

## TREATMENT OF MENTAL DISORDERS

ISSUE DATE: December 5, 1984

AUTHORITY: [32 CFR 199.4\(c\)\(3\)\(ix\)](#)

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### I. CPT<sup>1</sup> PROCEDURE CODE RANGES

90801 - 90899 for care provided through December 31, 2012.  
90785 - 90899 for care provided on or after January 1, 2013.

### II. POLICY

Benefits are payable for services and supplies that are medically or psychologically necessary for the treatment of mental disorders when: (1) the services are rendered by persons who meet the criteria of [32 CFR 199.6](#) for their respective disciplines (whether the person is an individual professional provider or is employed by another authorized provider), and (2) the mental disorder is one of those listed in DSM-IV and is of a severity not only to cause the patient distress but also to interfere with the patient's ability to carry out his or her usual activities.

### III. POLICY CONSIDERATIONS

#### A. Professional and institutional providers of mental health services.

1. List of authorized providers. Only the types of providers listed below are considered qualified providers of mental health services. The person providing the care must meet the criteria of [32 CFR 199.6](#), whether that person is an individual professional provider or is employed by another authorized provider.

- a. Psychiatrists and other physicians
- b. Clinical psychologists
- c. Certified psychiatric nurse specialists
- d. Clinical social workers
- e. Certified marriage and family therapists

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f. Pastoral counselors; and

g. Mental health counselors.

2. Professional staff of institutions providing mental health services. For those types of institutional providers that are certified by TMA, reviewers may assume that all professional staff meet regulatory criteria. Any evidence to the contrary is to be brought to the attention of the Special Contract Operations Office, TMA, immediately. Contractors shall notify institutional providers within their jurisdictions that payment is authorized only for professional services provided by employees meeting the program requirements. In any situation where the contractor obtains evidence that an institution is billing for professional services of unqualified staff, the case is to be submitted to the TMA Office of Program Integrity.

B. Review of Claims for Treatment of Mental Disorders. All claims for treatment of mental disorders are subject to review in accordance with claims processing procedures contained in the TRICARE Operations Manual (TOM).

1. Psychotropic drugs. All patients receiving psychotropic drugs must be under the care of a qualified mental health provider authorized by state licensure to prescribe drugs. That provider need not be the attending provider, but there must be evidence in the treatment plan of coordination between the various providers.

2. Electroconvulsive treatment (CPT<sup>2</sup> procedure codes 90870, 90871). Electroconvulsive treatment is covered when medically or psychologically appropriate and when rendered by qualified providers. However, the use of electric shock as negative reinforcement (aversion therapy) is excluded.

3. Ancillary therapies (no code, as separate reimbursement is not permitted). Includes art, music, dance, occupational, and other ancillary therapies, when included by the attending provider in an approved inpatient treatment plan and under the clinical supervision of a licensed doctoral level mental health professional. These ancillary therapies are not separately reimbursed professional services but are included within the institutional reimbursement.

4. Services by non-medical providers. With the exception of pastoral counselors, and mental health counselors, approved categories of non-medical providers may render covered services independent of physician referral and supervision. All providers, however, are expected to consult with, or refer patients to, a physician for evaluation and treatment of physical conditions that may co-exist with or contribute to a mental disorder. Failure to do so will result in denial of the non-physician provider's services on quality-of-care grounds. Questionable cases will be referred to peer review.

C. The first eight outpatient mental health visits per beneficiary in a fiscal year require no Primary Care Manager (PCM) or Health Care Finder (HCF) referral, nor is a preauthorization required (see [Chapter 1, Section 9.1](#) and the TOM, [Chapter 7, Section 2](#)).

**This applies to outpatient mental health visits identified by CPT<sup>2</sup> codes 90801 - 90857 for**

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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

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services provided through December 31, 2012; and CPT<sup>3</sup> codes 90791 - 90853 for services provided on or after January 1, 2013.

IV. EXCLUSIONS

- A. Sexual dysfunctions, paraphilias and gender identity disorders.
- B. Drug maintenance programs when one addictive drug is substituted for another on a maintenance basis.
- C. Specific developmental disorders.
- D. Home visits for individual, family, or marriage counseling (CPT<sup>3</sup> procedure code 99510).
- E. Microcurrent Electrical Therapy (MET), Cranial Electrotherapy Stimulation (CES), or any therapy that uses the non-invasive application of low levels of microcurrent stimulation to the head by means of external electrodes for the treatment of anxiety, depression or insomnia, and electrical stimulation devices used to apply this therapy.
- F. Transcranial Magnetic Stimulation (TMS) (also referred to as repetitive TMS (rTMS)) for the treatment of major depressive disorder (CPT<sup>3</sup> procedure codes 90867 and 90868), is unproven.

V. EFFECTIVE DATE            November 13, 1984.

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