatric nurse practitioners can bill codes from other sections of the *Official New York State Workers' Compensation Medical Fee Schedule* as appropriate (such as E/M, Medicine, etc.) and should determine their fees using the corresponding conversion factors listed in that manual's Introduction and General Guidelines section. Nurse practitioners and licensed clinical social workers should use appropriate modifiers and bill in accordance with General Ground Rules 9 and 12 herein.

New CPT Codes

The table below is a complete list of CPT codes that have been added to the Behavioral Health Fee Schedule since the June 1, 2012 fee schedule.

These codes are identified in the fee schedule with "■".

90785 90791 90792 90832 90833 90834
90836 90837 90838 90839 90840 97127

Changed Codes

Changed Values

The following table is a list of CPT and state-specific codes applicable to the Behavioral Health Fee Schedule that have a relative value change, an FUD change, or a PC/TC split change since the June 1, 2012 fee schedule. Codes that have had a description change are listed in a separate table below.

Columns that are blank for any code, either do not apply to the code or the code was not assigned a value on the current or previous (June 1, 2012) fee schedule.

For each code listed, the following information is included:

NY 2018 RVU. This is the current RVU for services rendered on or after April 1, 2019.

NY 2012 RVU. This is the RVU effective June 1, 2012.

NY 2018 FUD. This is the FUD for services rendered on or after April 1, 2019.

NY 2012 FUD. This is the FUD listed in the June 1, 2012 fee schedule.

NY 2018 PC/TC Split. This is the PC/TC split for services rendered on or after April 1, 2019. Only codes with distinct professional and technical components are assigned a PC/TC split; therefore, many codes will not have a value in this column.

NY 2012 PC/TC Split. This is the PC/TC split effective June 1, 2012.

These codes are identified in the fee schedule with "■."

CODE	NY 2018 RVU	NY 2012 RVU	NY 2018 FUD	NY 2012 FUD	NY 2018 PC/TC Split	NY 2012 PC/TC Split
99075	$350.00	$400.00				

Changed Descriptions

The table below is a list of CPT codes applicable to the Behavioral Health Fee Schedule that have had a description change since the June 1, 2012 fee schedule.

90846 90847 90875 90876 90889 96110
97533

Deleted CPT Codes

The table below is a list of CPT codes that have been deleted from the Behavioral Health Fee Schedule since the June 1, 2012 fee schedule.

90801 90802 90804 90806 90808 90810
90812 90814 90816 90818 90821 90823
90826 90828 90857 97532

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Behavioral Health Services Provided by Physicians, Psychiatric Nurse Practitioners, Psychologists and Licensed Clinical Social Workers

Behavioral health services will be rendered by a New York State Workers' Compensation Board (NYS WCB) authorized psychiatrist or a NYS WCB authorized physician with a rating code of PN-ADP (Addiction Medicine) or PN-PM (Pain Management), an authorized psychiatric nurse practitioner, psychologist or licensed clinical social worker. A physician, psychiatric nurse practitioner, psychologist or licensed clinical social worker who is not Board authorized may not provide treatment.

All reports and bills shall be submitted in the format prescribed by the Chair by the treating authorized provider. Fees shall be paid at the following rates:

- Psychiatric nurse practitioners shall bill at 80 percent of the applicable medical treatment code and conversion factor available to physicians
- Psychologists shall bill using the applicable behavioral health treatment code and conversion factor
- Licensed clinical social workers shall bill at 80 percent of the applicable medical treatment code and conversion factor for psychologists

Behavioral Health Ground Rules

1A. NYS Medical Treatment Guidelines

Treatment of work-related injuries should be in accordance with any applicable medical treatment guidelines adopted by the Chair of the Workers' Compensation Board. If there is a conflict between the fee schedule ground rules and the medical treatment guidelines, the guidelines will prevail. With limited exceptions that are clearly identified in the guidelines, treatment that correctly applies the treatment guidelines is pre-authorized regardless of the cost of the treatment. Treatment that is not a correct application of, or is outside or in excess of the treatment guidelines is not authorized unless the payer or Workers' Compensation Board has approved a variance.

