

Medical Necessity Guidelines: Outpatient Psychotherapy

Effective: September 21, 2022

Prior Authorization Required If <u>REQUIRED</u> , submit supporting clinical documentation pertinent to service request.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Applies to: COMMERCIAL Products <input checked="" type="checkbox"/> Tufts Health Plan Commercial products; Fax: 617.972.9409 <ul style="list-style-type: none"> CareLinkSM – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization TUFTS HEALTH PUBLIC PLANS Products <input checked="" type="checkbox"/> Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax: 888.977.0776 <input checked="" type="checkbox"/> Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.977.0776 <input checked="" type="checkbox"/> Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404 <input checked="" type="checkbox"/> Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 857.304.6304 *The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.	
SENIOR Products <ul style="list-style-type: none"> Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the Tufts Health Plan SCO Prior Authorization List Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List 	

OVERVIEW

Medically Necessary Outpatient psychotherapy services are covered for the diagnosis and treatment of mental health and substance use disorders specified in the most recent Diagnostic and Statistical Manual (DSM)TM or with the most recent International Classification of Diseases (ICD). The reported diagnosis should support the current symptom presentation and should be the focus of treatment.

CLINICAL COVERAGE CRITERIA

Medically Necessary Outpatient Psychotherapy services, delivered by a provider licensed in a discipline recognized by Tufts Health Plan are covered when the following are met:

Must meet either A or B

A. Meet all three of these criteria:

- When clinical data provide clear evidence of signs and symptoms consistent with a mental health or substance use disorder as defined in the most recent DSM or ICD
- And when there is a treatment plan, with measurable goals and approaches, that address the signs and symptoms of the patient's mental health or substance use disorder and that is consistent with current professional practice standards
- And when there is no less intensive or more appropriate level of service that can be safely and effectively provided

OR

B. When clinical data indicate that the Member's condition has stabilized and continued treatment at a less frequent maintenance level is needed to sustain the current level of functioning.

LIMITATIONS

Tufts Health Plan will not cover outpatient psychotherapy under the following circumstances:

- Regardless of medical necessity, services listed as exclusions, or not listed as covered benefits, in the member's benefit document.
- Services that could safely and effectively be provided at a lesser frequency or intensity
- Therapy visits more than once a week except in situations of acute crisis for a brief period of time. For example, situations when there is a risk of hospitalization, severe symptoms and/or severe functional impairments.

- When services are not documented in a medical record containing contemporaneous progress notes.

CODES

Ancillary providers may bill the following procedure codes:

Procedure Codes for All Clinicians

Procedure Code	Description
90791 ¹	Psychiatric diagnostic evaluation (no medical services)
90785	Interactive complexity (add on code)
90832	Psychotherapy, 30 minutes with patient or family member
90834	Psychotherapy, 45 minutes with patient or family member
90837	Psychotherapy, 60 minutes with patient or family member
90839	Psychotherapy for crisis, first 60 minutes
90840	Psychotherapy for crisis, each additional 30 minutes (add on code)
90846	Family Psychotherapy (without patient present)
90847	Family Psychotherapy (with patient present)
90849	Multiple-family group psychotherapy
90853	Group Psychotherapy

Additional Codes for Prescribing Clinicians - (Psychiatrists, prescribing nurse clinical specialists and MH clinics)

Procedure Code	Description
99201 ²	New patient, office or outpatient visit, problem focused
99202	New patient, office or outpatient visit, expanded problem-focused
99203	New patient, office or outpatient visit, low complexity
99204	New patient, office or outpatient visit, moderate complexity
99205	New patient, office or outpatient visit, high complexity
99211 ²	Established patient, office or outpatient visit, 5 minutes are spent
99212 ²	Established patient, office or outpatient visit, 10 minutes are spent
99213 ²	Established patient, office or outpatient visit, low complexity
99214	Established patient, office or outpatient visit, moderate complexity
99215	Established patient, office or outpatient visit, high complexity
90792 ¹	Psychiatric diagnostic evaluation with medical services
90833	Psychotherapy, 30 minutes with patient or family member with an evaluation & management service
90836	Psychotherapy, 45 minutes with patient or family member with an evaluation & management service
90838	Psychotherapy, 60 minutes with patient or family member with an evaluation & management service

APPROVAL HISTORY

- July 28, 2010: Addition of statement regarding therapy visits rendered more than once a week.
- September 28, 2011: Reviewed and renewed with changes: Moved statement regarding documentation of services in a medical record and added services that are not medically necessary to Limitations section.
- September 20, 2012: Reviewed and approved by the Mental Health Operations and Policy Committee. Removed: "Services are not delivered in a healthcare facility or professional

¹ Billing is limited to two 90791 or 90792 procedure codes per provider, per Member, per calendar year.

