United Behavioral Health

Coverage Determination Guideline: Feeding and Eating Disorders

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**Table of Contents**
- Introduction
- Instructions for Use
- Benefit Considerations
- Coverage Rationale
- Applicable Codes
- References
- Revision History

**INTRODUCTION**

*Coverage Determination Guidelines* are a set of objective and evidence-based behavioral health criteria used by Commercial plans that don’t have a provision for medical necessity to standardize coverage determinations, promote evidence-based practices, and support members’ recovery, resiliency, and wellbeing for behavioral health benefit plans that are managed by Optum®.

**INSTRUCTIONS FOR USE**

This guideline provides assistance in interpreting UnitedHealthcare Commercial benefit plans, and is used to make coverage determinations as well as to inform discussions about evidence-based practices and discharge planning for behavioral health benefit plans managed by Optum. When deciding coverage, the member’s specific benefits must be referenced.

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member’s benefits prior to using this guideline. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this guideline and the member’s specific benefit, the member’s specific benefit supersedes this guideline. Other clinical criteria may apply. Optum reserves the right, in its sole discretion, to modify its clinical criteria as necessary using the process described in *Clinical Criteria*.

This guideline is provided for informational purposes. It does not constitute medical advice.

Optum may also use tools developed by third parties that are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Optum may develop clinical criteria or adopt externally-developed clinical criteria that supersede this guideline when required to do so by contract or regulation.

**BENEFIT CONSIDERATIONS**

Before using this policy, please check the member-specific benefit plan document and any federal or state mandates, if applicable.

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1 Optum is a brand used by United Behavioral Health and its affiliates.
This Coverage Determination Guideline is provided for informational purposes. It does not constitute medical advice.

**Pre-Service Notification**
Admissions to an inpatient, residential treatment center, intensive outpatient, or a partial hospital/day treatment program require pre-service notification. Notification of a scheduled admission must occur at least five (5) business days before admission. Notification of an unscheduled admission (including emergency admissions) should occur as soon as is reasonably possible. Benefits may be reduced if Optum is not notified of an admission to these levels of care. Check the member’s specific benefit plan document for the applicable penalty and provision for a grace period before applying a penalty for failure to notify Optum as required.

**COVERAGE RATIONALE**

Available benefits for **Anorexia Nervosa and Bulimia Nervosa** include the following services:
- Diagnostic evaluation, assessment, and treatment planning
- Treatment and/or procedures
- Medication management and other associated treatments
- Individual, family, and group therapy
- Provider-based case management services
- Crisis intervention

**Binge-Eating Disorder, Pica, Rumination Disorder or Avoidant/Restrictive Food Intake Disorder (ARFID)** as a principal diagnosis, as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, may be excluded from the member’s benefit plan. Please check the member’s specific benefit plan requirements. When excluded from the benefit plan, indications for coverage are limited to circumstances where:
- **Binge-Eating Disorder, Pica, Rumination Disorder or ARFID** is a secondary diagnosis; and
- The principal diagnosis is a covered condition; and
- Treatment is primarily focused on the principal diagnosis;

When **Binge-Eating Disorder, Pica, Rumination Disorder or ARFID** is covered according to the member’s specific benefit plan and when mental health treatment is indicated, available benefits include the following services:
- Diagnostic evaluation, assessment, and treatment planning
- Treatment and/or procedures
- Medication management and other associated treatments
- Individual, family, and group therapy
- Provider-based case management services
- Crisis intervention

A principal diagnosis is defined as the condition that, after a complete evaluation, is determined to be chiefly responsible for the member seeking treatment, and also becomes the focus of clinical attention during treatment. When a person has multiple diagnoses, the first disorder listed is assumed to be the principal diagnosis, unless the provider specified otherwise (American Psychiatric Association [APA], 2013).

The requested service or procedure must be reviewed against the language in the member’s benefit document. When the requested service or procedure is limited or excluded from the member’s benefit document, or is otherwise defined differently, it is the terms of the member’s benefit document that prevails.

