BRAINFUTURES

FIRST EDITION

A Guide to CPT and HCPCS Codes for Psychedelic-Assisted Therapy

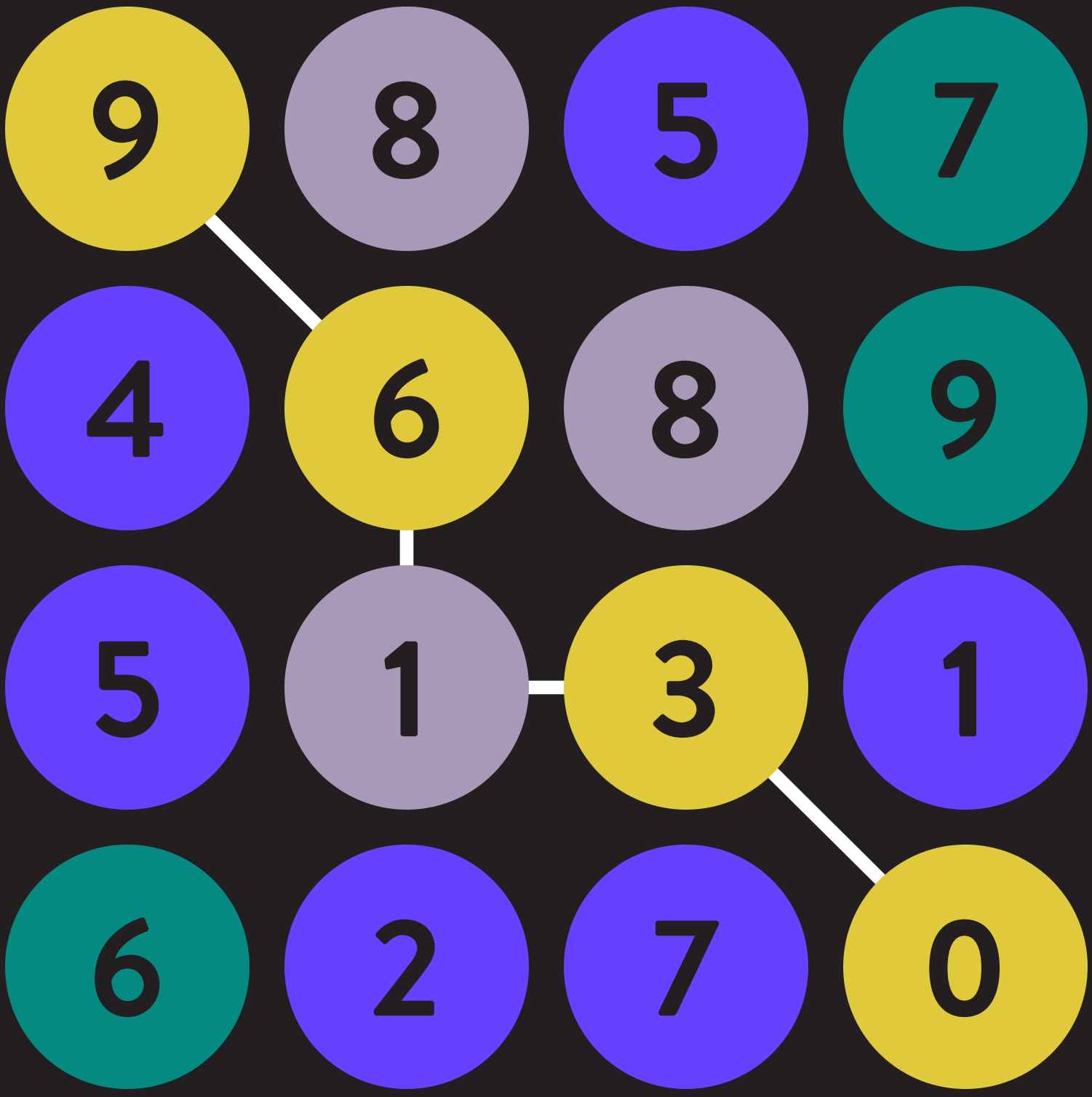

Table of Contents

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Introduction

Psychedelic-assisted therapy uses a combination of psychedelic medication and specialized psycho-therapeutic support to reduce symptomatology, promote healing, and improve patient outcomes for a targeted condition. This model of care currently includes patient medical and psychiatric assessment, screening, psychometrics (both clinician-administered and patient self-reported), preparatory psychotherapy, supervised medication administration session(s) lasting several hours, and integration psychotherapy. Trials using 3,4 methylenedioxy-methamphetamine (MDMA) and COMP360 psilocybin for the medication component of the therapy are currently in late-stage clinical trials and may be approved by the U.S. Food and Drug Administration (FDA) within the next few years.

Elements of this innovative drug-therapy combination present challenges for medical coding, which is the translation of healthcare diagnoses, procedures, items, and services into universal, alphanumeric codes (American Academy of Professional Coders, 2022). Providers use codes when submitting claims to third-party payers for reimbursement, thereby allowing patients to use their health insurance benefits rather than paying for the full cost of services out-of-pocket. Today, challenges in coding some elements of psychedelic-assisted therapy make submitting claims to third-party payers for reimbursement difficult. Resolving these challenges is imperative to ensure that access to psychedelic-assisted therapy is not limited only to those who can afford to pay out of pocket, which would reinforce existing and severe inequities in access to mental health care.

BrainFutures developed this guide to serve four key purposes:

1. To advance access to psychedelic-assisted therapy (following anticipated FDA approval) in a manner that promotes equity via third-party payer reimbursement. If patients are unable to use their insurance benefits, out-of-pocket costs will put this care financially out of reach for too many patients who may potentially benefit from it.
2. To both support the utilization and permanent adoption of new codes for psychedelic medication therapy and to identify previously existing codes that may facilitate third-party billing and patient access to psychedelic-assisted therapy through their health insurance coverage as soon as possible following FDA approval.
3. To provide practitioners with coding guidance for all elements of psychedelic-assisted therapy as delivered in late-stage clinical trials (described more fully in Appendix 1). This is particularly important as some practitioners are not currently paneled with health insurers and may seek to participate in insurer networks or provide patients with documentation with which to file an out-of-network claim.
4. To help facilitate productive conversations between healthcare payers and practitioners, which will be necessary to enable coverage and reimbursement of psychedelic-assisted therapy in the early stages of clinical adoption.

