High Day Billing of Psychotherapy Services

Last updated 08/05/2025

Scope & History

This guide applies to all providers, non-physician providers, subcontractors, and facilities who submit for reimbursement of psychotherapy services under CareOregon medical or mental health plan of benefits. The purpose of this guide is to provide clarity on the maximum allowable units that can be billed by a single rendering provider during a single date of service.

Policy & Guidelines

CareOregon is introducing a new policy to limit psychotherapy services to a maximum of eight (8) hours per provider per day. If a provider bills for more than eight (8) hours of services, using any combination of the specified codes below, all psychotherapy services for that day will be denied. Medical records will be required for claims payment on any day [or 24-hour period] in which a provider claims more than eight (8) hours of psychotherapy.

Psychotherapy Billing Codes affected:

- CPT Code 90832: Psychotherapy, 30 min with patient (16 minutes minimum)
- CPT Code 90833: Psychotherapy add on, 30 min with patient with evaluation and management (E&M) services (21 minutes minimum)
- CPT Code 90834: Psychotherapy, 45 min with patient (38 minutes minimum)
- CPT Code 90836: Psychotherapy add on, 45 min with patient with E&M services (43 minutes minimum)
- CPT Code 90837: Psychotherapy, 60 min with patient (53 minutes minimum)
- CPT Code 90838: Psychotherapy add on, 60 min with patient with E&M services (58 minutes minimum)

All services billed for the entire day will be denied if the total psychotherapy time exceeds the 8-hour limit. Denied claims will be eligible for reconsideration with submission of clinical records for ALL services performed on the date of service that is being reconsidered.

Required Documentation for Payment:

Denied claims will be eligible for reconsideration with submission of clinical records for ALL services performed on the date of service that is being reconsidered. Provider appeals/reconsiderations can be submitted via the Provider Connect Portal through the Submit Claim Attachments feature.

If a claim denial was received when more than 8-hours of services were provided, a provider must submit one of the following for payment to CareOregon's Payment Integrity (fax number 503 416-1381):

- A client appointment log for the day, including reception check-in and check-out times for each client.
- Medical records for client visits conducted on that day
- For EDI claims for which additional paperwork or documentation will be submitted, complete the "CareOregon Paperwork (PWK) Fax Cover Sheet" form and indicate submission in the PWK segment (Loop 2300).

- Form is available online on CareOregon's Provider Support page (www.careoregon.org/providers/support), under the section "Submitting claims and receiving payment" -> "How to submit claims, claim reconsiderations, and claim appeals" -> click the link "complete this form": https://www.careoregon.org/docs/default-source/providers/provider-support/ehipaa/pwk_cover_sheet.pdf?sfvrsn=df6bf72e_3

To avoid high day billing, it's important for providers to:

- **Accurately track time**: Ensure that the time spent on each session is recorded precisely.
- **Avoid overlapping sessions**: Do not bill for multiple sessions that occur simultaneously.
- **Regularly audit**: Conduct regular reviews of billing practices to identify and correct any discrepancies.

Definitions

High Day Billing - the practice of billing for more timed services than can be reasonably provided within a 24-hour period

References

https://downloads.cms.gov/medicare-coverage-database/lcd_attachments/34616_20/L34616_PSYCH014_BCG.pdf

https://www.cms.gov/files/document/mln1986542-medicare-mental-health-coverage.pdf