All services must be provided by or under the direction of a properly qualified behavioral health provider.
Indications for Coverage
Eating Disorders: General
A. Initial evaluation

- Optum recognizes the American Psychiatric Association’s Practice Guidelines for the Psychiatric Evaluation of Adults (2016):
  - http://www.psychiatry.org > Psychiatrists > Practice > Clinical Practice Guidelines

- Optum recognizes the American Academy of Child & Adolescent Psychiatry’s Practice Parameter for the Assessment and Treatment of Children and Adolescents with Eating Disorders (2015):
  - http://www.aacap.org > Practice Parameters

- Early recognition of eating disorders is necessary to prevent complications, chronicity, and ensure the best treatment outcomes (Gorrell et al., 2019).
  - Eating disorders often have high lifetime mortality rates attributed to physical and mental disease complications with the additional risk of suicide (Klein et al., 2020).
  - The risk for eating disorders is highest between 13 and 17 years of age (National Institute for Health and Care Excellence [NICE], 2017).
  - Adolescents and young adults are especially at risk for developing anorexia nervosa; onset after age 30 is particularly rare (Treasure et al., 2020).

- The first priority when evaluating individuals with eating disorders is to identify emergency medical conditions that require hospitalization and stabilization (Harrington et al., 2015).

- Validated, short, self-report measures that can be useful screening tools to identify eating disorders include (American Academy of Child & Adolescent Psychiatry [AACAP], 2015):
  - Eating Disorder Examination-Questionnaire (EDE-Q);
  - Eating Disorder Inventory (EDI);
  - Eating Attitudes Test (EAT).

- Validated eating disorder screening measures for use in younger children include (AACAP, 2015):
  - Kids’ Eating Disorder Survey (KEDS);
  - Child-Eating Attitudes Test (CHEAT);
  - Eating Disorder Examination-Questionnaire, Children’s Version (ChEDE-Q);
  - Eating Disorders Inventory for Children (EDI-C).

- A positive screening for an eating disorder should be followed by a comprehensive diagnostic evaluation, including co-morbidity screening, laboratory testing, and imaging studies as indicated (AACAP, 2015).
  - The best-characterized and most routinely used structured interview for assessing disordered eating behaviors and eating-related psychopathology is the Eating Disorder Examination (EDE); the EDE is reliable for individuals as young as 12 years of age. A child version for individuals < 14 years of age is also available (AACAP, 2015).
  - The Bulimia-Test-Revised (BULIT-R) is a measure specific to bulimia nervosa (AACAP, 2015).
  - Parental reports about the child’s behavior are an important component of the evaluation process (AACAP, 2015).

- Clinicians should be aware that emerging evidence suggests that disordered eating behavior in males may be increasing faster than previously acknowledged. Some clinical features of male eating disorder can differ from females, such as a focus on muscularity, increasing muscular weight, fear of muscle and weight loss, and an overregulation of protein consumption (Murray et al., 2018).

B. Treatment planning

- Optum recognizes the American Psychiatric Association’s Practice Guidelines for the Psychiatric Evaluation of Adults (2016):
- Optum recognizes the American Academy of Child & Adolescent Psychiatry’s Practice Parameter for the Assessment and Treatment of Children and Adolescents with Eating Disorders (2015):
  - http://www.aacap.org > Practice Parameters
- The best outcomes for children and adolescents with eating disorders are correlated with a collaborative approach utilizing an interdisciplinary team that includes family corroboration (DerMarderosian et al., 2018).
  - When an eating disorder is diagnosed, members of the interdisciplinary team should include a therapist and dietitian for optimal treatment outcomes (Klein et al., 2020).
- Goals for recovery include (Waller & Raykos, 2020):
  - Normalizing eating patterns with the return of flexibility in eating and participation in meal planning;
  - Psychological recovery consists of improved self-esteem and age-appropriate functioning, reduced anxiety, reduced avoidant behaviors, reduced perfectionist behavior styles;
  - Physical recovery includes weight regain and stabilization, return of menses and/or pubertal progression, and reversal of most or all organ damage.
- Treatment efforts focusing on weight restoration, reduction of blame, enhancing self-esteem and active incorporation of caregivers and families have emerged as particularly effective (Klein et al., 2020; Waller & Raykos, 2020).
- Most physical abnormalities can be reversible with sufficient diet and restoration of a healthy weight; however, some clinical abnormalities may be irreparable in those with chronic anorexia nervosa or other low-weight eating and feeding disorders (AACAP, 2015).
- Treatment should focus on multiple factors, including medical and symptom severity, course of illness, psychiatric comorbidity, and the availability of psychosocial and familial support (Harrington et al., 2015):
  - Treatment success may be reliant on the therapeutic alliance with the patient, involvement of the patient’s family, and close collaboration among the interdisciplinary team.