1B. Biofeedback

Biofeedback is a form of behavioral medicine that helps patients learn self-awareness and self-regulation skills for the purpose of gaining greater control of their physiology. Electronic instrumentation is used to monitor the targeted physiology and then displayed or fed back to the patient through visual, auditory or tactile means, with coaching by a biofeedback specialist. Treatment is individualized to the patient's work-related diagnosis and needs. Home practice of skills is required for mastery and may be facilitated by the use of home training tapes. The ultimate goal of biofeedback treatment is the transfer of learned skills to the workplace and daily life. Candidates for biofeedback therapy or training must be motivated to learn and practice biofeedback and self-regulation techniques.

Biofeedback is not appropriate for individuals suffering from acute pain or acute injury. It may be appropriate for non-acute pain when combined with a program including functional restoration.

- Time to Produce Effect: 3 to 4 sessions.
- Frequency: 1 to 2 times per week.
- Optimum Duration: 5 to 6 sessions.
- Maximum Duration: 10 to 12 sessions.

When more than one treatment is performed on the same day, the maximum reimbursement will be limited to the highest single relative value.

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2. Testing

Psychological tests should not be used routinely. When appropriate, documentation should include the specific indication for each test and overlapping and/or duplicate testing should be avoided. Tests, when administered, must be used in correlation with clinical interview data to monitor a patient's condition and progress. Repeat testing is not necessary or indicated when the clinical documentation supports improved outcomes.

Reimbursement for testing is limited to 11 hours of testing in any 12-month period.

3. Procedures Listed Without Specified Relative Value Units

By report (BR) items: "BR" in the Relative Value column represents services that are too variable in the nature of their performance to permit assignment of relative value units. Fees for such procedures need to be justified "by report." Pertinent information concerning the nature, extent, and need for the procedure or service, the time, skill, and equipment necessary, etc., is to be furnished. A detailed clinical record is not necessary, but sufficient information shall be submitted to permit a sound evaluation. It must be emphasized that reviews are based on records; hence the importance of documentation. The original official record, such as the chart notes will be given far greater weight than supplementary reports formulated and submitted at later dates. For any procedure where the relative value unit is listed in the schedule as "BR," the authorized medical provider shall establish a relative value unit consistent in relativity with other unit values shown in the schedule. The insurer shall review all submitted "BR" relative value units to ensure that the relativity consistency is maintained. The general conditions and requirements of the General Ground Rules apply to all "BR" items.

4. Medical Testimony

As provided in Part 301 of the Workers' Compensation regulations and following direction by the Board, whenever the attendance of the injured employee's treating or consultant authorized physician is required at a hearing or deposition, such physician shall be entitled to an attendance fee of $450. Fees for testimony shall be billed following a direction by the Board as to the fee amount using code 99075.

As provided in Part 301 of the Workers' Compensation regulations and following direction by the Board, whenever the attendance of the injured employee's treating or consultant authorized psychologist, psychiatric nurse practitioner, or licensed clinical social worker is required at a hearing or deposition, such psychologist, nurse practitioner, or social worker shall be entitled to an attendance fee of $350. Fees for testimony shall be billed following a direction by the Board as to the fee amount using code 99075.

5. Evaluation and Management

Evaluation and management services may be reported by physicians and psychiatric nurse practitioners with codes 90833, 90836, and 90838 when both services are performed and documented.

6. Central Nervous System Assessments/Tests (e.g., Neuro-cognitive, Mental Status, Speech Testing) (96101–96127)

CPT codes 96101–96127 are used to report the services provided during testing of the cognitive function of the central nervous system. The testing of cognitive processes, visual motor responses, and abstractive abilities is accomplished by the combination of several types of testing procedures. It is expected that the administration of these tests will generate material that will be formulated into a report. Qualifications of the "technicians" and "qualified health care professionals" referenced in these procedure codes must satisfy the requirements as provided for in Article 153 of the State Education Law.

7. Use of code 97127 and 97533

Reimbursement for code 97127 is limited to a maximum of 1 unit per day. Code 97533 may be reported a maximum of 2 units per day and is limited to 1 unit per day when reported on the same date with code 97127. Both services must be performed face-to-face.

When billing code 97127, an initial report must be submitted containing:

A) Outline of the claimant's current cognitive skill level

B) Proposed treatment plan

C) Expected goals

Thereafter, a progress report should be filed at least every four weeks that updates:

A) The claimant's current cognitive skill level

B) The treatment plan

C) Claimant's progress towards expected goals

All reporting requirements are inclusive in the fee for the service.

