

December 22, 2009

Charlene M. Frizzera  
Acting Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1413-FC  
P.O. Box 8013  
Baltimore, MD, 21244-8013

Submitted electronically at <http://www.regulations.gov>

Dear Ms. Frizzera:

The American Psychological Association (APA), the National Association of Social Workers (NASW), the American Nurses Association (ANA), and the American Psychiatric Nurses Association (APNA) are writing in response to the final rule with comment period on "Medicare Program; Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2010," as published in the *Federal Register* on November 25, 2009. Specifically, we are writing to request that the Centers for Medicare and Medicaid Services (CMS) review the work relative value units (RVUs) of the following codes within the Psychiatry section of CPT®<sup>1</sup> during the Five-Year Review of the Medicare Fee Schedule:

Psychiatric Diagnostic or Evaluative Interview Procedures  
90801, 90802

Office or Other Outpatient Facility Psychotherapy  
90804, 90806, 90808, 90810, 90812, 90814

Inpatient Hospital, Partial Hospital or Residential Care Facility Psychotherapy  
90816, 90818, 90821, 90823, 90826, 90828

Other Psychotherapy  
90845, 90846, 90847, 90849, 90853, 90857

Other Psychiatric Services or Procedures  
90875, 90876, 90880

The descriptors for these codes are provided in Attachment A. The American Psychiatric Association (Psychiatry), American Academy of Child & Adolescent Psychiatry (Child Psychiatry) and ANA will address having the codes for psychotherapy with evaluation and management (E/M) included in the Five-Year Review in a separate letter.

## **Compelling evidence demonstrating the need to review the psychotherapy codes**

The professional work for these services has changed significantly since the codes were last reviewed. In addition, rank order anomalies exist among the codes, and the codes were originally valued using problematic assumptions. For these reasons and as discussed below, the codes are now undervalued relative to other services in the physician fee schedule and should be reviewed. Lastly, the Omnibus Reconciliation Act of 1990 requires a comprehensive review of all CPT codes at least every five years in order to make any needed adjustments. The psychotherapy codes should be part of the Five-Year Review as they have not been evaluated since last surveyed over ten years ago.

### **I. Changes in the work involved in providing psychotherapy**

The professional work involved in providing psychotherapy has changed significantly since the codes were last valued in 1998. We begin discussion with a short common understanding of psychotherapy and psychotherapeutic practice techniques and then demonstrate how this work has changed based on factors suggested by the AMA/ Specialty Society Relative Value Scale Update Committee (RUC) as evidence of this change.

As defined in the CPT® manual, psychotherapy is the treatment for mental illness and behavioral disturbances in which the clinician establishes a professional contract with the patient and, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.<sup>ii</sup>

There are many different modalities of psychotherapy with the following among the most common. *Psychodynamic orientations* place a premium on self-understanding, with the assumption that increased self-understanding will produce salutary changes in the patient. *Humanistic orientations* are also designed to increase self-understanding but use treatment techniques that often are much more active than those likely employed by the psychodynamic clinician. *Behavioral orientations* are geared toward action, with a clear attempt to mobilize the resources of the patient in the direction of change, whether or not there is any understanding of the etiology of the problem. *Cognitive-behavioral therapy* is an integrated approach that focuses on changing the patient's thoughts and beliefs to promote adaptive behavior.<sup>iii</sup> *Interpersonal psychotherapy* is a short term therapy used most often to treat depression. It focuses on the interpersonal events (such as interpersonal disputes / conflicts, interpersonal role transitions, complicated grief that goes beyond the normal bereavement period) that seem to be most important in the onset and / or maintenance of the disorder.<sup>iv</sup>

### **Knowledge /Technology**

Furnishing psychotherapy involves more work now than when the codes were first valued as psychologists, psychiatrists, clinical social workers, psychiatric/mental health advanced practice registered nurses (APRNs), and other mental health care professionals must have a greater awareness of the needs of patients with comorbid conditions. The term "comorbid

conditions” means having more than one mental or physical disorder, including substance abuse.

According to a National Comorbidity Survey, 56% of those with any disorder had two or more. Of these, 27% had two disorders, while 29% had three or more.<sup>v</sup> Comorbidity also implies interactions between the disorders that affect the course and prognosis of each one.<sup>vi</sup> Psychologists, psychiatrists, clinical social workers, psychiatric/mental health APRNs, and other mental health care professionals must be aware of the potential interactions when providing psychotherapy to patients with comorbid conditions.

The work in treating patients with comorbid conditions is further complicated by the fact that most researched treatment protocols were designed for single disorders. While many randomized controlled trials for research purposes have focused on patients with a single, specific disorder, community and clinical samples indicate that comorbidity is the norm rather than the exception. Therefore, simple extrapolation from research studies is insufficient. Data suggests that psychologists, psychiatrists, clinical social workers, psychiatric/mental health APRNs, and other mental health care professionals using a variety of different theoretical orientations attend to their patients’ comorbid symptoms and adjust their intervention strategies accordingly.<sup>vii</sup>

The American Psychological Association Practice Organization (APAPO) represents psychologists in clinical practice. In a November 2008 APAPO survey, 4,843 psychologists practicing for at least ten years were asked to take part in a survey about changes in their practice patterns since 1998.<sup>viii</sup> The survey process employed the standard sampling strategies that APA uses for all data collection resulting in a random pool of members being invited to participate. APAPO received surveys from 1,040 psychologists for a response rate of 21%.

Seventy-nine percent of psychologists responding to the survey said that care is more complex now due to patients’ existing comorbid mental health disorders or a mental health disorder and a major / chronic physical disorder. Fifty percent of the respondents reported that at least a quarter of their patients have major or chronic physical health disorders. Forty-two percent reported an increase in the number of patients with comorbid physical and mental health disorders. Respondents also indicated that on average forty percent of their patients had comorbid mental health disorders.