C. Outpatient psychosocial interventions are the initial treatment of choice for individuals with eating disorders (AACAP, 2015; Society for Adolescent Health and Medicine [SAHM], 2015; American Psychiatric Association [APA], 2012).
- There is no clinical evidence that psychiatric hospitalization for eating disorders is more effective than outpatient treatment; no studies have been randomized or have compared residential and day treatment to outpatient treatment in adolescents (AACAP, 2015; Madden et al., 2015a).
  - Decisions about admission should be based on a comprehensive clinical assessment that reflects the seriousness of the individual’s physical and emotional health, rapidity of weight loss, available outpatient resources, and family circumstances (SAHM, 2015).
  - When more intensive programs are clinically necessary, the negative impacts, such as separation from family and community, can be mitigated by keeping length of stay short, using the lowest safe level of care, involving families in programming, and using experienced staff (AACAP, 2015).
- Psychotherapy can be particularly helpful once malnutrition has been corrected and weight gain has begun (APA, 2012).

Anorexia Nervosa
A. Evaluation and Treatment Planning
- Establishing a history and current timeline of anorexia nervosa symptoms can assist in developing an effective management plan (Kan & Treasure, 2019):
Identification of predisposing factors such as childhood life events, illnesses, childhood eating behaviors, personality and genetic traits, and childhood psychiatric comorbidities;

Identification of precipitating factors such as dieting, weight loss, stresses, and life events;

Identification of perpetuating factors:
- Addictive and avoidance behaviors;
- Interpersonal and social cognition difficulties;
- Behavioral traits of rigidity, anxiety, obsessive compulsive, anhedonia;
- Physical consequences such as secondary amenorrhea.

The subtypes of anorexia nervosa are described as (DSM-5, 2013):
- Restricting type – no recurrent episodes of binge eating or purging behavior during the last 3 months;
- Binge-eating/purging type – there have been recurrent episodes of binge eating or purging behavior during the last 3 months.

Anorexia nervosa symptoms may be expressed differently by children and adolescents when compared to adults (AACAP, 2015).

In anorexia nervosa, the potential presence of at least one other significant psychiatric comorbid condition is high, for both adolescents and adults (AACAP, 2015).

Co-morbid psychiatric diagnoses found with anorexia nervosa include major depression, bipolar disorder, anxiety disorders, obsessive–compulsive disorder, trauma-related disorders, and substance misuse (APA, 2013; Mitchell & Peterson, 2020).

B. Differential diagnosis for anorexia nervosa includes (Diagnostic and Statistical Manual of Mental Disorders 5th ed.; DSM-5; APA, 2013):
- Medical conditions (e.g., gastrointestinal disease, hyperthyroidism);
- Major depressive disorder;
- Schizophrenia;
- Substance use disorders;
- Social anxiety disorder (social phobia), obsessive-compulsive disorder, and body dysmorphic disorder;
- Bulimia nervosa;
- Avoidant/restrictive food intake disorder.

C. For anorexia nervosa, findings from studies suggest that family therapy, particularly family-based treatment (FBT - sometimes referred to as Maudsley Family Therapy), is effective and superior when compared to individual therapies for children and adolescents, and may be useful for older patients as well (AACAP, 2015; APA, 2012; SAHM, 2015).

- FBT typically consists of 10 to 20 family meetings over a 6 to 12-month treatment course (AACAP, 2015; Thomas et al., 2018, Chapter 17).
- Clinical evidence shows that FBT is both highly efficient and can decrease the need for hospitalization (AACAP, 2015).
- Individual approaches, such as adolescent-focused therapy (AFT) and cognitive behavioral therapy (CBT) can also be beneficial, particularly for individual that FBT is not a viable option (AACAP, 2015).
- Admission for medical stabilization followed by outpatient FBT has reported similar treatment outcomes to more prolonged admission for weight restoration (Madden et al., 2015b).

D. Hospitalization should be considered for initial treatment of any seriously malnourished patient to allow for daily monitoring of key markers such as weight, heart rate, hydration, kidney and liver function, serum laboratory tests such as blood counts and metabolic panels, and hormone testing (DerMarderosian et al., 2018; Harrington et al., 2015).

- Indications for hospitalization may include (Harrington et al., 2015):
  - Significant electrolyte abnormalities;
  - Arrhythmias or severe bradycardia;
  - Rapid persistent weight loss in spite of outpatient therapy;
Serious comorbid medical or psychiatric conditions, including suicidal ideation.

- Some data suggests that, when indicated, use of nasogastric tube feeding is more efficient than other approaches in promoting short-term weight gain in the context of hospitalization for weight restoration (AACAP, 2015; APA, 2012).

