Payment Policy: Psychotherapy Add-On Codes Billed with High-Level Evaluation and Management Services

Reference Number: NH.PP.50
Product Types: NHHF Medicaid
Effective Date: November 1, 2026
Last Review Date:

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
Psychotherapy add-on codes are time-based services furnished in conjunction with evaluation and management (E/M) service. Time attributed to psychotherapy must be distinct from time used to support the E/M service and must not overlap. Both services must be significant and separately identifiable.

High-level E/M services require substantial medical decision making while the psychotherapy add-on codes also require defined psychotherapy time. The combined requirements make it unlikely that both services represent significant, separately identifiable, and non-overlapping work.

Reimbursement
The Health Plan will deny reimbursement for psychotherapy add-on codes 90833, 90836, and 90838 when billed with E/M codes 99204, 99205, 99214, or 99215 for the same member, by the same provider, on the same date of service. The E/M service may remain eligible for reimbursement when all applicable coverage, coding, documentation, and contractual requirements are met.

Providers may request reconsideration and supply medical records to support that the services are significant, separately identifiable, and non-overlapping.

Documentation Standards
Providers are required to maintain complete, accurate, and contemporaneous documentation to substantiate the medical necessity and delivery of home health care services. Documentation must support services billed and be made available upon request for audit, utilization review, or program integrity activities conducted by the Health Plan, New Hampshire Medicaid, or their designees.

- Psychotherapy time must be separately documented and must not include time attributed to the E/M service.
- Time associated with history, examination, record review, medication management, and medical decision making may not also be counted as psychotherapy time when used to support the E/M service.
- The E/M level must be selected in accordance with current coding requirements.

- Prolonged service codes may not be reported when psychotherapy with E/M (90833, 90836, 90838) are reported.
- A separate diagnosis is not required solely because an E/M service and psychotherapy are reported on the same date; however, the record must support the medical necessity of each service.

The medical record must support all applicable requirements, including:

- The medical necessity of both the E/M and psychotherapy services.
- Separate identification of the E/M work and the psychotherapy service.
- Start and stop times or total psychotherapy time, as required by current coding guidance.
- No overlap between psychotherapy time and time spent on the the E/M service.
- The member's presence for the psychotherapy service, consistent with applicable coding requirements.

Insufficient documentation may result in denial, adjustment, recoupment, or other action permitted under applicable law, contract, and Health Plan policy.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2018, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Psychotherapy Add-On Codes	
CPT®* Codes	**Description**
90833	Psychotherapy add-on service, approximately 30 minutes, reported with E/M
90836	Psychotherapy add-on service, approximately 45 minutes, reported with E/M
90838	Psychotherapy add-on service, approximately 60 minutes, reported with E/M
High Level E/M Codes	
CPT®* Codes	**Description**
99204	New patient office or outpatient E/M service, moderate medical decision making
99205	New patient office or outpatient E/M service, high medical decision making
99214	Established patient office or outpatient E/M service, moderate medical decision making
99215	Established patient office or outpatient E/M service, high medical decision making

Related Policies

References

Revision History	
8/26/2026	Original Policy Draft

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

This payment policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited.

Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.

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