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8. Health and Behavior Assessment/Intervention

Assessment and intervention codes are reported for patients with physical health problems where the focus is not on mental health, but emotional and social factors contributing to the individual's well-being. When psychiatric services are performed during the same encounter, the dominating service should be reported, but not both services.

Information obtained through the assessment testing is interpreted and a written report is generated. The interpretation and report are included in the service.

Codes 96150–96155 describe services associated with an acute or chronic illness (not meeting criteria for psychiatric diagnosis), prevention of a physical illness or disability, and maintenance of health, not meeting criteria for a psychiatric diagnosis, or representing a preventive medicine service.

For patients that require psychiatric services (90785–90899) as well as health and behavior assessment/intervention (96150–96155), report the predominant service performed. Do not report codes 96150–96155 in addition to codes 90785–90899 on the same date.

9. Modifiers

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. Modifiers commonly used in the Medicine section are:

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service
It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. 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 (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. **Note:** This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

51 Multiple Procedures
When multiple procedures, other than E/M services, physical medicine and rehabilitation services, or provision of supplies (eg, vaccines), are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes (see Appendix D).

99 Multiple Modifiers
Under certain circumstances 2 or more modifiers may be necessary to completely delineate a service. In such situations modifier 99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

1B∞ Behavioral Health Provider Enhanced Reimbursement
Provides a 20 percent reimbursement increase for E/M and Medicine Behavioral Health services when rendered by Licensed Clinical Social Workers and the providers with the following WCB assigned provider rating codes:

Rating Code	Description
PN-P	PSYCHIATRY
OPPN-P	OSTEOPATHIC PSYCHIATRY/NEUROLOGY – PSYCHIATRY
CPN-P	PSYCHIATRY CONSULTANT
OPCPN-P	OSTEOPATHIC PSYCHIATRY
PN-ADP	ADDICTION PSYCHIATRY
OPPN-ADP	OSTEOPATHIC PSYCHIATRY/NEUROLOGY – ADDICTION PSYCHIATRY
CPN-ADP	ADDICTION PSYCHIATRY CONSULTANT
OPCPN-ADP	OSTEOPATHIC ADDICTION PSYCHIATRY
PN-PM	PAIN MANAGEMENT
OPPN-PM	OSTEOPATHIC PSYCHIATRY/NEUROLOGY – PAIN MANAGEMENT
CPN-PM	PAIN MANAGEMENT CONSULTANT
OPCPN-PM	OSTEOPATHIC PAIN MANAGEMENT
PSY	PSYCHOLOGY

* A supervising physician needs to have a rating code eligible for the modifier 1B enhancement.

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Rating Code	Description
LCSW	LICENSED CLINICAL SOCIAL WORKER
LCSW-R	LICENSED CLINICAL SOCIAL WORKER – PSYCHOTHERAPY
NP-P	NURSE PRACTITIONER IN PSYCHIATRY
PHYAS	PHYSICIAN ASSISTANT*

* A supervising physician needs to have a rating code eligible for the modifier 1B enhancement.

10. Treatment by Out-of-State Providers

Claimant lives outside of New York State—A claimant who lives outside of New York State may treat with a qualified out-of-state medical provider. The medical treatment shall conform to the Medical Treatment Guidelines and the Ground Rules included herein. Payment for medical treatment shall be at the Fee Schedule for work related injuries and illnesses as available in the state where treatment is rendered, or if there is no such fee schedule, then such charges shall be as prevail in the community for similar treatment. All fees shall be subject to the jurisdiction of the Board.

Claimant lives in New York State but treats outside of New York State—A claimant who lives in New York State may treat with a qualified or Board authorized out-of-state medical provider when such treatment conforms to the Workers' Compensation Law and regulations, the Medical Treatment Guidelines and the Medical Fee Schedule. Payment shall be made to the medical provider as set forth herein and using the regional conversion factor for the ZIP code where the claimant resides.

Out-of-state medical treatment that does not "further the economic and humanitarian objectives" of Workers' Compensation Law may be denied by the Board.

A medical provider who has had a NYSWCB authorization suspended, revoked or surrendered shall not be qualified to treat out-of-state.

Permanency—The New York State guidelines on permanent impairment, pertaining to both the schedule loss of use and classification, apply regardless of whether claimant lives in or out of New York State.

11. Non-Schedule Permanency Evaluations

Code 99243 is used to report a non-scheduled permanency evaluation. Codes 99455–99456 may not be used for this purpose.

