



PAYMENT POLICY		
Behavioral Health Outpatient Services		
Original Date Approved	Effective Date	Revision Date
10/11/2021	12/1/2025	8/12/2025
Applies to Products:		
☒ Senior Care Options MA ☒ One Care MA		

PAYMENT POLICY STATEMENT:

Commonwealth Care Alliance, Inc. (CCA) has established a payment policy that outlines behavioral health (BH) outpatient services for all products and aligns with behavioral health state and federal guidelines.

DEFINITIONS:

BH Outpatient Services: Mental health and substance use disorder services provided in an ambulatory setting such as a mental health center or substance use disorder clinic, hospital outpatient department, community health center, or practitioner's office.

Type of Bill (TOB): A 3-digit numeric code located on an institutional/facility claim that describes the type of facility, type of care, and episode of care (frequency) for the services rendered.

Revenue Codes: A 4-digit number that is used on facility claims to tell where the patient was when they received treatment, or what type of item a patient may have received.

Current Procedural Terminology (CPT): A numerical or alphanumeric five-digit code used to classify medical services and procedures to help report information more accurately and efficiently.

Healthcare Common Procedure Coding System (HCPCS): (Also known as HCPCS Level II) A alphanumeric code starting with an alphabetical letter followed by 4 numeric digits; it is used to identify medical related products, supplies, and services not included in the CPTS codes for billing purposes.

Modifier: A two-digit alphabetic, numeric, or alphanumeric code used to indicate a specific circumstance that altered a procedure or service without changing its definition or code and provides more information about the procedure or service performed.

International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM): A standardized system used to code diseases and medical conditions when diagnosing patients.

CMS-1450: (also known as UB-04) Claim form used for institutional (facility) services.



CMS-1500: (also known as HCFA) Claim form used for professional services.

AUTHORIZATION REQUIREMENTS (If applicable):

Prior authorization is required for Vagus Nerve Stimulation for Treatment Resistant Depression, Repetitive Transcranial Magnetic Stimulation, and Esketamine for Treatment-Resistant Depression. No authorization is required for all other outpatient behavioral health services for in network providers.

BH services rendered by out of network (OON) providers do require prior authorization.

REIMBURSEMENT GUIDELINES:

CCA covers medically necessary outpatient BH and SUD services as outlined in state and federal guidelines. Providers rendering BH services must be enrolled with Medicare and/or MassHealth to be reimbursed, depending on licensure. BH services are restricted to only one visit of a single type of service (therapy, consultation, counseling, or psychological testing) per member per date of service, excluding diagnostic services. Return visits rendered on the same day are not reimbursable. All BH codes are also subject to standard limits and MUEs set forth by state and federal guidelines.

The outpatient BH services include the following:

Diagnostic Evaluation Services: A diagnostic evaluation is an assessment of a member's level of functioning which includes physical, psychological, social, economic, educational, vocational, and environmental capabilities and disabilities for the purpose of diagnosis and designing a treatment plan. Diagnostic evaluations should be billed using the following procedure codes:

Code	Description
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services

*1 unit = 1 hour

NOTE: Procedure code 90792 may only be rendered by a doctoral level provider or nurse practitioner.

Annual Behavioral Health Wellness Examinations: Annual Behavioral Health Wellness Examination is a wellness exam that includes a screening or assessment to identify any behavioral or mental health needs and the appropriate resources for treatment. Effective July 1, 2024, this service became a benefit when the service is provided by a primary care provider or a licensed mental health professional. Like psychiatric diagnostic evaluations, this service utilizes procedure code 90791. To distinguish the psychiatric diagnostic evaluation from BH wellness exam, providers must bill code 90791 with primary diagnosis code Z13.30 (Encounter for screening examination for mental health and behavioral disorders, unspecified).