This guide is one part of the case that stakeholders will make to secure third-party reimbursement for the professional services provided in psychedelic-assisted therapy. This guide does not contemplate coding for the psychedelic compounds themselves, which will be assigned National Drug Codes (NDCs) following FDA approval. As described more fully in the "Next Steps" section, additional, well-researched documentation describing this care model's efficacy, clinical effectiveness, and cost effectiveness will provide payers with additional context as they consider coverage and reimbursement of psychedelic-assisted therapy.

Principles and Methods of Guide Development

To inform the creation of this coding guide, BrainFutures convened a workgroup of experts in psychedelic-assisted therapy, behavioral health, and coding and billing for such services. BrainFutures is indebted to the following workgroup members who gave generously of their time and expertise: Carlene MacMillan, MD, Brian Richards, PsyD, and Dan Rome, MD. Brief biographies for each workgroup member may be found in Appendix 4.

The workgroup began by articulating several principles to which a coding guide must adhere. These principles are:

- **Accuracy** in describing services provided by practitioners.
- **Simplicity** in coding, billing, and reimbursement, to the greatest extent possible.
- **Accessibility and Equity** via third-party payment for patients with public or private health insurance.
- **Flexibility** to evolve as science and clinical practices evolve.

Medical Code Basics

Medical codes provide healthcare organizations—including providers, systems, and payers—a uniform way to accurately describe and efficiently categorize medical items, services, and procedures. The Healthcare Common Procedure Coding System (HCPCS) is a set of codes, divided into two principal subsystems or 'levels,' produced by the Centers for Medicare & Medicaid Services (CMS) and the American Medical Association (AMA) (National Library of Medicine, n.d., U.S. Centers for Medicare & Medicaid Services, 2022a). Level I consists of Current Procedural Terminology (CPT) codes developed and managed by the CPT Editorial Panel, an entity convened by the AMA (American Medical Association, 2019). CPT codes are the national coding set for physician and other healthcare professional services. Level II codes (referred to as HCPCS codes) describe health items and services not included in the CPT codes.

Within Level I CPT codes, the AMA has established three separate categories of codes as follows:

- **Category I:** numeric codes corresponding to a procedure or service;
- **Category II:** optional, alpha-numeric tracking codes used for performance measurement;
- **Category III:** temporary codes for emerging technology, services, and procedures (American Medical Association, 2019).

When submitting a claim for healthcare services to a third-party payer, each provider must discern the factors necessary and present to bill and ensure any submitted claim accurately reflects the services provided. To facilitate claims payment, providers should ensure they have a clear understanding of the documentation necessary to support a claim as billed. While specific requirements may vary slightly by payer, in general, accurate clinical documentation of each patient encounter is necessary to support each claim. Nothing should appear on a claim that is not documented in the patient's medical record. For example, when using time-based psychotherapy codes, the medical record should document the time spent face-to-face with the patient. For evaluation and management codes, the provider should document either the time spent with the patient and non-face-to-face time spent on the patient on the same day, or the level of medical decision-making required.

Payers differ regarding the codes they will reimburse and which providers are authorized to use those codes. A provider's contract with an insurer typically identifies the codes that the provider is authorized to use in submitting claims to the payer. To provide flexibility, this coding guide offers different coding options where possible, recognizing that there may be more than one way to code for a particular service.

Psychedelic-Assisted Therapy Coding Developments and Challenges

On June 30, 2023, the AMA released three new Category III CPT codes describing services provided during a medication administration session for use beginning January 1, 2024 (American Medical

Association, 2023). These codes describe the provision of one hour of continuous in-person monitoring and intervention (including psychotherapy or crisis intervention) during what the AMA refers to as "psychedelic medication therapy." The codes may be used by a physician or other qualified healthcare professional (QHP) (0820T), a second physician or QHP, concurrently with the first physician or QHP (0821T), and clinical staff under the direction of a physician or other QHP (0822T).[1] This is a critical and exciting first step toward the permanent establishment of codes for the medication administration session.

However, Category III codes have some major limitations compared to more established and more frequently utilized Category I codes which makes their use by providers more challenging. First, Category III codes are temporary; they are archived five years after publication, though use may be extended or they may be converted into Category I codes. Second, Category III codes are not considered by the AMA's Relative Value Scale Update Committee (RUC), which provides CMS with recommendations on the Relative Value Units (RVUs) assigned to each code. RVUs are used by Medicare and other third-party payers to calculate payment rates for each code; without an RVU, a code does not have a standardized payment. Finally, because Category III codes are assigned to emerging technologies, services, and procedures, public and private health insurers often consider them experimental, investigational, and unproven, and only cover and reimburse such codes on a case-by-case basis.

Coding for preparation and integration psychotherapy presents a second challenge. There is currently no code, or set of codes, for a 90-minute psychotherapy session, which is the duration of preparatory and integration psychotherapy in several clinical trials. This leaves many mental health providers without any method to bill for the 90-minute or longer sessions considered by experts in the field to be prerequisite to the delivery of effective psychedelic-assisted therapy. For example, meaningful patient preparation may include guided imagery, review of video or virtual reality, music, and breathing exercises. These elements could exceed the typical 60-minute psychotherapy session for which codes are currently available. Codes to extend psychotherapy beyond 60 minutes were eliminated effective January 1, 2023. A replacement code for use by all clinicians eligible to bill for psychotherapy is reportedly in development, signified by a placeholder code. However, at this time, only clinicians eligible to use evaluation and management codes (i.e. physicians, nurse practitioners, etc.) are able to bill for longer sessions.

Codes for the Medical Model of Psychedelic-Assisted Therapy

Recognizing these developments and challenges, Chart 1 offers recommended codes for each element of psychedelic-assisted therapy, noting that some codes are available only to certain clinicians. Chart 2 proides details of the codes used in Chart 1. Additional explanation of coding options for preparation, medication administration, and integration are provided after these charts to assist in the decision-making process. Finally, Appendix 1 includes descriptions and assumptions for the elements of psychedelic-assisted therapy as provided in late-stage clinical trials—the model anticipated for use in early clinical practice—and Appendix 2 offers a series of charts, each focused on one clinician type.