#### Treating patients with comorbid mental health and substance abuse conditions

A high prevalence of comorbid mental disorders and substance abuse has been documented in multiple national population surveys. Data show that persons diagnosed with mood, anxiety, or antisocial personality disorders, were about twice as likely to also have drug problems. Similarly, persons diagnosed with drug disorders were roughly twice as likely to also suffer from mood and anxiety disorders.<sup>ix</sup>

The Substance Abuse and Mental Health Services Administration (SAMHSA) has recorded the increase in comorbid conditions. According to SAMHSA’s Treatment Episode Data Set,

admissions for patients with comorbid substance abuse and mental disorders rose from 12% in 1995 to 16% in 2001.<sup>x</sup>

SAMHSA's 2002 National Survey on Drug Use and Health (NSDUH) found that 17.5 million adults aged 18 or older were estimated to have a serious mental illness in the past year. About 4 million of these seriously mentally ill adults also were dependent on or abused alcohol or an illicit drug.<sup>xi</sup> The 2005 NSDUH found that 24.5 million adults aged 18 or older had a serious mental illness in the past year and that 5.2 million adults suffered from both a mental illness and substance dependence or abuse.<sup>xii</sup>

Because of this high rate of comorbidity, a psychologist, psychiatrist, clinical social worker, psychiatric/mental health APRN, or other mental health care professional assessing a patient must incorporate into the decision-making knowledge of both types of conditions to determine if a patient presenting with a mental disorder also has a substance abuse disorder and vice versa. They also need to educate themselves about the most effective behavioral techniques for treating substance abuse. Patients with both a substance abuse disorder and a mental illness often exhibit symptoms that are more persistent, severe, and resistant to treatment compared with patients who have either disorder alone.<sup>xiii</sup>

#### Treating patients with comorbid mental and physical health conditions

The co-occurrence of chronic physical illness such as diabetes and cardiovascular disease with mental illness is well documented in terms of increased treatment complexity and more adverse outcomes.<sup>xiv</sup> Mental and emotional challenges often compromise medical care when it is provided, and adherence to treatment protocols is likely diminished as well. Psychological interventions also address the side effects of medications and ameliorate the potential for cognitive challenges and unhealthy lifestyle choices in order to improve overall physical and emotional wellbeing.

The existence of comorbid conditions complicates the decision-making involved in providing psychotherapy because it increases the number of different factors the psychologist, psychiatrist, clinical social worker, psychiatric/mental health APRN or other mental health care professional must take into consideration and necessitates more communication with other health care professionals about the patient's condition and progress.

Based on the 2008 APAPO survey data, psychologists are more likely to be treating patients who have chronic, comorbid physical disorders than they were ten years ago and therefore must have a greater awareness of how these disorders impact the patient's mental health. Examples of the work involved when treating patients suffering from diabetes, cardiovascular disease, and cancer with psychotherapy are provided below.

#### *Diabetes*

Research shows that depression is more prevalent in patients with diabetes than in the general population, and diabetic patients with depression are more than twice as likely to report self-care problems.<sup>xv</sup> Having diabetes and depression is also associated with a 1.3-fold increased

risk of death from all causes compared with people with only diabetes, a 2-fold increased risk of death from all causes compared to people with only depression and a 2.5-fold increased risk of death compared with people with neither diabetes nor depression.<sup>xvi xvii</sup>

A psychologist, psychiatrist, clinical social worker, psychiatric/mental health APRN or other mental health care professional providing psychotherapy to treat depression in a patient with diabetes must factor in the patient's level of cognitive functioning. Because cognitive changes associated with diabetes include impaired attention and processing speed the patient may have difficulty learning new information. To make an accurate diagnosis in the assessment phase, the psychologist, psychiatrist, clinical social worker, psychiatric/mental health APRN or other mental health care professional must take into consideration that mood symptoms may be a byproduct of the disease process or treatment for diabetes. When managing the patient's mood, the psychologist, psychiatrist, clinical social worker, psychiatric/mental health APRN or other mental health care professional incorporates the importance of integrating health-related self-care (e.g. taking medications, insulin, eating and sleeping properly, managing pain).

### *Cardiovascular (heart) disease*

Psychologists, psychiatrists, clinical social workers, psychiatric/mental health APRNs, and other mental health care professionals using psychotherapy to treat depression in patients with heart disease must consider more factors than if treating physically healthy patients. They also must communicate with other health care professionals, including patients' treating physicians, nurses, and cardiac rehabilitation specialists, about such issues as medication side effects and interactions, treatment adherence, and mental health progress. Depression predicts poor adherence to prescribed treatment for patients with many medical problems, including coronary artery disease, and non-adherence is associated with decreased survival for these patients.<sup>xviii</sup>

When evaluating the patient the psychologist, psychiatrist, clinical social worker, psychiatric/mental health APRN or other mental health care professional will have to consider a depressive syndrome frequently referred to as "vascular depression." Vascular depression is thought to be a direct result of damage to brain cells. Medications for heart problems can lower energy level, increase irritability, impede sexual functioning, and/or disrupt sleep, all of which are also symptoms of depression. The psychologist, psychiatrist, clinical social worker, psychiatric/mental health APRN, or other mental health care professional needs to decide whether the best approach is to start psychotherapy, refer for psychotropic medication, or, if the patient's somatic complaints warrant it, refer for medical assessment.<sup>xix</sup>

### *Cancer*

The process of dealing with the diagnosis and treatment of cancer represents one of the greatest medical and emotional challenges that many individuals will face. Research indicates that psychological services play an essential role in supporting patients', and their

families', journey from the time of diagnosis, through treatment, and at various outcome points (e.g., remission, recurrence, and end of life).<sup>xx</sup>

In concert with assessing multiple aspects of cancer patients' functioning, psychologists, psychiatrists, clinical social workers, psychiatric/mental health APRNs, and other mental health care professionals provide these patients with psychotherapy and other intervention services. Most typically, initial interventions will focus on several goals that require knowledge of medical aspects of cancer as well as psychological factors.