² Billing 99201, 99211, 99212 or 99213 alone or with 90785 does not require authorization. These medical management services do not decrement the Member's mental health benefit.

office". Added "Any service, supply or procedure performed in a non-conventional setting (including, but not limited to, spas/resorts, therapeutic programs, and camps)"

- January 1, 2013: Add new 2013 CPT codes, Delete end dated 2012 CPT codes
- February 8, 2013: Added; "Billing 99201, 99211, 99212 or 99213 alone or with 90785 does not require authorization. These medical management services do not decrement the Member's mental health benefit."
- October 1, 2013: Reviewed and approved by the Mental Health Operations and Policy Committee with changes: Added "When clinical data provide evidence that the signs and symptoms of the patient's mental health or substance use disorder are active, resulting in impairment in daily functioning, as evidenced by, but not limited to, one or more of the following: Functional impairments: Member is unable to work or attend school as required, Member requires assistance with ADLs, In the last 3 months from date of this request the Member: Is increasingly isolative, Has experienced a new interpersonal crisis, Has an active eating disorder, Has experienced frequent feelings of hopelessness and/or worthlessness, Has experienced sleep and/or appetite disturbance, Experienced a panic attack or increased anxiety, Experienced a decrease in their ability to control impulsive behavior, Engaged in self-injurious behaviors"; Removed "The Member is making progress toward symptom reduction" ; change Substance abuse to substance use, added services provided in a school setting, "as part of an educational program".
- November 5, 2014: Reviewed and approved by the Mental Health Operations and Policy Committee with changes: remove the fax number from the Type of Review box.
- March 16, 2015: Added fax number back into "Applies to" Section.
- September 8, 2015: Reviewed and approved by the Mental Health Operations and Policy Committee with changes: Overview – added – "or with the most recent International Classification of Diseases (ICD). Coverage Guidelines: deleted – "for the assessment of symptoms to determine if a disorder is present" and added: Must meet all three of these criteria. Second bullet after DSM added – or with the most recent International Classification of Diseases (ICD). Added after 3rd bullet – AND must meet one of these criterions. Limitations: Removed – Services that are not medically necessary.
- September 2015: Branding and template change to distinguish Tufts Health Plan products in "Applies to" section. Added Tufts Health Freedom Plan products, effective January 1, 2016.
- November 9, 2015: Updated to include New Hampshire Telemedicine mandate – approved by the Mental Health Operations and Policy Committee.
- December 3, 2015: Reviewed by the Behavioral Health Practitioner Advisory Committee with no changes recommended.
- December 9, 2015: Reviewed and approved by the Integrated Medical Policy Advisory Committee, description added to "overview" section outlining notification and authorization process.
- March 15, 2016: Reviewed by the Behavioral Health Operations and Policy Committee with recommended changes: Overview – deleted last sentence and replaced with "Coverage for services beyond those covered at initial notification may require submission of clinical documentation in order to receive continued coverage." This change better reflects notification process and allows for medical necessity review.
- April 13, 2016: Reviewed and approved by the Integrated Medical Policy Advisory Committee with changes: Deleted last sentence of Overview section; shortened previous sentence by adding period after "Coverage for outpatient psychotherapy requires notification". Under "coverage guidelines" changed from "approved" to "covered."
- December 14, 2016: Reviewed by the Integrated Medical Policy Advisory Committee (IMPAC), renewed without changes
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
- July 11, 2017: Reviewed by Behavioral Health Operations and Policy Committee with the following changes: in overview section, deleted requirement for notification; In coverage guidelines section restructured coverage criteria, and removed "acute as evidenced by but not limited to" time based criteria, in limitations section consolidated 4 bullet points on specific benefit exclusions to say: "Regardless of medical necessity, services listed as exclusions, or not listed as covered benefits, in the member's benefit document." in Codes section, changed word "ancillary" to "behavioral health."
- November 3, 2017: Reviewed by Behavioral Health Practitioner Advisory Committee. Sentence added to coverage guidelines referencing other applicable telemedicine policies and guidelines.

- November 8, 2017: Reviewed by the Integrated Medical Policy Advisory Committee and approved with one change. Section on Telemedicine was removed.
- October 10, 2018: Reviewed by Integrated Medical Policy Advisory Committee (IMPAC), renewed without changes
- October, 2018: Template and disclaimer updated
- October 16, 2019: Reviewed by IMPAC, renewed without changes
- October 21, 2020: Reviewed by IMPAC, renewed without changes
- November 4, 2020: Fax number for Unify updated
- November 18, 2020: Reviewed by IMPAC, language requiring notification removed from Overview section, effective January 1, 2021.
- March 17, 2021: Reviewed by IMPAC, Added Tufts Health Direct, Tufts Health Together and Tufts Health RITogether to applicable products for MNG effective April 1, 2021. Addition of code 90849 to MNG. Fax number for Tufts Health Direct and Tufts Health updated. Addition of Unify Product to guideline effective January 1, 2022.
- September 15, 2021: Reviewed by IMPAC, renewed without changes
- February 1, 2022: Template Updated
- September 21, 2022: Reviewed by Medical Policy Approval Committee (MPAC), renewed without changes

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.