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1 The American Medical Association defines a physician or other qualified healthcare professional (QHP) as "an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his or her scope of practice and independently reports that professional service" (American Medical Association, n.d.). QHPs are distinct from "clinical staff," defined as "a person who works under the supervision of a physician or other qualified healthcare professional, and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specific professional service but does not individually report that professional service" (American Medical Association, n.d.).

CHART 1. CODE OPTIONS FOR PSYCHEDELIC-ASSISTED THERAPY: QUICK GUIDE

	Credentialed Clinicians Licensed to Provide Psychotherapy	Evaluation and Management (E/M)-Eligible Clinicians Only	Clinical Staff or Technician[1]
SCREENING, ASSESSMENT, AND INTAKE CHOICE DEPENDS ON CLINICIAN TYPE AND SERVICES PROVIDED			
Testing	**96130** +96131 **96136** +96137	**96127** **96146**	**96138** +96139
Psychiatric Diagnostic Evaluation	**90791** +90785	**90792** +90785	
E/M		**99202-99205** +99415-99417	
MEDICATION MANAGEMENT ONLY FOR E/M-ELIGIBLE CLINICIANS			
E/M (psychotherapy add-on if appropriate)		**99212-99215** +90833 +90836 +90838 +90785	
PREPARATION CHOICE DEPENDS ON PAYER NEGOTIATION, SESSION DURATION, AND CLINICIAN TYPE			
If two licensed psychotherapists, consider negotiating use of modifier XP	**90832** +90785 **90834** +90785 Consider payer negotiation to bill twice for 90 min.	**90837** +90785 **90837 and 90853** +90785 Include modifier 59	
E/M (psychotherapy add-on if appropriate)		**99212-99215** +90833 +90836 +90838 +90785	

CHART 1. CODE OPTIONS FOR PSYCHEDELIC-ASSISTED THERAPY: QUICK GUIDE

	Credentialed Clinicians Licensed to Provide Psychotherapy	Evaluation and Management (E/M)-Eligible Clinicians Only	Clinical Staff or Technician[1]
MEDICATION ADMINISTRATION SESSION CHOICE DEPENDS ON PAYER NEGOTIATION AND CLINICIAN TYPE			
Psychedelic medication therapy codes **+** **E/M codes for medical oversight only**	**0820T** +0821T		**+0822T**
		99212-99215 +99415 +99416 +99417	
Negotiate to compensate all practitioners (including medical oversight)	**H2020**		
Negotiate to compensate two practitioners (medical oversight billed separately)	**H2020**	**99212-99215** +99415 +99416 +99417	**H2020**
INTEGRATION			
	See code options above for Preparation		

[1] The American Medical Association (n.d.) defines clinical staff as "a person who works under the supervision of a physician or other qualified health care professional, and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specific professional service but does not individually report that professional service." Technician certification levels may range from a high school diploma to baccalaureate or even master's degree in psychology and they may have undertaken additional training in standardized administration and scoring of psychological and/or neuropsychological testing.

Italics = add-on code for practitioner consideration based on services provided and factors present

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CHART 2. CODE DESCRIPTIONS

CODE	SHORT DESCRIPTION	RESTRICTIONS ON USE	TIME	RVU·	MUE
+90785	Interactive complexity; may be added to psychotherapy services (90791, 90832, 90834, 90837, or 90853) when complicating factors are present during the visit	A		0.44	1
90791	Psychiatric diagnostic evaluation	A		5.16	1
90792	Psychiatric diagnostic evaluation with medical services	A		5.80	1
90832	Psychotherapy, 30 minutes with patient	A	16-37 min	2.23	2
+90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service	B	16-37 min	2.05	2
90834	Psychotherapy, 45 minutes with patient	A	38-52 min	2.95	2
+90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service	B	38-52 min	2.60	2
90837	Psychotherapy, 60 minutes with patient	A	53+ min	4.34	2
+90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service	B	53+ min	3.44	2
90853	Group psychotherapy (other than of a multiple-family group), no more than 12 participants	A	45-60 min	0.79	
96127	Brief emotional/behavioral assessment (e.g. depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument. Report code for each instrument used	A		0.14	3
96130	Psychological testing evaluation services by a physician or other QHP, 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	A	~60 min	3.55	1
+96131	Each additional hour of 96130	A	~60 min	2.56	7
96136	Psychological or neuropsychological test administration and scoring by a physician or other QHP, two or more tests, any method, first 30 minutes	A	~30 min	1.26	1
+96137	Each additional 30 minutes of 96136	A	~30 min	1.16	11
96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method, first 30 minutes	Technician	~30 min	1.01	1
+96139	Each additional 30 minutes of 96138	Technician	~30 min	1.04	11
96146	Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only	A		0.07	1
99202	Evaluation and Management (E/M) new patient, straightforward MDM, minimal number and complexity of problems addressed	B	15-29 min	2.15	1
99203	E/M New patient, low MDM, low number and complexity of problems addressed	B	30-44 min	3.33	1