Collaborations with physicians can also be beneficial in situations where physicians engage the aid of psychologists, psychiatrists, clinical social workers, psychiatric/mental health APRNs, and other mental health care professionals in the delivery of distressing news. In many cases, immediate psychological interventions to address a patient's acute anxiety, anger, and distress can help bolster his/her ability to cope, and can help maintain a positive relationship between the physician and the patient.

#### The importance of cultural competency

Due to the changing U.S. demographics, psychologists, psychiatrists, clinical social workers, psychiatric/mental health APRNs, and other mental health care professionals are increasingly encountering patients who differ from them in terms of race, ethnicity, and culture.

Guidelines issued by APA in 2002 note that patients' worldviews and life experiences may affect how they present symptoms, the meaning that illness has in their lives, motivation and willingness to seek treatment, social support networks, and perseverance in treatment. In addition to educating themselves about their patients' experiences and cultural beliefs, psychologists need to examine the appropriateness of traditional interventions and when necessary, replace or supplement them with more culturally-specific strategies.<sup>xxi</sup>

Cultural competence is a relatively new construct to help psychologists, psychiatrists, clinical social workers, psychiatric/mental health APRNs, and other mental health care professionals improve service delivery by increasing their understanding of cultural factors. They must educate themselves about cultural differences and alter their techniques to accommodate such differences. To illustrate, one model used to explore patients' socio-cultural identities is the ADDRESSING framework. This extensive framework requires taking into account ten influences on patients: Age and generation, Developmental or acquired Disability, Religion and spirituality, Ethnicity, Socio-economic status, Sexual orientation, Indigenous heritage, National origin, and Gender.<sup>xxii</sup>

Reducing the stigma against mental health has made psychotherapy a viable option for many more people and in turn has led to greater diversity among the patient population. This heterogeneity increases the complexity and decision-making when providing psychotherapy services.

#### **Increased Complexity in Data to Be Evaluated / Care to Be Managed**

Because psychologists, psychiatrists, clinical social workers, psychiatric/mental health APRNs, and other mental health care professionals are seeing more complex patients than

they did ten years ago, providing psychotherapy requires greater integration of more data about the patient. This is so in large part because they have more frequent interactions with physicians and other health care professionals. The work involved in providing psychotherapy services has changed due to the increasing number of patients who have severe disorders, comorbid conditions and/or are taking medication. As discussed under Physician / Mental Health Care Professional Time (immediately below), providing psychotherapy to complex patients requires more pre-and post-service work than it does in treating patients with fewer complicating factors.

### **Physician / Mental Health Care Professional Time**

As we have discussed under Knowledge / Technology on pages two and three, psychologists, psychiatrists, clinical social workers, psychiatric/mental health APRNs and other mental health care professionals now treat more patients with comorbid conditions. Providing psychotherapy services to patients with comorbid conditions is more time-consuming than it is for patients without comorbid conditions because of the additional information that must be gathered and shared. For example, before making recommendations about physical activities for a patient with diabetes safety issues based on the patient's problems with vision, mobility and pain must be considered. All of this adds to the pre-and post-service time that is spent talking with the patient's physician about the patient's compliance, needs, and progress.

A psychologist, psychiatrist, clinical social worker, psychiatric/mental health APRN or other mental health care professional treating patients with depression related to heart disease may also need to discuss the increased risk of exacerbating their heart disease, and assess patients for the presence of other risk factors, including obesity, a high-fat diet, smoking, and a sedentary lifestyle. In the inpatient setting, psychologists, psychiatrists, clinical social workers, psychiatric/mental health APRNs and other mental health care professionals work and communicate with a treatment team. In the outpatient setting, more time and effort may be needed to gather and provide information to physicians and other health care professionals treating the patient.

Consultation and communication with other health care professionals, occurring from the time of diagnosis and throughout treatment and follow-up, are essential components of psychological services provided to cancer patients. As part of providing psychotherapy services, psychologists often collaborate with physicians on decisions regarding psychotropic medications to address emotional distress. (S. Reid-Arndt, Ph.D., personal communication, October 8, 2009)

Psychologists providing psychotherapy to patients taking psychotropic medications also devote considerable time to communicating with physicians. In a study published in 2000, practicing psychologists on average estimated that 43% of their current patients were using psychotropic medications, 94% reported they had consulted with physicians about changing medications, and 87% indicated they had been involved in medication decision-making for some portion of their case load. The study involved one thousand licensed psychologists and had a response rate of 60%.<sup>xxiii</sup>

The likelihood of psychotherapy patients being on psychotropic medication is increasing over time. This is especially true for children and adolescents. According to a national study, the estimated number of outpatient office visits by children and adolescents that included antipsychotic medication soared between 1993 and 2002, increasing from 201,000 to over 1.2 million.<sup>xxiv</sup>

In the 2008 APAPO survey discussed on page two, 97% of the respondents said they are treating patients who are taking psychotropic medications and 69% reported that the number of patients taking such medications has increased from ten years ago. Fifty-four percent said they spend more patient time now discussing issues related to the efficacy of those medications.

### **Patient Population**

Fifty one percent of respondents in the APAPO survey indicated that the severity of patients' presenting problems has increased over the last ten years. Increased patient severity presents more complex circumstances when treating the patient and increases the stress and level of decision-making by the psychologist, psychiatrist, clinical social worker, psychiatric/mental health APRN or other mental health care professional.