E. Studies have shown only limited benefit of medications in the treatment of anorexia nervosa (AACAP, 2015; APA, 2012; Harrington et al., 2015).
- Antidepressants may help mitigate symptoms of depression and suicidal ideation; however, they have not proved beneficial in facilitating weight restoration or preventing relapse (Harrington et al., 2015).
  - Medication should not be the sole treatment for anorexia nervosa (NICE, 2017).
- While potentially useful for comorbid conditions such as anxiety, controlled studies have not demonstrated significant benefit of antipsychotic medications. Further study is necessary to determine their efficacy on core symptoms regarding anorexia nervosa (AACAP, 2015; APA, 2012; Crow, 2019; Harrington et al., 2015).

Bulimia Nervosa

A. Evaluation and Treatment Planning
- Establishing collateral history from family members and a longitudinal clinical course is recommended in the evaluation (Thomas et al., 2018, Chapter 17).
- Because bulimia can occur at a normal or elevated weight, observable and physical signs are important to evaluate (Harrington et al., 2015; Thomas et al., 2018, Chapter 17):
  - Dental enamel erosions and gum disease
  - Edema
  - Parotid gland enlargement
  - Scars or calluses on fingers or hands (Russell’s sign [knuckle calluses])
  - Weight fluctuations
- The binge-eating with inappropriate compensatory behaviors both occur, on average, a minimum of once weekly for 3 months duration (DSM-5, 2013).
- Self-injury, substance abuse, and other impulsive and risk-taking behaviors may be common in individuals with bulimia nervosa, particularly among adults and older teens (AACAP, 2015).

B. Differential diagnosis for bulimia nervosa includes (Diagnostic and Statistical Manual of Mental Disorders 5th ed.; DSM-5; APA, 2013):
- Anorexia nervosa, binge-eating/purging type;
- Binge-eating disorder;
- Kleine-Levin syndrome;
- Major depressive disorder, with atypical features;
- Borderline personality disorder.

C. Outpatient treatment of bulimia nervosa is recommended, except when there are complicating factors, such as serious general medical problems or suicidal behaviors, or severe disabling symptoms that do not respond to outpatient treatment (APA, 2012).
- Cognitive behavioral therapy (CBT) is recommended as the most effective and best-studied intervention for individuals with bulimia nervosa (APA, 2012; Gorrell & LeGrange, 2019; Waller & Raykos, 2019);
- Interpersonal therapy (IPT) is also recommended, particularly for patients who do not respond to CBT (APA, 2012);
- Limited studies have favored family-based treatment (FBT) among adolescents with bulimia nervosa (AACAP, 2015).

D. Studies have suggested that antidepressants may be beneficial in decreasing the frequency of binge eating and purging, particularly among adult patients who refuse or do not have an optimal response to CBT (AACAP, 2015; APA; 2012; Harrington et al., 2015).
fluoxetine is approved by the us food and drug administration (fda) as a treatment for bulimia nervosa in adults (der marderosian et al., 2018).

binge-eating disorder

a. evaluation and treatment planning

- binge-eating disorder is distinguished from bulimia nervosa in that binge eating episodes are not associated with inappropriate compensatory behaviors (aacap, 2015; guerdjikova et al., 2017).
- onset is usually adolescence or young adulthood, with most individuals presenting for treatment in middle adulthood (academy for eating disorders, 2019).
- clinicians should be aware that binge-eating disorder is more prevalent than anorexia nervosa and bulimia nervosa combined; in addition, it is the most common eating disorder in males (guerdjikova et al., 2017).
- parental interviews and other collateral reports are often necessary for making a definitive diagnosis (aacap, 2015).
- in adults, binge-eating disorder may be associated with depressive disorders, anxiety disorders, posttraumatic stress disorder, impulse control disorders, substance use disorders, and personality disorders (aacap, 2015; guerdjikova et al., 2017).
- the binge eating episodes occur, on average, a minimum of once per week for 3 months (dsm-5, 2013).

b. differential diagnosis for binge-eating disorder includes (diagnostic and statistical manual of mental disorders 5th ed.; dsm-5; apa, 2013):

- bulimia nervosa;
- obesity;
- bipolar and depressive disorders;
- borderline personality disorder.

c. studies in adults with binge-eating disorder recommend cognitive behavioral therapy (cbt), primarily for achieving abstinence and reducing binge frequency (agras, 2019; aacap, 2015; agency for healthcare research & quality, 2015; apa, 2012).

- interpersonal therapy (ipt) and dialectical behavior therapy (dbt) may also be considered for some adult patients, while preliminary studies support the use of ipt in adolescents (aacap, 2015; apa, 2012).

d. studies have suggested that antidepressants may be beneficial in decreasing the frequency of binge eating and purging, and may be particularly useful for patients not responding to an initial trial of psychotherapy or those with major depression or another comorbid disorder responsive to antidepressant medications (apa, 2012; harrington et al., 2015).