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CHART 2. CODE DESCRIPTIONS

CODE	SHORT DESCRIPTION	RESTRICTIONS ON USE	TIME	RVU·	MUE
99204	E/M new patient, moderate MDM, moderate number and complexity of problems addressed	B	45-59 min	4.94	1
99205	E/M new patient, high MDM, high number and complexity of problems addressed	B	60-74 min	6.52	1
99212	E/M established patient, straightforward MDM, minimal number and complexity of problems addressed	B	10-19 min	1.68	2
99213	E/M established patient, low MDM, low number and complexity of problems addressed	B	20-29 min	2.68	2
99214	E/M established patient, moderate MDM, moderate number and complexity of problems addressed	B	30-39 min	3.79	2
99215	E/M established patient, high MDM, high number and complexity of problems addressed	B	40-54 min	5.31	1
+99415	Prolonged clinical staff service during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (Use 99415 with 99202-99205, 99212-99215)	B	30+ min	0.56	1
+99416	Prolonged clinical staff service during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; each additional 30 minutes (Use 99416 with 99415)	B	15+ min	0.26	3
+99417	Prolonged office or other outpatient E/M service beyond the total time for Level 5 E/M code only (99205, 99215); each 15 minutes	B	15 min	0.92	6
H2010	Comprehensive medication services, per 15 minutes (not payable by Medicare)		15 min	N/A	
0820T	Continuous in-person monitoring and intervention (e.g. psychotherapy, crisis intervention), as needed, during psychedelic medication therapy; first physician or other QHP, each hour	Physician or other QHP	60 min	N/A	
+0821T	Continuous in-person monitoring and intervention (e.g. psychotherapy, crisis intervention), as needed, during psychedelic medication therapy; second physician or other qualified health care professional, concurrent with first physician or other QHP, each hour	Physician or other QHP	60 min	N/A	
+0822T	Continuous in-person monitoring and intervention (e.g. psychotherapy, crisis intervention), as needed, during psychedelic medication therapy; clinical staff under the direction of a physician or other QHP, concurrent with the first physician or other QHP, each hour	Clinical staff	60 min	N/A	

· 2023 Medicare Non-facility Total Relative Value Unit (RVU), includes Work, Practice Expense, and Malpractice RVUs

+ Add-on code, list separately in addition to the code for the primary procedure

A For Medicare billing purposes, eligible providers include Physicians (MD, DO), Clinical Psychologists (CP), Clinical Social Workers (CSWs), Clinical Nurse Specialists (CNSs), Nurse Practitioners (NPs), Physician Assistants (PAs), Certified Nurse-Midwives (CNMs), Independently Practicing Psychologists (IPPs), and Certified Registered Nurse Anesthetists (CRNAs) (for supervision of diagnostic psychological and neuropsychological tests) (U.S. Centers for Medicare & Medicaid Services, 2022b).

B CPT guidance instructs that E/M codes (CPT codes 99091, 99202-99499) should only be reported by physicians (MD, DO) or other qualified healthcare professionals, which CMS defines as NPs, CNSs, CNMs, and PAs.

MUE Medically Unlikely Edit. Part of the National Correct Coding Initiative to reduce improper payments, an MUE represents the maximum units of service that a provider would report under most circumstances for a single patient on a single date of service.

Coding Options for Preparation, Integration, and Medication Administration Session

Coding recommendations for screening, assessment, intake, and medication management are quite straightforward. However, several different coding options are suggested for preparation, integration, and the medication administration session, reflecting the coding challenges presented by the duration of the session and participation of multiple providers in these elements. Stakeholder negotiation with payers will likely be required to pursue any of these options. Simply put, in the early stages of clinical practice, the best coding option will likely be the one to which payers agree. The following descriptions of each option may help facilitate those conversations.

Coding options for preparation and integration sessions include:

- Negotiate use of XP modifier to indicate a distinct service performed by a different practitioner on the same day.
- Conform duration of these sessions to fit existing psychotherapy codes, potentially offering more sessions with durations shorter than 90 minutes.
- Offer a 90-minute psychotherapy session, but bill for and accept payment at the 60-minute rate or bill patient directly for the remaining time as a non-covered service.
- Offer a 60-minute, individual session (90837), followed by a group session (90853). The provider would need to use modifier 59 with one of these codes to indicate the provision of a distinct service on the same day.
- Negotiate to bill for two, 45-minute psychotherapy sessions by the same provider on the same day (though this will be an operational challenge for most payers' claims systems).
- Combine an E/M code and add-on codes for extended duration and psychotherapy, if indicated (providers eligible to use evaluation and management (E/M) codes only).

Coding options for the medication administration session include:

- Negotiate for coverage of and reimbursement for Category III codes (0820T, 0821T, and 0822T) together with codes for the provision of medical oversight. Coverage of and payment for the Category III codes will require provider negotiation with third-party payers. As previously described, Category III codes are not assigned an RVU by CMS and are typically covered by payers on a case-by-case basis, via a payer-specific coverage or clinical policy, or under a Local Coverage Determination (LCD) or National Coverage Determination (NCD), if applicable.
- Negotiate for coverage of and reimbursement for H2010 (comprehensive medication services, per 15 minutes) and negotiate a team-based rate for either:
    - All providers, including the prescriber providing medical oversight, the licensed psychotherapist, and the additional provider (if such provider is required); OR
    - A licensed psychotherapist and an additional provider (if required). Prescriber bills E/M codes for provision of medical oversight.

H-codes may be less familiar to providers and commercial payers, so providers should be sure to confirm usage with commercial payers. Like Category III codes, H2010 does not have an assigned RVU and is not priced by Medicare. Without a reimbursement rate associated with this code, there may be flexibility in rate negotiations. If using H-codes, this guide recommends negotiating a team-based rate, including compensation for the licensed psychotherapist, the additional healthcare provider (if required), and potentially for the prescriber providing medical oversight. Providers may also wish to negotiate compensation for other requirements of psychedelic-assisted therapy, such as safe drug storage, the cost of other Risk Evaluation and Mitigation Strategy (REMS) requirements (if applicable), and/or team meetings to discuss patient care.

Future Developments in the Field

The field of psychedelic-assisted therapy continues to advance at a rapid pace. While these developments are exciting, they increase the risk of any coding guide becoming quickly outdated. Some of these potential future developments may include:

Group preparation and integration psychotherapy. Some investigator-initiated trials are experimenting with the addition of group therapy (90853) to individual preparation and integration psychotherapy (90837). Practitioners have noted the power of group therapy in other behavioral and mental health contexts and are exploring the impact of gathering individuals to prepare for and then integrate their experiences with psychedelic-assisted therapy. As noted in Chart 1 and Appendix 2, practitioners may combine individual and group psychotherapy as part of the same patient visit.

Group medication administration session. Some investigators are exploring the feasibility of safely monitoring more than one patient during a medication administration session. The shortage of mental health providers in the U.S. may limit the availability of psychedelic-assisted therapy, and the use of two practitioners for each patient's medication administration session further strains this already limited workforce. Finding a way for practitioners to monitor more than one patient at a time would help relieve some of this pressure.