Patient severity is related to several factors including comorbidity, aging, and use of psychotropic medication. A National Comorbidity Survey Replication found that 14% of the population surveyed between 2001 and 2003 had mental health disorders that were moderate to serious. Severity was strongly related to comorbidity as 25% of those with two diagnoses and almost 50% of those with three or more diagnoses were classified as severe.<sup>xxv</sup>

According to a report prepared for SAMHSA, individuals age 65 and older will comprise 20% of the country's population by the year 2030. There will be increased demand for mental health treatment as the number of older adults with mental disorders, including depression, anxiety, and dementia, grows from 7 to 15 million. Treatment for these individuals will be more complicated because mental disorders in older persons are associated with adverse outcomes such as poorer functioning, increased morbidity and mortality, and a higher risk of institutionalization.<sup>xxvi</sup>

While not all older adults will require the services of geriatric specialists, psychologists, psychiatrists, clinical social workers, psychiatric/mental health APRNs, and other mental health care professionals furnishing mental health services to seniors must have knowledge of aging-related issues such as development across the lifespan. Because many have little training in gerontology, they must educate themselves about the biological, social, and psychological aspects of aging, as well as the ethical and legal considerations involved in treating older adults.<sup>xxvii</sup>

## **Site-of-Service/Length of Hospital Stay**

The site of service for mental health treatment shifted dramatically between 1970 and 2000 as the number of psychiatric beds dropped by more than 60% while outpatient mental health care grew.<sup>xxviii</sup> From 1986 to 2003, inpatient spending on inpatient mental health treatment services fell from 41% of total mental health expenditures down to 24%. Conversely, spending on outpatient mental health services increased by 7.9% annually to physicians and 6% to non-physician mental health professionals.<sup>xxix</sup>

Data from the National Hospital Discharge Survey indicates that from 1995 through 2002 average lengths of stay for patients with mental illness decreased by almost 10 percent. Of those patients whose care involved serious mental illness, the stays decreased by 34.7%, or 12.8 days in 1995 compared to 9.7 days in 2002.<sup>xxx</sup> As a result, psychologists, psychiatrists, clinical social workers, psychiatric/mental health APRNs, and other mental health care professionals are now treating, on an outpatient basis, individuals with problems formerly severe enough to require hospitalization. When making decisions about psychotherapy for these patients, they must take into account the lack of structure and support that the patients would otherwise have received if placed in an inpatient facility.

## **II. Rank Order Anomalies**

While this letter focuses on the changes involving individual psychotherapy services it is essential that the codes for services such as group therapy, family therapy and medication management be included in the Five-Year Review to prevent rank-order anomalies within the family of codes. Because the untimed codes for these services contain work that is very similar in nature to the individual psychotherapy codes, failing to re-assess all of the codes risks creating rank-order anomalies across the family of codes.

We believe there is already an anomalous relationship between at least two of the codes. There may be others, and for this reason as well, the code values require reexamination. According to the RUC database<sup>xxxi</sup>, code 90806 is valued higher than 90845 even though their work is similar and the latter has 11 more minutes of total service time. Code 90806 is valued at 1.86 while 90845 is valued at only 1.79. Normally if two codes have similar work but one has more service time the code for the longer service is valued higher.

## **Lack of Relativity across Services**

The way the psychotherapy codes were valued in 1998 would likely not be acceptable to the RUC today because the basis for valuing the codes was not relative to other codes in the Resource-Based Relative Value Scale (RBRVS). Instead of being compared to other codes in the RBRVS, the final recommended work value of 1.30 for base code 90804 was derived from a blend of data including the 1.11 work value assigned by the former Health Care Financing Administration, the survey median value of 1.25, the regression analysis recommendation of 1.40, and a work neutrality adjustment.

Over time the RUC has increasingly looked for relativity in the process of valuing codes. In a comment letter to CMS about the proposed rule on the 2010 fee schedule, the RUC objects to the use of any methodology that ignores relativity under RBRVS.<sup>xxxii</sup> According to the letter, the RUC determines what is a reasonable code value after reviewing the survey data and making comparisons to other codes within the RBRVS. In contrast, the psychotherapy codes lack this relativity because they have not been compared to other codes within the RBRVS.

Including the psychotherapy codes as part of the Five-Year Review will ensure they are valued relative to other services in the Medicare fee schedule, thereby meeting the standard that the RUC now requires for other codes.

### **III. Evidence of Problematic Assumptions Made in Previous Valuation**

The majority of timed psychotherapy codes have not been reviewed since their initial valuation in 1998, and virtually all of the untimed codes have not been reviewed since 1995. As we have demonstrated, a substantial body of compelling evidence now exists to merit review of these codes.

It is well understood that the survey data used to initially establish the psychotherapy code values in 1998 was substantially flawed. A regression analysis was employed at that time to make the survey data usable for purposes of valuing the codes. Our organizations offered this regression and the RUC accepted it in order to value the codes.

In light of the timeliness for review, our organizations have recently reassessed the survey data and have reexamined the regression analysis employed in 1998. We find that the regression analysis contains assumptions about the survey data that merit reconsideration. In addition, we note that the RUC database contains some discrepancies regarding psychotherapy code valuation. According to information compiled from the RUC database, pre-and post-service time is identified for the codes reviewed by the RUC in 1995 but not for the codes reviewed in 1998 (See Attachment B). In view of the weak survey data, a questionable regression analysis, and RUC database discrepancies, psychotherapy work values in our opinion do not accurately reflect the services involved.