12. Behavioral Health Provider Enhanced Reimbursement

In an effort to increase the number of Board-authorized providers in behavioral health to render care and treatment to injured workers, the WCB has established WCB-specific modifier 1B which will provide a 20 percent reimbursement increase to providers with WCB assigned rating codes for designated services. Modifier 1B provides a 20 percent reimbursement increase for E/M and Medicine Behavioral Health services when rendered by licensed clinical social workers and the providers with the following WCB assigned provider rating codes:

Rating Code	Description
PN-P	PSYCHIATRY
OPPN-P	OSTEOPATHIC PSYCHIATRY/NEUROLOGY – PSYCHIATRY
CPN-P	PSYCHIATRY CONSULTANT
OPCPN-P	OSTEOPATHIC PSYCHIATRY
PN-ADP	ADDICTION PSYCHIATRY
OPPN-ADP	OSTEOPATHIC PSYCHIATRY/NEUROLOGY – ADDICTION PSYCHIATRY
CPN-ADP	ADDICTION PSYCHIATRY CONSULTANT
OPCPN-ADP	OSTEOPATHIC ADDICTION PSYCHIATRY
PN-PM	PAIN MANAGEMENT
OPPN-PM	OSTEOPATHIC PSYCHIATRY/NEUROLOGY – PAIN MANAGEMENT
CPN-PM	PAIN MANAGEMENT CONSULTANT
OPCPN-PM	OSTEOPATHIC PAIN MANAGEMENT
PSY	PSYCHOLOGY
LCSW	LICENSED CLINICAL SOCIAL WORKER
LCSW-R	LICENSED CLINICAL SOCIAL WORKER – PSYCHOTHERAPY
NP-P	NURSE PRACTITIONER IN PSYCHIATRY
PHYAS	PHYSICIAN ASSISTANT*

* A supervising physician needs to have a rating code eligible for the modifier 1B enhancement.

13. Codes in the Behavioral Health Fee Schedule

An authorized psychologist and licensed clinical social worker may only use CPT codes contained in the Behavioral Health Fee Schedule for billing of treatment. A psychologist and social worker may not use codes that do not appear in the Behavioral Health Fee Schedule.

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BEHAVIORAL HEALTH 90785–99499

Behavioral Health Fee Schedule Effective April 1, 2019

		Code	Description	Relative Value	FUD
■	+	**90785**	Interactive complexity (List separately in addition to the code for primary procedure)	2.80	ZZZ
■		**90791**	Psychiatric diagnostic evaluation	25.84	XXX
■		**90792**	Psychiatric diagnostic evaluation with medical services	27.75	XXX
■		**90832**	Psychotherapy, 30 minutes with patient	12.59	XXX
■	+	**90833**	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	13.13	ZZZ
■		**90834**	Psychotherapy, 45 minutes with patient	16.83	XXX
■	+	**90836**	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	16.55	ZZZ
■		**90837**	Psychotherapy, 60 minutes with patient	25.24	XXX
■	+	**90838**	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	21.89	ZZZ
■		**90839**	Psychotherapy for crisis; first 60 minutes	26.34	XXX
■	+	**90840**	Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)	12.59	ZZZ
		90845	Psychoanalysis	16.43	XXX
■		**90846**	Family psychotherapy (without the patient present), 50 minutes	16.91	XXX
■		**90847**	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	20.42	XXX
		90849	Multiple-family group psychotherapy	5.42	XXX
		90853	Group psychotherapy (other than of a multiple-family group)	5.42	XXX
■		**90875**	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); 30 minutes	11.01	XXX
■		**90876**	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); 45 minutes	17.55	XXX
		90880	Hypnotherapy	20.26	XXX
		90882	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions	13.36	XXX
		90885	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes	8.93	XXX
		90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	13.72	XXX
■		**90889**	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other individuals, agencies, or insurance carriers	NC	XXX
		90899	Unlisted psychiatric service or procedure	BR	XXX
		90901	Biofeedback training by any modality	9.81	000
		90911	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry	16.91	000
		96101	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report	24.52	XXX
		96102	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face	11.16	XXX
		96103	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI), administered by a computer, with qualified health care professional interpretation and report	7.10	XXX
		96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour	18.50	XXX

✚ Add-on Procedure ∞ State Specific Code ® Altered CPT Code ⊘ Modifier 51 Exempt ⑤ Optum360 Mod 51 Exempt
■ New code, changed description, or changed value from June 1, 2012
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