New provider types and changes to the care team. The field is working towards the creation of a certifying board which would develop criteria to identify appropriately trained individuals who may sit for an exam to identify them as psychedelic-assisted therapy practitioners. Though still in early stages, it is possible that different types of certification could be open to various provider types. These would include, in addition to psychiatrists and psychologists, licensed therapists of all types, individuals with a bachelor's degree who may have specialized training in medication administration session monitoring, and other new provider types.

Shorter-acting psychedelic compounds. While the two compounds in late-stage clinical trials (MDMA and psilocybin) require a medication administration session of six-to-eight hours, new compounds in earlier stages of development have shorter half-lives and may require a much shorter medication administration session. Similarly, when ketamine is used off-label in psychedelic-assisted therapy, the medication administration session may be much shorter and such services may be described by 90865 (narcosynthesis, 60 minutes).

Additional drug administration routes. Psychedelic compounds in early stages of development may be injected, delivered intravenously, delivered via a nasal spray, or other administration routes. To the extent these drug administration routes require different professional services, providers may need to consider billing codes not presented in this guide.[1]

Restoration or creation of CPT codes for psychotherapy sessions longer than 60 minutes. Preparation sessions of 90 or 120 minutes in duration may be optimal to adequately prepare patients for the psychedelic medication administration session. These sessions may include a combination of guided imagery, video or virtual reality, and breathing practices to help patients self-regulate the physiological stress response and direct their attention to the present moment. As of January 1, 2023, non-prescribers do not have access to codes for psychotherapy sessions longer than 60 minutes, though a replacement code for use by these providers is reportedly in development, signified by a placeholder code. At the time of publication, only clinicians eligible to use evaluation and management codes (i.e., physicians, nurse practitioners, etc.) can bill for these longer sessions (using 99417).

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1 This guide does not include codes for esketamine nasal spray (SpravatoTM), which has specific CPT codes.

Next Steps

At least three actions are required to both facilitate a short-term solution to the coding challenges facing psychedelic-assisted therapy and to work toward a long-term strategy to achieve robust payer coverage and codes designed specifically for this purpose.

First, stakeholders should develop information about psychedelic-assisted therapy to help educate payers in advance of FDA approval. For example, BrainFutures has assembled information on clinical trial efficacy (Sky, 2022). Additional information on anticipated clinical effectiveness following FDA approval, cost-effectiveness, and recommended coverage policies may also be useful in payer education efforts. Because the lay press does not always clearly delineate between the medical model and other efforts to legalize psychedelics, care must be taken in communicating with payers regarding this care modality.

Second, providers will likely need support to negotiate with health insurers on coverage of and reimbursement rates for either the Category III codes for psychedelic drug monitoring services (0820T, 0821T, and 0822T) or for comprehensive medication services (H2010). This support will likely include assembling well-researched documentation for these conversations and suggested methods for calculating the cost to provide these services. Because these codes are not assigned an RVU and priced by Medicare, payers are unlikely to have a rate associated with the code, which should allow for some flexibility. Some stakeholders have noted that the consistent and effective delivery of high-quality psychedelic-assisted therapy requires training, skill, practice, and stamina, among many other things. Consequently, a preferred rate from insurers would help to incentivize clinicians to commit to this training and their own ongoing professional development, helping to create and sustain the workforce required for nationwide accessibility (R. Doblin, personal communication with B. Richards, October 2022). In addition to compensation for all providers involved in the medication administration session, providers may also wish to negotiate compensation for other requirements of psychedelic-assisted therapy, such as safe drug storage, the cost of other REMS requirements, and/or team meetings to discuss patient care.

Stakeholders have also expressed interest in advocating for a case rate encompassing an entire psychedelic-assisted therapy course of treatment (including screening, medication management, preparation psychotherapy, the medication administration session, and integration psychotherapy). This effort would require similar support, likely in the form of research and cost calculators, to facilitate negotiation with payers.

Third, as previously noted, codes allowing providers who are not prescribers to bill for psychotherapy sessions extending beyond 60 minutes were eliminated effective January 1, 2023 (prescribers may use 99417 in 15-minute increments). A replacement code for use by all clinicians eligible to bill for psychotherapy is reportedly in development, signified by a placeholder code, but at this time, only clinicians eligible to use evaluation and management codes (i.e. physicians, nurse practitioners, etc.) are able to bill for these longer sessions (using 99417). While this guide offers several suggested codes for preparation and integration sessions, these are not long-term solutions. For psychedelic-assisted therapy to fit neatly within the medical code language, specific codes for preparation and integration sessions up to at least 90, and possibly 120, minutes are required. An alternative, and likely the fastest route to reimbursement, would be to constrain preparation and integration sessions to 60 minutes in duration.

Appendix 1. Elements of Psychedelic-Assisted Therapy

The workgroup used the following descriptions of and assumptions for each element of psychedelic-assisted therapy as it considered applicable codes.

Patient screening, clinical interview and psychometric assessment, and intake. In this critical first step, the provider conducts a clinical interview of the patient, gathering history and symptom description, conducting a physical exam, and using physiological and psychological assessment tools to determine whether a psychedelic compound is indicated for treatment and to ensure there are no contraindications (Sky et al., 2022). Clinical trials use psychological diagnostic testing and research-backed, validated symptom assessments. Psychometric assessments may be used for initial screening and, when repeated over time, can help track symptom changes and care efficacy and help to optimize patient care.[1] As the model of care continues to evolve, accurate measurement of outcomes will be foundational to treatment innovation.

Medication management. Medication management in the outpatient setting typically involves assessing a patient's need for medication, providing a prescription for an appropriate medication when indicated, reconciling all medications a patient may be using, and monitoring patient response and outcomes. The use of some psychedelics may require titration or temporary discontinuation of other medications to avoid undesired interactions.

Preparatory psychotherapy. To prepare for the medication administration session, current clinical trials typically use a minimum of three, 90-minute psychotherapy sessions during which at least one practitioner licensed to provide psychotherapy works to build therapeutic rapport with the patient, educates the patient about the psychedelic experience, explains logistics and potential risks of the medication administration session, and provides neuroscience-based approaches for self-regulation and directing attention to the present moment. These are critical skills for patients experiencing psychedelic-assisted therapy. In some trials, a second practitioner or trainee participates in these sessions; typically the same person who will be with the patient and the licensed psychotherapist during the medication administration session.