#### *Survey Data*

During the first Five-Year Review, CMS did not accept the RUC's recommendations for the existing psychotherapy codes but instead developed 24 new codes to better differentiate among various modalities for providing psychotherapy. CMS distinguished psychotherapy through four factors:

- whether E/M services are provided with psychotherapy,
- the approximate length of the psychotherapy session,
- the type of psychotherapy provided, and
- the setting in which the psychotherapy is provided.

In order to assign relative work values to the new codes, it was necessary to determine the incremental work values of these four factors. If an incremental value for each factor was established, then it would be possible to create a psychotherapy relative value scale among all the codes by adding the increments in a logical sequence to a base value.

The RUC subsequently surveyed a range of clinicians, practicing in various settings, on the 24 new codes. Psychiatry, Child Psychiatry, and ANA had their members survey all 24 codes. Members of APA and NASW surveyed only the 12 codes for psychotherapy without E/M.

At the April 1997 RUC meeting, the five organizations presented the RUC with a joint proposal based on the survey data from all health care professionals, employing a work neutral regression technique to eliminate inconsistencies among practice patterns. Even with the use of the regression technique the survey data was still unworkable. After reviewing the proposal the RUC could not reach a conclusion about values for the codes, in part because there was no type of rank order among the codes in the proposal. Following the RUC's suggestion, the five organizations contracted with The Lewin Group (Lewin) for assistance on the data collection and statistical analysis.

Lewin analyzed the survey results and found that the estimates of the four factors were not consistent across the codes. Differentials between the codes for the four factors (each differential being the difference between a given code's median RVU and the median RVU of the equivalent code without the factor) showed high variability across the codes. In some instances the differentials were negative, where for example the factor would have been expected to increase a value but instead decreased a value.

The survey data was substantially flawed, which Lewin attributed to several factors. First, practitioners surveyed appeared to misunderstand the logical associations among the codes. These codes, after all, were new to practitioners, who may have misunderstood their meaning in providing survey responses. In addition, differential practice patterns, variance in standards of care and diversity in patient populations appeared to have impacted survey responses.

### *Regression Analysis*

Lewin applied a correction to the regression technique to adjust for inconsistencies among practice patterns and to maintain budget neutrality, so that the Medicare program's payment allocated for the work values for the 24 new psychotherapy codes would not differ from payment under the previous psychotherapy codes. The RUC adopted Lewin's approach to compute the final work values, and this valuation is explained in the RUC database:

The base code is 90804, individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient. 90804 is currently valued by HCFA at 1.11 RVUs. The survey found a median work RVU of 1.25 and the regression analysis indicated a work RVU of 1.40. The work neutrality

analysis comparing the total pool of survey RVUs to the pool of regression derived RVUs showed that the base RVU from the regression should be reduced by 0.10 work RVUs to 1.30. Therefore, the organizations recommended and the RUC has accepted 1.30 work RVUs for 90804. This recommendation is further supported by the current HCFA RVU for 90805 of 1.47. The only difference between 90804 and 90805 is the provision of E/M. If the estimated work effect for E/M (0.17) is removed from 90805 the result is 1.30: the recommended work RVU for 90804.

The RUC's recommendation is for an acceptance of 1.30 work RVUs for 90804 as the base and the additive methodology derived from the regression analysis. The addition of the estimated work effect to the base code allows the creation of a consistent work scale across all 24 psychotherapy codes.

The intent of linear regression, and as employed by Lewin in this instance, is to model the relationship between a dependent variable, in this case the work RVU for 90804, and independent variables related to the four factors. As noted, our organizations fully accepted the Lewin analysis, which was necessary for the initial valuation of the new psychotherapy codes at the time. Our recent reexamination of the analysis reveals some shortcomings that merit review.

First, the linear regression analysis model employed by Lewin contained a limited number of predictor variables, namely the four factors identified above. For example, when applied to the codes for 45-50 and 75-80 minutes of outpatient psychotherapy, the regression analysis failed to consider the additional stress and intensity that occurs during longer psychotherapy sessions. Therefore, employing an increased number of factors could have provided for more accurate code values.

Second, linear regression models also assume that the data are normally distributed, that the variance of errors are equal across all levels of the independent variables, and that the relationship between the dependent and independent variables (here, the work value for 90804 and the four factors respectively) is linear in nature. Because these assumptions may not be correct in this case there may have been anomalies caused by the model that affected the values.

#### RUC Database Discrepancies Regarding Psychotherapy Code Valuation

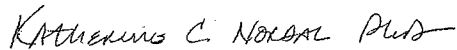
The RUC database contains discrepancies in how the psychotherapy codes are valued. These discrepancies may have occurred when the original values were set in 1998. To illustrate, the intra-service times for all outpatient services show the *maximum* number of face-to-face minutes that are noted in the code descriptor while some of the inpatient codes reflect lesser amounts of time (See Attachment B). For example, code 90804 has 30 intra-service minutes for 20-30 minutes of outpatient psychotherapy but 90816 has only 28.5 minutes of intra-service time for 20-30 minutes of inpatient psychotherapy. This same discrepancy is found in the 75-80 minute psychotherapy with E/M codes with 90809 (outpatient) having 80 minutes of intra-service time while 90822 (inpatient) has 78.5 minutes of intra-service time.

## Conclusion

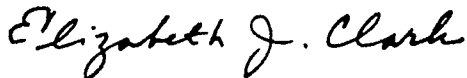
We believe that the services noted above warrant inclusion in the upcoming Five-Year Review because (1) the work involved in providing psychotherapy has become more complex since the last time these codes were reviewed, (2) reviewing all of the codes will address existing and potential rank-order anomalies, and (3) weak survey data led to inaccurate code values in the previous valuation of the psychotherapy services.

We urge CMS to include the psychotherapy codes in the 2010 Five-Year Review. If there are any questions regarding this request please contact APA's Director of Regulatory Affairs, Diane M. Pedulla, J.D., by telephone at 202-336-5889 or by email at [dpedulla@apa.org](mailto:dpedulla@apa.org).

