Spravato (Esketamine) Administration and Observation

For Mental Health Billing and Coding Guide

Last revised: 01/01/2026

Background

The purpose of this guide is to establish policy on all forms of ketamine therapy for the treatment of mental health conditions. This applies to all providers, non-physician providers, and subcontractors who submit Ketalar (ketamine) and Spravato (esketamine) claims.

• The FDA and CMS recognize Spravato (esketamine) for treatment-resistant depression (TRD) and major depressive disorder (MDD) with acute suicidal ideation or behavior.
• Ketamine (Ketalar) is off-label when used to treat mood disorders or TRD and is not routinely covered.
• Spravato is subject to a Risk Evaluation and Mitigation Strategy (REMS).
• Non-covered ketamine therapies include compounded, intramuscular, or troche formulations.
• Intravenous ketamine may be considered through the CareOregon exception (prior authorization) process.

Policy

Ketamine (Ketalar) therapy for TRD, MDD, or mood disorders is not covered unless approved through prior authorization. Spravato (esketamine) therapy may be covered when billed appropriately and in accordance with CareOregon policy.

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Spravato (Esketamine) Coverage

Medicaid (OHP/CCOs):
• Spravato must be dispensed by a specialty pharmacy.
• Coverage is determined by OHA fee-for-service (mental health drug carve-out).
• Prior authorization through OHA FFS is required.
• CareOregon allows coverage of administration-related services when billed appropriately.

Medicare (CareOregon Advantage):
• CareOregon Advantage is responsible for administration-related services only.
• Spravato may be supplied as a Part D benefit.
• CareOregon does not cover HCPCS G2082 or G2083 under any line of business.

Billing Guidance for Spravato (Esketamine)

There is no administration CPT code for nasal spray medications. Billing must distinguish between physician/Qualified Healthcare Professional (QHP) services and clinical staff services. Required REMS observation time does not automatically qualify as billable prolonged services.
Physician or Qualified Health Care Professional (QHP):

• Bill the appropriate office or outpatient E&M service based on medical decision-making or total physician/QHP time.
• Use CPT 99417 (AMA) or HCPCS G2212 (CMS) only when prolonged service thresholds are met.
• Clinical staff time may not be counted toward physician/QHP prolonged services.
Clinical Staff (CareOregon Policy):
• CareOregon allows CPT 99415 and 99416 for prolonged clinical staff services when:

- Services are provided under direct supervision
- Time thresholds are met
- Documentation supports active clinical involvement beyond custodial monitoring

• Clinical staff time must be tracked separately from physician/QHP time.

Drug Billing

• If Spravato is dispensed by a pharmacy (Part D or OHP carve-out), the drug cannot be billed to the health plan.
• Provider buy-and-bill is not applicable under CareOregon policy.
• G2082 and G2083 are not covered by CareOregon and should not be billed. Because these codes include the cost of the medication, which should already be covered by the pharmacy.

Compliance Reminder

Documentation must clearly distinguish physician/QHP services from clinical staff services. Failure to follow CareOregon policy or national coding rules may result in recoupment or audit findings.

Billing Tables – Physician/QHP Time

CPT code 99417 remains an active CPT code for AMA prolonged services and has not been deleted.
Documentation must support physician/QHP time thresholds.
HCPCS code G2212 can be used interchangeably with CPT 99417 for Medicare members.

Total Time Phys/QHP Only	Level of Medical Decision Making	Billable Evaluation and Management for Established Patient
10-19 minutes	Straightforward	99212
20-29 minutes	Low	99213
30-39 minutes	Moderate	99214
40-54 minutes	High	99215
55-69 minutes	Time Based Code Selection only	99215 + 99417
70-84 minutes	Time Based Code Selection only	99215 + 99417x2
85-99 minutes	Time Based Code Selection only	99215 + 99417x3
100-114 minutes	Time Based Code Selection only	99215 + 99417x4
115-129 minutes	Time Based Code Selection only	99215 + 99417x5
130-144 minutes	Time Based Code Selection only	99215 + 99417x6
145-159 minutes	Time Based Code Selection only	99215 + 99417x7
160-174 minutes	Time Based Code Selection only	99215 + 99417x8
175-189 minutes	Time Based Code Selection only	99215 + 99417x9

Billing Tables – Physician/QHP Time and Clinical Staff Services

Total Time Phys/QHP and Clinical Staff Services	Level of Medical Decision Making	Billable Evaluation and Management for Established Patient
Physician time optional (10-19 minutes)	Straightforward	99212
Physician time optional (20-29 minutes)	Low	99213
Physician time optional (30-39 minutes)	Moderate	99214
Physician time optional (40-54 minutes)	High	99215
+60-89 minutes by staff	Additional time documented by staff	Add 99415
+90-119 minutes by staff	Additional time documented by staff	Add 99415 and 99416
+120-149 minutes by staff	Additional time documented by staff	Add 99415 and 99416x2
+150-179 minutes by staff	Additional time documented by staff	Add 99415 and 99416x3
+150-179 minutes by staff	Additional time documented by staff	Add 99415 and 99416x4

This document is provided for informational purposes only and should not be construed as legal advice. Any cited statutes are current as of the date of publication of this guide.

These guidelines have been developed to accompany and complement the official conventions and instructions provided within the American Medical Association's Current Procedural Terminology (CPT) itself. Additions and deletions conform it to the most recent publications of CPT and HCPCS Level II and to changes in CareOregon and its affiliates coverage policy and payment status, and as such these guidelines are current as of 01/01/2026. Every reasonable effort has been taken to ensure that the educational information provided is accurate and useful. CareOregon and its affiliates make no claim, promise, or guarantee of any kind about the accuracy, completeness, or adequacy of the content for a specific claim, situation, or provider office application, and expressly disclaim liability for errors and omissions in such content. As CPT codes change annually, you should reference the current version of published coding guidelines and/or recommendations from nationally recognized coding organizations for the most detailed and up-to-date information.