Individual Treatment: Individual treatment is the use of psychotherapeutic techniques in the treatment of a member on a one-on-one basis. The following procedure codes should be used for individual psychotherapy services:

Code	Description
90832	Psychotherapy, 30 minutes with patient
90833	Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure.)
90834	Psychotherapy, 45 minutes with patient
90836	Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure.)
90837	Psychotherapy, 60 minutes with patient

*Time increments differ depending on code and/or modifier used

NOTE: Add-on codes 90833 and 90836 should be rendered with evaluation and management services and are restricted to physician and midlevel (PA, NP, CNS) provider types.

Couples/Family Treatment: Couples and/or family treatment is the use of psychotherapeutic techniques in the treatment of the member and the member's partner and/or family by a psychiatrist or registered nurse clinical specialist simultaneously in the same session. The following procedure codes should be used for couples/family psychotherapy services:

Code	Description
90846	Family psychotherapy (without the patient present), 50 minutes
90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes
90849	Multiple-family group psychotherapy (per person per session, not to exceed 10 clients)

*Time increments differ depending on code and/or modifier used

Group Treatment: Group treatment is the use of psychotherapeutic techniques in the treatment of a group of unrelated individuals. For group therapy, reimbursement is limited to one fee per group with a maximum of 12 individuals per group. Group therapy will not be reimbursed if performed as part of psychiatric day treatment services or intensive outpatient program (IOP) services. The following procedure codes should be used for group psychotherapy services:

Code	Modifier	Description
90853		Group psychotherapy (other than multiple-family group) (per person per session not to exceed 12 clients)
90853	EP	Group psychotherapy (other than of a multiple-family group) (per person not to exceed 12 clients) (preventive behavioral health session)

*Time increments differ depending on code and/or modifier used



Family Consultation: A family consultation is a meeting with the member's family, legal guardians, foster parents, or others significant persons who are clinically relevant to the member's treatment. The consultation can be done either in person or by telephone and is used to identify/plan for additional services, coordinate a treatment plan, review the member's progress, or revise the treatment plan as required. The following procedure codes should be used for family consultations:

Code	Description
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

*1 unit = 15 minutes; For additional modifier guidance or appropriate time increments, please refer to the following references: 101 CMR 329, 101 CMR 306, 101 CMR 305

Case Consultation: A case consultation is a scheduled intervention on behalf of the member with agencies, employers, or institutions that is rendered via audio-only telephonic, audio-video, or in-person meetings for behavioral and medical management purposes. This service may include the preparation of reports of the member's psychiatric status, history, treatment, or progress (other than for legal purposes) for other physicians, agencies, or insurance carriers. This service should not include clinical supervision or consultation with other clinicians within the same provider organization. The following codes should be used for case consultations:

Code	Modifier	Description
90882	HF	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions (substance abuse program) (case consultation) (per 30-minute unit) (two units maximum per day)
90882		Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions

*1 unit = 15 minutes (billed without modifier HF)

Psychiatric Consultation on an Inpatient Medical Unit: Psychiatric consultation on an inpatient medical unit is a meeting between a psychiatrist or advanced practice registered nurse clinical specialist and the member at the request of the medical unit. It is used to assess the member's mental status and to consult on a BH plan or psychopharmacological plan with the medical staff. The following procedure codes should be used for psychiatric consultations on an inpatient medical unit:

Code	Description
99231	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.

99232	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.
99233	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded.
99252	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.
99253	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
99254	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
99255	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 80 minutes must be met or exceeded.

*Time increments differ depending on the E/M code used

Medication Visit: A medication visit is a visit that is specifically for psychopharmacological evaluation, prescription, review, and monitoring of psychotropic medications by a psychiatrist, psychiatric clinical nurse specialist, advanced practice registered nurse (APRN), or physician assistant (PA), or for the administration of a prescribed intramuscular medication by a physician, nurse, or PA. Medication visit services should be billed using an appropriate evaluation and management (E/M) procedure code:

E/M Office/OP Visit Codes
<i>New Patient</i> - 99202, 99203, 99204, 99205 <i>Established Patient</i> - 99211, 99212, 99213, 99214, 99215, 99417
E/M Nursing Facility Care
<i>New Patient</i> - 99304, 99305, 99306
E/M Subsequent Nursing Facility Care
99307, 99308, 99309, 99310
E/M Rest Home - New Patient
<i>New Patient</i> - 99324, 99325, 99326, 99327, 99328 <i>Established Patient</i> - 99334, 99335, 99336, 99337