Medication administration session. Psychedelic medicines are administered during a multi-hour appointment typically under the supervision of two healthcare practitioners, at least one of whom is licensed to provide psychotherapy. The care team remains with the patient until the effects of the psychedelic drug have resolved. For compounds currently in late-stage trials, this is approximately six-to-eight hours. For longer-acting psychedelics in earlier stages of the FDA approval process, such as LSD, these sessions could be 12 hours or more. During the medication administration session, the healthcare team provides psychotherapy (if within the scope of their licensure) and other therapeutic interventions and monitors the patient for signs of physiological or psychological distress, offering support as needed. This coding guide assumes the patient self-administers the psychedelic drug, though drugs in earlier stages of development may be administered via other routes (e.g., intramuscular injection, inhaled, or insufflated).

It is possible that the FDA, as part of a REMS, will require up to three practitioners for a medication administration session. First, medical oversight will be provided by an authorized prescriber, likely onsite and available for the duration of the session, but not necessarily in the room with the patient. Second, at least one licensed mental healthcare provider will be with the patient for the duration of the medication

1 Brian Richards, a workgroup member and therapist with Sunstone Therapies, uses a package of psychometric assessment tools for new patients that includes: Patient Health Questionnaire (PHQ-9), General Anxiety Disorder Scale (GAD-7), Brief Symptom Inventory (BSI), Demoralization-Scale II, Self-Compassion Scale, General Self-Efficacy Scale, Well-Being Locus of Control Scale, Alcohol Abuse Screening Test (MAST), Mood Disorder Questionnaire (MDQ), Brief Obsessive Compulsive Checklist (BOCS), McLean Screening for Borderline Personality Disorder, Adult ADHD Self-Report Scale (ASRS-v 1.1), Inventory for symptoms of Post-Traumatic Stress (PCL-5), and HELPS Traumatic Brain Injury Screen (B. Richards, personal communication, September 28, 2022).

administration session. Finally, another provider may be with the patient for the duration of the medication administration session. Whether this last provider is required to be a licensed mental health provider or may be a technician, peer specialist, or other unlicensed practitioner is uncertain at this time.

Integration psychotherapy. Current clinical trials typically require a series of three or more integration psychotherapy sessions during the few days and weeks after the medication administration session. During these psychotherapy sessions, at least one licensed mental health provider (sometimes with the second practitioner who attended the medication administration session) helps patients "assimilate the insights of the psychedelic experience into their daily life and gain longer-term mental health benefits" (Sky et al., 2022). These sessions are vital to encoding new memories and consciously embodying the behavioral changes that support the potential long-term efficacy of these medicines (Griffiths et al., 2017; Griffiths et al., 2008). Further, emerging neuroscience findings that psychedelics reopen the social reward learning critical period suggest that intentional, repetitive practices are focal to integration and enhancing the long-term efficacy of these therapies (Nardou et al., 2023).

Appendix 2A: For Credentialed Clinicians Licensed to Provide Psychotherapy

SCREENING, ASSESSMENT, AND INTAKE

TESTING

96130 **First hour**

+96131 *Each additional hour*

96136 **First 30 minutes**

+96137 *Each additional 30 minutes*

96127 **One standardized instrument**

96146 **One standardized instrument via electronic platform**

PSYCHIATRIC DIAGNOSTIC EVALUATION

90791

Consider +90785, interactive complexity

MEDICATION MANAGEMENT

N/A

PREPARATION AND INTEGRATION

90832 30 minutes

90834 45 minutes

90837 60 minutes

Consider +90785, interactive complexity

Practitioners using **group therapy** may consider:

90837 60 minutes

90853 Group psychotherapy (modifier 59, distinct procedural service)

Negotiate with insurer to bill **90834** twice for a 90-minute session

If using **two licensed psychotherapists**, consider negotiating use of modifier XP (distinct service performed by a different practitioner)

MEDICATION ADMINISTRATION SESSION

0820T 60 minutes

+0821T *if second practitioner is a physician or other qualified healthcare professional*

H2010 negotiate a **team-based rate** (per 15 minutes) to compensate all providers

Appendix 2B: For Evaluation And Management-Eligible Clinicians Only

SCREENING, ASSESSMENT, AND INTAKE

99202-99205
E/M code for new patient

+99415-99417 with add-on codes for time if needed

TESTING

96130	**First hour**
+96131	*Each additional hour*
96136	**First 30 minutes**
+96137	*Each additional 30 minutes*
96127	**One standardized instrument**
96146	**One standardized instrument via electronic platform**

PSYCHIATRIC DIAGNOSTIC EVALUATION

90792

Consider +90785, interactive complexity

MEDICATION MANAGEMENT

99212-99215
E/M code for existing patient

Psychotherapy add-on if appropriate

+90833 30 minutes

+90836 45 minutes

+90838 60 minutes

Consider +90785, interactive complexity

PREPARATION AND INTEGRATION

99212-99215
E/M code for existing patient

90832	30 minutes
90834	45 minutes
90837	60 minutes

Consider +90785, interactive complexity

Practitioners using **group therapy** may consider using:

90837	60 minutes
90853	Group psychotherapy (modifier 59, distinct procedural service)

Negotiate with insurer to bill **90834** twice for a **90-minute session**

Psychotherapy add-on if appropriate

+90833 30 minutes

+90836 45 minutes

+90838 60 minutes

Consider **+90785**, *interactive complexity*

If using **two licensed psychotherapists**, consider negotiating use of modifier XP (distinct service performed by a different practitioner)

MEDICATION ADMINISTRATION SESSION

0820T	60 minutes
+0821T	*if second practitioner is a physician or other qualified healthcare professional*

Medical oversight only
E/M code for existing patient (**99212-99215**)
+99415 +99416 +99417, if necessary

H2010 negotiate a **team-based rate** (per 15 minutes) to compensate all providers

Appendix 2C: Clinical Staff or Technician[1]

SCREENING, ASSESSMENT, AND INTAKE

TESTING

96138 **First 30 minutes**

+96139 Each additional 30 minutes

MEDICATION MANAGEMENT

N/A

PREPARATION AND INTEGRATION

N/A

MEDICATION ADMINISTRATION SESSION

+0822T If second practitioner is a clinical staff member under the direction of a physician or other QHP

H2010 negotiate a **team-based rate** (per 15 minutes) to compensate all providers

1 The American Medical Association (n.d.) defines clinical staff as "a person who works under the supervision of a physician or other qualified health care professional, and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specific professional service but does not individually report that professional service." Technician certification levels may range from a high school diploma to baccalaureate or even master's degree in psychology and they may have undertaken additional training in standardized administration and scoring of psychological and/or neuropsychological testing.

