

Policy: Group Psychotherapy in Nursing Facility Settings (CPT 90853)

Effective Date: Immediately

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I. Purpose

To outline medical necessity criteria for CPT code 90853 – Group Psychotherapy (other than of a multiple-family group) when rendered in nursing facility settings, including Skilled Nursing Facilities (POS 31) and Nursing Facilities (POS 32). This policy ensures services are furnished in a manner consistent with Medicare coverage rules, medically necessary care, and generally accepted standards of practice.

II. Background

Group psychotherapy is a covered Medicare Part B service when medically necessary, furnished by qualified providers, and delivered in a therapeutic environment. Effective delivery requires:

- A therapeutic environment that ensures privacy, safety, and adequate space.
- Participants capable of engaging in and benefiting from group interaction.

In nursing facility settings, barriers such as high patient acuity, cognitive impairment, and environmental limitations often limit the clinical effectiveness of group psychotherapy. Therefore, medical necessity must be carefully documented to support coverage.

III. Policy Statement

1. General Rule:

- Group psychotherapy (90853) in POS 31 or POS 32 may be covered when documentation demonstrates that all Medicare coverage criteria are met.
- Because of frequent clinical and environmental limitations in these settings, medical necessity is rarely established without specific justification.
- Claims without adequate documentation will be denied.

2. Medical Necessity Concerns in NF/SNF Settings:

- Patients with advanced cognitive impairment (e.g., severe dementia) often cannot meaningfully participate.
- Custodial or supportive interventions are not covered as skilled psychotherapy.
- Environments lacking privacy or therapeutic structure do not support coverage.

IV. Coverage Criteria

A. Substance Use Disorder Diagnoses

90853 may be covered when all of the following are met:

1. The primary diagnosis is a substance-related and addictive disorder (F10–F19 codes per ICD-10, excluding remission codes).
2. The group is part of a structured, facility-based substance abuse treatment program.

3. A treatment plan with measurable goals related to substance use recovery is documented.
4. The environment supports therapeutic interaction and provider qualifications meet Medicare/state requirements.

B. Non–Substance Abuse Diagnoses

Coverage may be considered if documentation clearly supports:

1. Medical Necessity:
 - Clinical rationale why individual therapy or alternate settings are not appropriate.
 - Evidence the patient can meaningfully participate in group therapy.
2. Therapeutic Environment:
 - Description of the space (privacy, adequate seating, minimal interruptions).
 - Group size consistent with clinical standards (generally 6–12 participants).
3. Therapeutic Benefit:
 - Progress notes showing patient engagement and measurable progress.
 - Therapy is part of an individualized treatment plan reviewed at least every 30 days.

V. Documentation Requirements

All claims must include:

- Diagnosis and clinical justification.
- Signed treatment plan by a qualified mental health professional.
- Progress notes for each session.
- Group size, composition, and therapy setting.
- For substance use disorder treatment, documentation of a structured program.

VI. Limitations & Exclusions

- Social, recreational, or diversionary group activities are not covered.
- Educational groups without psychotherapeutic content are not covered.
- Services furnished by unqualified personnel or in non-therapeutic environments are not covered.

VII. References

- CMS Medicare Benefit Policy Manual, Ch. 6, §§70–80
- CPT® 2025 Professional Edition – American Medical Association
- American Psychiatric Association Practice Guidelines