healthfirst
Health Insurance for New Yorkers

Reimbursement Policy

Subject:	Psychiatric Diagnostic Evaluation		
Policy Number:	PO-RE-149v1		
Effective Date:	10/01/2025	**Last Approval Date:**	08/18/2025

I. Policy Description

This policy outlines the circumstances under which Healthfirst will reimburse claims for Psychiatric Diagnostic Evaluations, specifically utilizing CPT codes 90791 and 90792. In accordance with the guidelines established by the Local Coverage Determination (LCD) L35101 and the Local Coverage Article (LCA) A57130 for Jurisdictions H & L, this policy aims to ensure appropriate utilization and prevent overuse of psychiatric diagnostic services. Reimbursement will be contingent upon adherence to the specified billing limits and frequency restrictions outlined herein.

The information below applies to the following lines of business:

- Child Health Plus (CHP)
- Medicaid Managed Care (MMC)
- Medicare Advantage
- Personal Wellness Plan (PWP)/Health & Recovery (HARP)
- Medicaid Managed Care (MMC)
- Essential Plan (EP)
- Medicaid Advantage Plus/MAP (CompleteCare)
- Medicare PPO
- Qualified Health Plan (QHP)

Reimbursement Guide

1. Billing Limitations:
   - Healthfirst will not reimburse Psychiatric Diagnostic Evaluations billed more than three (3) units within a calendar year by the same provider for the same the Healthfirst member.

2. Applicable CPT Codes:
   - The following CPT codes are subject to this policy:
     - 90791: Psychiatric diagnostic evaluation (without medical services)
     - 90792: Psychiatric diagnostic evaluation with medical services

   - A combination of these codes should not be reported more than three (3) times per beneficiary per year by the same provider.

3. Coverage Considerations:

- Reimbursement is approved only when the services are medically necessary and appropriately documented.

- Providers must ensure that services are within the covered benefits as specified under the LCD L35101 and LCA A57130 guidelines for Jurisdictions H & L.

4. Documentation Requirements:
   - Providers must maintain thorough documentation supporting the medical necessity, clinical findings, and the number of diagnostic evaluations conducted within the year.

Adjudication and Appeal Process

1. Reimbursement for psychiatric diagnostic services will be determined based on the provider's scope of services and the reimbursement rates outlined in the provider's contract with Healthfirst.

2. Claims submitted by providers that do not adhere to this policy will be denied or rejected. It is the responsibility of the provider to ensure claims are coded accurately.

3. If the line of business (LOB) is not mentioned in this policy, the services are not covered and not eligible for reimbursement.

4. Reimbursement is subject to member eligibility, program coverage, and medical necessity at the time the service is provided.

5. Claims submissions will be subject to timely filing requirements, as set forth in the provider contract with Healthfirst and in the Healthfirst Provider Manual. Refer to: Healthfirst Provider Manual Subsection 17.6, "Claims Inquiries, Corrected Claims, Claim Reconsideration, and Appeal Process" in this section.

II. Applicable Codes

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

III. Definitions

Term	Meaning
LCD	Local Coverage Determination

IV. Related Policies

Policy Number	Policy Description
N/A	

Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.

V. Reference Materials

LCD - Psychiatric Codes (L35101)
Article - Billing and Coding: Psychiatric Codes (A57130)

VI. Revision History

Revision Date	Summary of Changes
01/01/2024	(LCD L35101) Issue Description CMS created a new Medicare benefit effective 01/01/2024 for Mental Health Counselors (MHCs) and Marriage and Family therapists (MFTs) authorizing them to bill for services furnished for the diagnosis and treatment of mental illnesses. To ensure that the LCD is consistent with the new CMS guidance, indication #8 under Section I, Psychiatric Diagnostic Evaluation has been revised. #8-Coverage for the diagnostic interview is limited to providers who are practicing within their scope of practice and are authorized to perform the

	service in their state

Disclaimer

Healthfirst's claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst's coding edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles, National Uniform Billing Editor's revenue coding guidelines, CPT Assistant guidelines, New York State-specific coding, billing, and payment policies, as well as national physician specialty academy guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for the services outlined. Reimbursement decisions are based on the terms of the applicable evidence of coverage, state and federal requirements or mandates, and the provider's participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.