Appendix 3. Unusual Circumstances and Additional Codes

The clinical trial environment is, by design, far more controlled than the clinical practice environment, which will include circumstances and events not experienced in the clinical trial model of care but for which practitioners must nevertheless be prepared. Some of these circumstances may include the need for crisis management, the potential for interactive complexity, and the use of a technician for certain elements of psychedelic-assisted therapy. These circumstances are described below and the chart that follows provides more information on codes.

The chart also identifies a wide range of other medical codes that may be used in billing for psychedelic-assisted therapy, recognizing that payers may differ in their code preferences and coverage policies. Further, some codes included in the chart below may not be utilized in the current model of care but may be relevant as the field of psychedelic-assisted therapy evolves (see 'Future Developments in the Field').

Crisis therapy and management. When a patient in high distress presents with a problem that is life-threatening or complex and that requires immediate attention, a licensed mental health practitioner may need to provide psychotherapy for crisis. CPT codes 90839 (first 60 minutes) and 90840 (each additional 30 minutes) are the appropriate codes to use in this situation. The American Psychological Association notes that a crisis psychotherapy session requires "urgent assessment and history of the crisis state, mental status exam, and disposition" (American Psychological Association Services, Inc., 2022a).

Interactive complexity. When specific communication factors arise during a psychotherapy session that make it difficult to deliver a service or administer treatment resulting in interactive complexity, it may be appropriate to utilize CPT add-on code 90785 in conjunction with the appropriate psychotherapy service code. The American Psychological Association notes that the interactive complexity codes may be used if at least one of the following complicating factors are present and documented in the patient record:

1. The need to manage maladaptive communication among participants that complicates delivery of care.
2. When a caregiver is present, the caregiver's emotions or behaviors interfere with the caregiver's understanding and ability to assist in the implementation of the treatment plan.
3. Evidence or disclosure of a sentinel event and mandated reporting to a third party with initiation of discussion of the sentinel event and/or report with a patient and other vital participants.
4. Use of play equipment or other physical devices to communicate with the patient to overcome barriers to therapeutic or diagnostic interaction and a patient who does not have either expressive language communication skills or a patient lacks the receptive communication skills to understand the provider (American Psychological Association Services, Inc., 2022b).

UNUSUAL CIRCUMSTANCES AND OTHER POTENTIALLY APPLICABLE CPT CODES FOR PSYCHEDELIC-ASSISTED THERAPY

CODE	SHORT DESCRIPTION	RESTRICTIONS ON USE	TIME	RVU·	MUE
90839	Psychotherapy for crisis, first 60 minutes	A	30-74 min	4.17	1
+90840	Psychotherapy for crisis, each additional 30 minutes	A	30 min	2.07	3
90846	Family psychotherapy (without the patient present), 50 minutes	A	26+ min	2.82	1
90847	Family psychotherapy (with the patient present), 50 minutes	A	26+ min	2.94	1
90849	Multiple-family group psychotherapy (use code once for each family group present)	A		1.10	1
90865	Narcosynthesis for psychiatric diagnostic and therapeutic purposes	MD/DO only	60 min	4.83	1
G0323	Care management for behavioral health conditions, at least 20 minutes of clinical psychologist or clinical social worker time, per calendar month	CP, LCSW	20 min	1.27	
+G2212	Prolonged office or other outpatient E/M service beyond the total time for 99205 (60 min) or 99215 (40 min); each 15 minutes, with or without patient contact	B	15 min	0.95	6

· 2023 Medicare Non-facility Total Relative Value Unit (RVU), includes Work, Practice Expense, and Malpractice RVUs

\+ Add-on code, list separately in addition to the code for the primary procedure

A For Medicare billing purposes, eligible providers include Physicians (MD, DO), Clinical Psychologists (CP), Clinical Social Workers (CSWs), Clinical Nurse Specialists (CNSs), Nurse Practitioners (NPs), Physician Assistants (PAs), Certified Nurse-Midwives (CNMs), Independently Practicing Psychologists (IPPs), and Certified Registered Nurse Anesthetists (CRNAs) (for supervision of diagnostic psychological and neuropsychological tests) (U.S. Centers for Medicare & Medicaid Services, 2022b).

B CPT guidance instructs that E/M codes (CPT codes 99091, 99202-99499) should only be reported by physicians (MD, DO) or other qualified healthcare professionals, which CMS defines as NPs, CNSs, CNMs, and PAs.

MUE Medically Unlikely Edit. Part of the National Correct Coding Initiative to reduce improper payments, an MUE represents the maximum units of service that a provider would report under most circumstances for a single patient on a single date of service.

Appendix 4. Workgroup Member Biographies

CARLENE MACMILLAN, MD

Carlene MacMillan, MD, a Harvard-trained adult and child psychiatrist, is the Chief Medical Officer at Osmind. Osmind is a technology platform that enables clinicians to deliver breakthrough mental health treatments. She is on the Board of the Clinical TMS Society and is the Co-Chair of the Clinical TMS Society Insurance Committee. She is the Co-Chair of the American Academy of Child and Adolescent Psychiatry Consumer Issues Committee. Dr. MacMillan also serves on the Board of the Ketamine Taskforce for Access to Safe Care and Insurance Coverage as a Vice President. She practices clinically as the co-founder of Fermata, an interventional psychiatric group practice in New York.