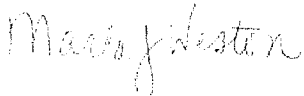
Sincerely,



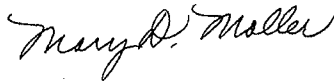
Katherine C. Nordal, PhD  
Executive Director for Professional Practice



Elizabeth J. Clark, PhD, ACSW, MPH  
NASW, Executive Director



Marla J. Weston, PhD, RN  
Chief Executive Officer  
American Nurses Association



Mary D. Moller, DNP, ARNP, APRN, PMHCNS-BC, CPRP, FAAN  
President, American Psychiatric Nurses Association

## References

- <sup>i</sup> *Current Procedural Terminology* (CPT®) 2009, Professional Edition. Copyright American Medical Association. All Rights Reserved.
- <sup>ii</sup> CPT® 2009, Professional Edition. *Psychiatric Therapeutic Procedures*.
- <sup>iii</sup> The National Institute of Mental Health, *Mental Health Topics: Psychotherapies* ([www.nimh.nih.gov](http://www.nimh.nih.gov)) and *Mental Health: A Report of the Surgeon General* (1999), *Chapter 2 The Fundamentals of Mental Health and Mental Illness, Introduction to Range of Treatments*.
- <sup>iv</sup> University of Michigan Hospital System, Department of Psychiatry *Interpersonal Psychotherapy for Depression*, [www.med.umich.edu/depression/ipt.htm](http://www.med.umich.edu/depression/ipt.htm)
- <sup>v</sup> National Health Policy Forum (1998) Issue Brief No. 718, *Dual Diagnoses: The Challenge of Serving People with Concurrent Mental Illness and Substance Abuse Problems*.
- <sup>vi</sup> National Institutes of Health, National Institute on Drug Abuse, Research Report Series *Comorbidity: Addiction and Other Mental Illnesses*, <http://www.nida.nih.gov/researchreports/comorbidity/whatis.html>
- <sup>vii</sup> Westen, D., Novotny, C., Thompson-Brenner, H. (2004) The Empirical Status of Empirically Supported Psychotherapies: Assumptions, Findings, and Reporting in Controlled Clinical Trials. *Psychological Bulletin*, 130 (4), 631-663.
- <sup>viii</sup> 2008 APAPO Survey. Compiled by the APA Practice Organization (APAPO). November 2009
- <sup>ix</sup> National Health Policy Forum (1998) Issue Brief, No. 718, *Dual Diagnoses*.
- <sup>x</sup> The DASIS Report: *Admissions with Co-Occurring Disorders, 1995 and 2001*. Drug and Alcohol Services Information System, Office of Applied Studies, Substance Abuse and Mental Health Administration, 2004.
- <sup>xi</sup> National Survey on Drug Use and Health, June 23, 2004. *Adults with Co-Occurring Serious Mental Illness and a Substance Use Disorder*. <http://www.oas.samhsa.gov/2k4/coOccurring/coOccurring.cfm>
- <sup>xii</sup> Substance Abuse and Mental Health Services Administration (2006). *Results from the 2005 National Survey on Drug Use and Health: National Findings*. (Office of Applied Studies, NSDUH Series H-30, DHHS Publication No. SMA 06-4194) Rockville, MD.

<sup>xiii</sup> National Institutes of Health, National Institute on Drug Abuse, Research Report Series *Comorbidity: Addiction and Other Mental Illnesses*, <http://www.nida.nih.gov/researchreports/comorbidity/treatment.html>

<sup>xiv</sup> Fleischhacker, W.W., Cetkovich-Bakmas, M., De Hert, M., Hennekens, C.H., Lambert, M., Leucht, S., et al. (2008). Comorbid somatic illnesses in patients with severe mental disorders: Clinical, policy, and research challenges. *Journal of Clinical Psychiatry*, 69 (4), 514-519.

<sup>xv</sup> Agency for Healthcare Quality and Research. (2008) People with diabetes and depression are less likely to self-manage their diabetes. *Research Activities*. <http://www.ahrq.gov/research/dec08/1208RA19.htm>

<sup>xvi</sup> Egede, L.E., Nietart, P.J., Zheng D. (2005) Depression and All-Cause and Coronary Heart Disease Mortality Among Adults With and Without Diabetes. *Diabetes Care*, 28, 1339-1345.

<sup>xvii</sup> Goldney R. D., Phillips P.J., Fisher L.J., Wilson D.H. (2004) Diabetes, Depression and Quality of Life. *Diabetes Care*, 27,1066-1070.

<sup>xviii</sup> Lett, H. S.; Blumenthal, J. A.; Babyak, M. A; Strauman, T.; Newman, M. F.; Robins, C.; Sherwood, A. (2004) Depression as a Risk Factor for Coronary Artery Disease: Evidence, Mechanisms, and Treatment. *Psychosomatic Medicine*, 66 (3), 305-315.

<sup>xix</sup> Schwartzman, J.B., and Glaus, K.D. (2000) Depression and Coronary Heart Disease in Women: Implications for Clinical Practice and Research. *Professional Psychology: Research and Practice*, 31(1), 48-57.

<sup>xx</sup> Baum, A., & Andersen, B.L. (2001). *Psychosocial Interventions for Cancer*. Washington, D.C.: American Psychological Association.

<sup>xxi</sup> American Psychological Association (2002). *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists*.

<sup>xxii</sup> Hays, P. A. (2008). *Addressing cultural complexities in practice: Assessment, diagnosis, and therapy* (2nd ed.). Washington, DC: American Psychological Association.