E/M Home Visits - New Patient

New Patient - 99341, 99342, 99343, 99344, 99345

Established Patient - 99347, 99348, 99349, 99350

*Time increments differ depending on the E/M code used

Dialectical Behavioral Therapy (DBT): DBT is an outpatient treatment involving strategies from behavioral, cognitive, and supportive psychotherapies for members with certain disorders, including members with borderline personality disorder. The following procedure codes should be used for DBT:

Code	Description
H2020	Therapeutic behavioral services, per diem

*1 unit = 1 day

Inpatient/Outpatient Bridge Visit: Inpatient/outpatient bridge visit is a single-session consultation conducted by an outpatient provider while a member remains in an inpatient psychiatric unit. This service involves a meeting with the outpatient provider, the member, and the inpatient team or designated inpatient treatment team clinician and is limited to one visit per inpatient stay. The following procedure codes should be used for inpatient/outpatient bridge visits:

Code	Modifier	Description
H0032	HO	Mental health service plan development by nonphysician

*1 unit = 15 minutes

Psychological Testing: Psychological testing is the use of standardized test instruments and procedures to assess the member's cognitive, emotional, neuropsychological, verbal, and defensive functioning. This service should be rendered by a psychologist or a trained technician supervised by a licensed psychologist. Psychological testing/assessment is limited to one in a six-month period unless it is demonstrated that the purpose of the repeated testing is to ascertain changes following special forms of treatment/intervention such as electroshock therapy or psychiatric hospitalization; or to ascertain changes relating to suicidal, homicidal, toxic, traumatic, or neurological conditions. Periodic evaluations to measure responses to psychotherapy, self-rating forms (unless administered as part of comprehensive battery of test), and intelligence test performed at the same time as a brain assessment are not covered. The following procedure codes should be used for psychological testing:

Code	Description
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgement, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour.
96121	Neurobehavioral assessment; each additional hour. (List separately in addition to code for primary procedure.) (Add-on code to 96116.)

96130	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour (not to exceed one unit).
96131	Psychological assessment; each additional hour. (List separately in addition to code for primary procedure.) (Add-on code to 96130 – not to exceed seven one-hour units).
96132	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour (not to exceed one one-hour unit).
96133	Neuropsychological assessment; Each additional hour. (List separately in addition to code for primary procedures.) (Add-on code to 96132 – not to exceed seven one-hour units.)
96136	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes (not to exceed one thirty-minute unit).
96137	Psychological or neuropsychological test administration and scoring; Each additional 30 minutes. (List separately in addition to code for primary procedure.) (Add-on code to 96136 – not to exceed eleven thirty-minute units.)
96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first thirty minutes (not to exceed one thirty-minute unit).
93139	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure). (Add-on code to 96138 – not to exceed eleven thirty-minute units).
96146	Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only

*** NOTE: The procedure code description includes time increment and/or limit for several of the codes.**

Prior Authorized BH Services

The following BH services can be used for the treatment of moderate to severe major depression disorder (MDD). These services require prior authorization and are diagnosis restricted to MDD ICD-10-CM codes (dx F32.0 – F33.9). If the procedure codes are billed with other diagnosis outside of MDD, the services will be denied.

Vagus Nerve Stimulation (VNS) for Treatment Resistant Depression (TRD): VNS is a pulse generator that is surgically implanted under the skin of the left chest and connected to the left vagus nerve to help stimulate the vagus nerve. The following procedure codes should be used for VNS for TRD:

Code	Description
64568	Open implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator

64569	Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator
*64970	Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator

*Code 64970 does not require prior authorization

Repetitive Transcranial Magnetic Stimulation (rTMS): rTMS is a noninvasive treatment that uses pulsed magnetic fields to induce an electric current in a localized region of the cerebral cortex. The following procedure codes should be used for rTMS:

Code	Description
90867	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management
90868	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session
90869	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management

Esketamine for Treatment-Resistant Depression (TRD): Esketamine is a nasal spray that could be used for the treatment of TRD or MDD. The following procedure codes should be used for Esketamine for TRD:

Code	Description
G2082	Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care professional and provision of up to 56 mg of esketamine nasal self administration, includes 2 hours post administration observation
G2083	Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care professional and provision of greater than 56 mg esketamine nasal self administration, includes 2 hours post administration observation
S0013	Esketamine, nasal spray, 1 mg

Primary Care Related BH Services

The following BH services are rendered by primary care providers (PCPs), which include physician/non-physician practitioners and FQHCs/CHCs:

Behavioral Health Integrated (BHI) Services: BHI services consist of two types of services, General BHI and Psychiatric Collaborative Care Management (CoCM).

- General BHI includes initial assessment/follow-up monitoring, BH care planning, and facilitating/coordinating BH treatment. These services are allowed once per calendar month per member.
- Psychiatric CoCM involves a PCP team working in collaboration with a psychiatric consultant to provide structured care management to a member.



The following procedure codes should be used for BHI services:

TOS	Provider	Code	Description
BHI	FQHC/CHC	G0511	Rural health clinic or federally qualified health center (RHC or FQHC) only, general care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM), per calendar month (Behavioral health integration; applies to all MassHealth community health centers)
BHI	PCP	99484	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales, behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes, facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation, and continuity of care with a designated member of the care team.
CoCM	FQHC/CHC	G0512	Rural health clinic or federally qualified health center (RHC or FQHC) only, psychiatric collaborative care model (psychiatric COCM), 60 minutes or more of clinical staff time for psychiatric COCM services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM) and including services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month (applies to all MassHealth community health centers)
CoCM	PCP	99492	Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional, initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan, review by the psychiatric consultant with modifications of the plan if recommended, entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant, and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.

CoCM	PCP	99493	Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: tracking patient follow-up and progress using the registry, with appropriate documentation, participation in weekly caseload consultation with the psychiatric consultant, ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers, additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant, provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies, monitoring of patient outcomes using validated rating scales, and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.
CoCM	PCP	99494	Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (List separately in addition to code for primary procedure)

Health and Behavior Assessment and Intervention (HBAI): HBAI are services used to identify the psychological, behavioral, emotional, cognitive, and social factors that are important to the prevention, treatment or management of physical problems. The following procedure codes should be used for HBAI services:

Code	Description
96156	Health behavior assessment, or re-assessment (i.e., health-focused clinical interview, behavioral observations, clinical decision making)
96158	Health behavior intervention, individual, face-to-face; initial 30 minutes
96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
96164	Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes
96165	Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
96167	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes
96168	Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)



*Time increments are included in code description

Modifier Definitions

Below is a list of modifiers to identify the provider type delivering BH services and ensure proper reimbursement at the correct rate.

Modifier	Description
AF	Services performed by a psychiatrist
AH	Services performed by a doctor level clinician (i.e. psychologist)
AJ	Clinical social worker (i.e. LICSW, LCSW)
HL	Services performed by an intern (i.e. intern level clinicians, including Post-Doctoral Fellows and Psychology Interns, Post-Master's Mental Health Counselors and Mental Health Counselor Interns, Post-Master's Marriage and Family Therapist, Licensed Alcohol and Drug Counselor IIs (LADC II), Certified Addiction Counselor/ Certified Alcohol & Drug Abuse Counselor)
HO	Services performed by a master level clinician (i.e. LMFT, LMHC, LICSW, LCSW)
SA	NP/PA services rendered in collaboration with a physician (nonsurgical)

RELATED SERVICE POLICIES:

Behavioral Health Diversionary Services

Behavioral Health Inpatient Services

AUDIT and DISCLAIMER:

As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization, and utilization management guidelines when applicable and adherence to plan policies and procedures and claims editing logic. CCA has the right to conduct audits on any provider and/or facility to ensure accuracy and compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, CCA has the right to expect the provider/facility to refund all payments related to non-compliance. CCA reserves the right to amend a payment policy at its discretion. CPT and HCPCS codes are updated as applicable; please adhere to the most recent CPT and HCPCS coding guidelines.