BRIAN RICHARDS, PSYD

Dr. Brian D. Richards completed a Master's degree in Existential-Phenomenological Psychology at Duquesne University, a PsyD at the University of Denver School for Professional Psychology, and a Postdoctoral Fellowship at the Johns Hopkins Behavioral Pharmacology Research Unit, where he contributed to some of the original research administering psilocybin with cancer patients and healthy normal adults. Dr. Richards was formerly a Clinical Director with MedOptions, the largest behavioral health provider in the United States. He now cares for patients with a cancer diagnosis at Maryland Oncology Hematology, The Aquilino Cancer Center. Dr. Richards also teaches and mentors students at the California Institute for Integral Studies, the leading Psychedelic Medicine Certificate Program worldwide. He is a Subject Matter Expert on Psilocybin with the Board of Psychedelic Medicine and Therapies, and is working with BrainFutures on Coding and Reimbursement for Psychedelic-Assisted Therapy.

Dr. Richards was a Lead Psychologist on an innovative, simultaneous group administration high-dose psilocybin trial with cancer patients at the Bill Richards Center for Healing in Rockville, Maryland. This cutting-edge, purpose-built psychedelic medicine clinic—located in a busy outpatient oncology center, is the first of its kind in the world, and may serve as a prototype for future Sunstone Therapies clinics nationwide.

Dr. Richards' clinical and research interests include meaning-centered psychotherapy, mystical experience, brain science-based approaches to vibrant health and wellness, and working with treatment refractory patients. He finds joy and meaning practicing yoga, gourmet cooking, working in nature, growing medicinal mushrooms, and caring for the natural world.

DAN H. ROME, MD

Dr. Dan Rome is a senior physician executive with more than 30 years of experience in direct patient care, healthcare administration and leadership, managed behavioral healthcare, and healthcare consulting. He currently serves as Chief Medical Officer at Enthea Benefits, Inc, a health benefits organization.

He has served in numerous physician leadership roles including Medical Director, Behavioral Health, at Evolent Health, a population health organization, Medical Director at Fallon Total Care, a state-wide Medicare/Medicaid health plan, and as Chief Medical Officer at Beacon Health Strategies, a nation-wide managed behavioral health organization. He has also served as Vice President for Medical Affairs at Tufts Health Plan, a major, nationally ranked non-profit health plan and, earlier, as Tufts Health Plan's (THP) Assistant Vice President for Mental Health Services.

Prior to joining THP, Dr. Rome was Psychiatrist-in-Charge at McLean Hospital in Belmont, Massachusetts, a Clinical Instructor in Psychiatry at Harvard Medical School, and an attending psychiatrist at Deaconess Waltham Hospital in Waltham. Dr. Rome is a graduate of Harvard College and Harvard Medical School.

References

American Academy of Professional Coders. (2022, December 25). What Is Medical Coding? https://www.aapc.com/medical-coding/medical-coding.aspx

American Medical Association. (n.d.). CPT® Evaluation and Management (E/M) Code and Guideline Changes. In American Medical Association. https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

American Medical Association. (2019, June 25). CPT® overview and code approval. American Medical Association. https://www.ama-assn.org/practice-management/cpt/cpt-overview-and-code-approval

American Medical Association. (2023, June 30). Category III Codes. American Medical Association. https://www.ama-assn.org/practice-management/cpt/category-iii-codes

American Psychological Association Services, Inc. (2022a, January). Psychotherapy Codes for Psychologists. https://www.apaservices.org/practice/reimbursement/health-codes/psychotherapy

American Psychological Association Services, Inc. (2022b, January 28). 2022 guidelines for reporting interactive complexity. https://www.apaservices.org/practice/reimbursement/health-codes/2022-reporting-interactive-complexity

Griffiths, R., Richards, W., Johnson, M., McCann, U., & Jesse, R. (2008). Mystical-type experiences occasioned by psilocybin mediate the attribution of personal meaning and spiritual significance 14 months later. Journal of Psychopharmacology, 22(6), 621–632. https://doi.org/10.1177/0269881108094300

Griffiths, R. R., Johnson, M. W., Richards, W. A., Richards, B. D., Jesse, R., MacLean, K. A., Barrett, F. S., Cosimano, M. P., & Klinedinst, M. A. (2017). Psilocybin-occasioned mystical-type experience in combination with meditation and other spiritual practices produces enduring positive changes in psychological functioning and in trait measures of prosocial attitudes and behaviors. Journal of Psychopharmacology, 32(1), 49–69. https://doi.org/10.1177/0269881117731279

Nardou, R., Sawyer, E., Song, Y. J., Wilkinson, M., Padovan-Hernandez, Y., De Deus, J. L., Wright, N., Lama, C., Faltin, S., Goff, L. A., Stein-O'Brien, G. L., & Dölen, G. (2023). Psychedelics reopen the social reward learning critical period. Nature, 618(7966), 790–798. https://doi.org/10.1038/s41586-023-06204-3

National Library of Medicine. (n.d.). UMLS Metathesaurus - HCPCS (HCPCS - Healthcare Common Procedure Coding System) - Synopsis. Retrieved February 4, 2022, from https://www.nlm.nih.gov/research/umls/sourcereleasedocs/current/HCPCS/index.html

Sky, J. (2022). Psychedelic Medicine: A Review of Clinical Research for a Class of Rapidly Emerging Behavioral Health Interventions. In H. McCormack, L. Raines, H. Harbin, J. Glastra, F. Wolswijk, & I. Burgess (Eds.), BrainFutures. BrainFutures. Retrieved January 18, 2023, from https://www.brainfutures.org/wp-content/uploads/2022/05/BrainFutures-Psychedelic-Medicine-Report.pdf

Sky, J., Esselman, D., & Glastra, J. (2022). An Expert-Informed Introduction to the Elements of Psychedelic-Assisted Therapy. D. Esselman, H. Harbin, & J. Glastra (Eds.), BrainFutures.org. https://www.brainfutures.org/mental-health-treatment/elementsofpat/

U.S. Centers for Medicare & Medicaid Services. (2022a, January). HCPCS - general information | CMS. Retrieved February 4, 2022, from https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo

U.S. Centers for Medicare & Medicaid Services. (2022b, March). Medicare Mental Health: Medicare Learning Network Booklet. CMS.gov. Retrieved December 2, 2022, from https://www.cms.gov/files/document/mln1986542-medicare-mental-health.pdf

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