<sup>xxiii</sup> VandenBos, G.R., Williams, S. (2000) *Is Psychologists' Involvement in the Prescribing of Psychotropic Medication Really a New Activity?* *Professional Psychology: Research and Practice* 2000, 31 (6), 615-618.

<sup>xxiv</sup> Olfson, M., Blanco, C., Linxu, L., Moreno, C., Laje, G. (2006) National Trends in the Outpatient Treatment of Children and Adolescents with Antipsychotic Drugs. *Arch Gen Psychiatry*, 6, 679-685.

- <sup>xxv</sup> Kessler, R.C., Chiu, W.T., Demler, O. Walters, E.S. (2005) Prevalence, Severity, and Comorbidity of 12-Month DSM-IV Disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry*, 62
- <sup>xxvi</sup> Bartels, S.J. (2007). *Older Adults and the Behavioral Health Workforce*. Chapter 16 of the Action Plan prepared for SAMHSA by the Annapolis Coalition on the Behavioral Health Workforce.
- <sup>xxvii</sup> The Center for Health Workforce Studies, School of Public Health, University of Albany (2005). *The Impact of the Aging Population on the Health Workforce in the United States*.
- <sup>xxviii</sup> Frank, R.G., Goldman, H.H., McGuire, T.G. (2009) Trends in Mental Health Cost Growth: An Expanded Role for Management? *Health Affairs*, 28 (1).
- <sup>xxix</sup> Mark, T. L., Levit, K., R., Buck, J.A., Coffey R.M., Vandivort-Warren, R. (2007) Mental Health Treatment Expenditure Trends, 1986-2003. *Psychiatric Services*, 58 (8), 1041-1048.
- <sup>xxx</sup> Watanbe-Galloway, S., Zhang, W. (2007) Analysis of U.S. Trends in Discharges from General Hospitals for Episodes of Serious Mental Illness, 1995-2002. *Psychiatric Services*, 58 (4), 496-502.
- <sup>xxxi</sup> RBRVS Data Manager : <http://www.ama-assn.org/ama/no-index/physician-resources/18407.shtml>
- <sup>xxxii</sup> Levy, B. [2009, August 17]. Letter from the Chair of the RVS Update Committee (RUC) to CMS.

## **Attachment A**

### Psychiatric Diagnostic or Evaluative Interview

90801 Psychiatric diagnostic interview examination

90802 Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication

### Psychiatric Therapeutic Procedures

#### *Office or Outpatient Facility*

90804 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient;

90806 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;

90808 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;

90810 Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient;

90812 Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;

90814 Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;

#### *Inpatient Hospital, Partial Hospital or Residential Care Facility*

90816 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient;

- 90818 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;
- 90821 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient;
- 90823 Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient;
- 90826 Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;
- 90828 Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient;

#### Other Psychotherapy

- 90845 Psychoanalysis
- 90846 Family psychotherapy (without the patient present)
- 90847 Family psychotherapy (conjoint psychotherapy) (with patient present)
- 90849 Multiple-family group psychotherapy
- 90853 Group psychotherapy (other than of a multiple-family group)
- 90857 Interactive group psychotherapy

#### Other Psychiatric Services or Procedures

- 90875 Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); approximately 20-30 minutes

90876 Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); approximately 45-50 minutes

90880 Hypnotherapy

| Attachment B                                                              |                                                                                                                                                                              |                     |                  |                    |                   |            |                                 |  |  |
|---------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|------------------|--------------------|-------------------|------------|---------------------------------|--|--|
| Breakdown of Pre, Intra, and Post-Service Times per the 2009 RUC Database |                                                                                                                                                                              |                     |                  |                    |                   |            |                                 |  |  |
| CPT Code                                                                  | Descriptor                                                                                                                                                                   | Source of Time Data | Pre-Service Time | Intra-Service Time | Post-Service Time | Total Time | Date of last RUC meeting review |  |  |
| 90801                                                                     | Psychiatric diagnostic interview examination                                                                                                                                 | RUC                 | 10               | 60                 | 55                | 125        | Aug95                           |  |  |
| 90802                                                                     | Interactive psychiatric diagnostic interview examination                                                                                                                     | RUC                 | 15               | 75                 | 80                | 170        | Feb96                           |  |  |
| 90804                                                                     | Individual psychotherapy, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient                                                  | RUC                 |                  | 30                 |                   | 30         | Feb98                           |  |  |
| 90805                                                                     | Individual psychotherapy, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services | RUC                 |                  | 30                 |                   | 30         | Feb98                           |  |  |
| 90806                                                                     | Individual psychotherapy, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient                                                  | RUC                 |                  | 50                 |                   | 50         | Feb98                           |  |  |
| 90807                                                                     | Individual psychotherapy, 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services                                                    | RUC                 |                  | 50                 |                   | 50         | Feb98                           |  |  |
| 90808                                                                     | Individual psychotherapy, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient                                                  | RUC                 |                  | 80                 |                   | 80         | Feb98                           |  |  |
| 90809                                                                     | Individual psychotherapy, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services | RUC                 |                  | 80                 |                   | 80         | Feb98                           |  |  |
| 90810                                                                     | Individual psychotherapy, interactive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient                                     | RUC                 |                  | 30                 |                   | 30         | Feb98                           |  |  |