REFERENCES:

MassHealth 130 CMR 411.000 Psychologist Manual

<https://www.mass.gov/doc/psychologist-services-regulations/download>

MassHealth 130 CMR 434.000 Psychiatric Outpatient Hospital Manual

<https://www.mass.gov/doc/psychiatric-outpatient-hospital-services-regulations-0/download>

MassHealth 130 CMR 418.000 Substance Use Disorder Treatment Manual

<https://www.mass.gov/doc/130-cmr-418-substance-use-disorder-treatment-services/download>



MassHealth All Provider Bulletin 392 Annual Behavioral Health Wellness Examinations
<https://www.mass.gov/doc/all-provider-bulletin-392-annual-behavioral-health-wellness-examinations-0/download>

MassHealth MCE Bulletin 108
<https://www.mass.gov/doc/managed-care-entity-bulletin-108-updates-to-minimum-rates-for-mental-health-centers-and-to-provider-billing-rules-for-gj-modifier-0/download>

MassHealth MCE Bulletin 83
<https://www.mass.gov/doc/managed-care-entity-bulletin-83-provides-rate-increase-guidance-to-specific-mces-for-covid-19-positive-members-covering-behavioral-health-services-and-to-temporarily-suspend-concurrent-review-for-ccs-services-0/download>

MassHealth All Provider Bulletin 103 Integrated Behavioral Health Service Code, Description, and Billing Requirements
https://www.mass.gov/doc/physician-bulletin-103-integrated-behavioral-health-service-code-description-and-billing-requirements-0/download?_ga=2.55518824.27207663.1737646845-1479779760.1695311973&_gl=1*1b61kol*_ga*MTQ3OTc3OTc2MC4xNjk1MzExOTcz*_ga_MC_LPEGW7WM*MTczNzY0Njg0NC4xNzluMS4xNzM3NjQ3MjEwLjAuMC4w

CMS A57481 Billing and Coding: Psychological and Neuropsychological Testing
<https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=57481>

CMS MLN Booklet - Evaluation and Management Services Guide
<https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/eval-mgmt-serv-guide-icn006764.pdf>

CMS Vagus Nerve Stimulation (VNS) for Treatment Resistant Depression (TRD)
<https://www.cms.gov/medicare/coverage/evidence/vagus-nerve-stimulation>

CMS NCD Vagus Nerve Stimulation (VNS)
<https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCID=230#:~:text=Effective%20for%20services%20performed%20on%20or%20after%20February%2015%2C%202019,blind%2C%20randomized%2C%20placebo%2Dcontrolled>

CMS LCD A57692 Billing and Coding: Transcranial Magnetic Stimulation (TMS)
<https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=57692>

CMS A59249 Billing and Coding: Esketamine
<https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=59249>

CMS A52434 Health and Behavior Assessment/Intervention – Medical Policy Article
<https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=52434#:~:text=Health%20Behavior%20Assessment%20and%20Intervention,in%20addition%20to%20clinical%20psychologists>

POLICY TIMELINE DETAILS:

1. Effective October 2021
2. Revision: January 2022
3. Revision: April 2022, addition of H2015-HG, T1040, T1040-HQ, G0470, G0511 codes
4. Revision: August 2022, add H0040 & H0046 PACT Codes
5. Revision: September 2022, added section for codes that do not require prior authorization
6. Revision: May 2023
 - a. Addition: H0046-HE, H2016-HE
 - b. Deletion: H0040 see Inpatient and Intermediate/Diversionary Behavioral Health Services payment policy for PACT codes
 - c. Modification: Prior authorization requirement for Psychological and Neuropsychological testing and Electroconvulsive Therapy have been removed
7. Revision: August 2025, updated template, added definitions, added descriptions for each service with table showing allowed codes, updated authorization requirements, removed reimbursement percentage for modifiers