### Breakdown of Pre, Intra, and Post-Service Times per the 2009 RUC Database

| CPT Code | Descriptor                                                                                                                                                                                             | Source of Time Data | Pre-Service Time | Intra-Service Time | Post-Service Time | Total Time | Date of last RUC meeting review |
|----------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|------------------|--------------------|-------------------|------------|---------------------------------|
| 90811    | Individual psychotherapy, interactive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services              | RUC                 |                  | 30                 |                   | 30         | Feb98                           |
| 90812    | Individual psychotherapy, interactive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient                                                               | RUC                 |                  | 50                 |                   | 50         | Feb98                           |
| 90813    | Individual psychotherapy, interactive, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services                                                   | RUC                 |                  | 50                 |                   |            | Feb98                           |
| 90814    | Individual psychotherapy, interactive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient                                                               | RUC                 |                  | 80                 |                   | 80         | Feb98                           |
| 90815    | Individual psychotherapy, interactive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services              | RUC                 |                  | 80                 |                   | 80         | Feb98                           |
| 90816    | Individual psychotherapy, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient                                         | RUC                 |                  | 28.5               |                   | 28.5       | Feb98                           |
| 90817    | Individual psychotherapy, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management | RUC                 |                  | 25                 |                   | 25         | Feb98                           |

| Breakdown of Pre, Intra, and Post-Service Times per the 2009 RUC Database |                                                                                                                                                                                                        |                     |                  |                    |                   |            |                                 |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|------------------|--------------------|-------------------|------------|---------------------------------|
| CPT Code                                                                  | Descriptor                                                                                                                                                                                             | Source of Time Data | Pre-Service Time | Intra-Service Time | Post-Service Time | Total Time | Date of last RUC meeting review |
| 90818                                                                     | Individual psychotherapy, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient                                         | RUC                 |                  | 47                 |                   | 47         | Feb98                           |
| 90819                                                                     | Individual psychotherapy, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management | RUC                 |                  | 45                 |                   | 45         | Feb98                           |
| 90821                                                                     | Individual psychotherapy, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient;                                        | RUC                 |                  | 80                 |                   | 80         | Feb98                           |
| 90822                                                                     | Individual psychotherapy, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management | RUC                 |                  | 78.5               |                   | 78.5       | Feb98                           |
| 90823                                                                     | Individual psychotherapy, interactive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient                            | RUC                 |                  | 30                 |                   | 30         | Feb98                           |
| 90824                                                                     | Individual psychotherapy, interactive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient;                           | RUC                 |                  | 25                 |                   | 25         | Feb98                           |
| 90826                                                                     | Individual psychotherapy, interactive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes fa                                                       | RUC                 |                  | 50                 |                   | 50         | Feb98                           |

| Breakdown of Pre, Intra, and Post-Service Times per the 2009 RUC Database |                                                                                                                                                                             |                     |                  |                    |                   |            |
|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|------------------|--------------------|-------------------|------------|
| CPT Code                                                                  | Descriptor                                                                                                                                                                  | Source of Time Data | Pre-Service Time | Intra-Service Time | Post-Service Time | Total Time |
| 90827                                                                     | Individual psychotherapy, interactive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient | RUC                 |                  | 50                 |                   | 50         |
| 90828                                                                     | Individual psychotherapy, interactive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient | RUC                 |                  | 80                 |                   | 80         |
| 90829                                                                     | Individual psychotherapy, interactive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient | RUC                 |                  | 80                 |                   | 80         |
| 90845                                                                     | Psychoanalysis                                                                                                                                                              | RUC Time            | 5                | 45                 | 11                | 61         |
| 90846                                                                     | Family psychotherapy (without the patient present)                                                                                                                          | CMS/Other           |                  | 50                 |                   | 50         |
| 90847                                                                     | Family psychotherapy (conjoint psychotherapy) (with patient present)                                                                                                        | RUC Time            | 5                | 50                 | 21                | 76         |
| 90849                                                                     | Multiple-family group psychotherapy                                                                                                                                         | RUC Time            | 11               | 84                 | 14                | 109        |
| 90849                                                                     | Multiple-family group psychotherapy                                                                                                                                         | Harvard             | 8                | 83                 | 13                | 104        |
| 90853                                                                     | Group psychotherapy (other than of a multiple-family group)                                                                                                                 | RUC Time            | 10               | 80                 | 44                | 134        |
| 90857                                                                     | Interactive group psychotherapy                                                                                                                                             | RUC Time            | 15               | 50                 | 58                | 123        |
| 90862                                                                     | Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy                                             | RUC Time            | 5                | 25                 | 23                | 53         |
| 90865                                                                     | Narcosynthesis for psychiatric diagnostic and therapeutic purposes (eg, sodium amobarbital (Amytal) interview)                                                              | Harvard             |                  | 90                 |                   | 90         |

| Breakdown of Pre, Intra, and Post-Service Times per the 2009 RUC Database |                                                                                                                                                                                                                                                   |                     |                  |                    |                   |            |                                 |
|---------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|------------------|--------------------|-------------------|------------|---------------------------------|
| CPT Code                                                                  | Descriptor                                                                                                                                                                                                                                        | Source of Time Data | Pre-Service Time | Intra-Service Time | Post-Service Time | Total Time | Date of last RUC meeting review |
| 90870                                                                     | Electroconvulsive therapy (includes necessary monitoring)                                                                                                                                                                                         | Harvard             |                  | 23                 |                   | 23         | Aug95                           |
| 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); approximately 20-30 minutes | RUC Time            | 10               | 25                 | 10                | 45         | Feb97 (HCPAC)                   |
| 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); approximately 45-50 minutes | RUC Time            | 10               | 50                 | 10                | 70         | Feb97 (HCPAC)                   |
| 90880                                                                     | Hypnotherapy                                                                                                                                                                                                                                      | RUC                 | 8                | 50                 | 40                | 98         | Aug95                           |
| 90882                                                                     | Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions                                                                                                            | No Data             |                  |                    |                   |            | Aug96                           |
| 90885                                                                     | Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes                                                                           | CMS/Other           |                  |                    |                   | 60         | Aug97                           |
| 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                                      | RUC Time            | 10               | 50                 | 28                | 88         | Aug95                           |