- medications that have been studied with positive results include fluoxetine, fluvoxamine, citalopram, escitalopram, bupropion, duloxetine, lamotrigine, sertraline, and atomoxetine (crow, 2019).

pica, rumination disorder, and avoidant/restrictive food intake disorder (arfid)

a. evaluation and treatment planning

- for pica, rumination disorder, and arfid, a multidisciplinary treatment approach including both medical providers and experienced behavioral specialists is generally recommended, with involvement dependent on the severity of the condition (bryant-waugh, 2019).

- physical examination and clinical assessments with attention to serious complications are important in the clinical evaluation of pica (kliegman et al., 2020, chapter 36):

  - pica can occur across the lifespan, but presents most frequently in childhood and is more common in those with intellectual disability and autism spectrum disorders;
  - evaluation includes possible neglect and lack of family supervision combined with psychiatric assessment for comorbid psychiatric disorders and developmental delay.
• Although pica may occur in those with other psychiatric disorders or medical conditions, a separate diagnosis is made when the severity of the eating behavior warrants specific clinical management (APA, 2013; Treasure et al., 2020).
  o Children with pica are at greater risk for medical complications such as lead poisoning, iron-deficiency anemia, mechanical bowel problems, intestinal obstruction, intestinal perforations, dental problems, and parasitic infections (Kliegman et al., 2020, Chapter 36).
• Rumination as a symptom may occur in association with other eating disorders, including anorexia and bulimia nervosa (Kliegman et al., 2020, Chapter 36).
  o Although rumination disorder has conventionally been associated with infants, rumination disorder has also been identified in otherwise healthy individuals across the life span and can be overlooked in adolescents (Kliegman et al., 2020, Chapter 36).
  o If the rumination behavior occurs exclusive of another eating disorder or a medical condition and the severity of the behavior necessitates clinical attention, then a diagnosis of rumination disorder is warranted (APA, 2013).
• Distinguishing features for ARFID, in comparison to anorexia nervosa, include a lack of fear of weight gain, no shape or weight concerns, and no specific focus on weight loss (AACAP, 2015; Treasure et al., 2020).
  o The essential feature of ARFID is avoidance or restriction of food intake demonstrated by a clinically significant failure to meet adequate nutritional and/or energy requirements (DSM-5, 2013).
  o ARFID typically presents in infancy or childhood, and can potentially continue into adulthood; the prevalence and incidence rates remain essentially unknown (Bryant-Waugh, 2019; DSM-5, 2013).

B. Differential diagnosis for pica, rumination disorder, or ARFID may include (DSM-5, 2013):
• Anorexia nervosa;
• Bulimia nervosa;
• Obsessive-compulsive disorder;
• Other medical conditions (e.g., gastrointestinal conditions);
• Reactive attachment disorder;
• Schizophrenia spectrum disorders;
• Specific neurological/neuromuscular, structural, or congenital disorders and conditions associated with feeding difficulties;
• Specific phobia, social anxiety disorder, and other anxiety disorders.

C. Treatment
• Much of the empirical evidence for behavioral treatment of pica has been among individuals with co-occurring developmental disability (Kliegman et al., 2020, Chapter 36).
• Behavioral treatments, especially those combining with social and medical interventions are well-established treatments for pica (Kliegman et al., 2020, Chapter 36).
• Behavioral approaches for treatment of rumination disorder are supported by a number of case reports; however no controlled trials have been reported to date (Treasure et al., 2020).
• For children and adolescents with ARFID, there are no empirical studies to guide treatment, but use of CBT and family interventions may be helpful (AACAP, 2015).
• Evidence-based pharmacological treatments for pica, rumination disorder, and ARFID are lacking; the recommendation is to consider using treatments for the eating disorder it most accurately resembles (NICE, 2017).

**APPLICABLE CODES**

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member-specific benefit plan document and applicable laws that may require
coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other clinical criteria may apply.

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F50.00</td>
<td>Anorexia nervosa, unspecified</td>
</tr>
<tr>
<td>F50.01</td>
<td>Anorexia nervosa, restricting type</td>
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<tr>
<td>F50.02</td>
<td>Anorexia nervosa, binge-eating/purging type</td>
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<td>F50.2</td>
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<td>F50.89</td>
<td>Other specified eating disorder</td>
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<td>Rumination disorder of infancy</td>
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<td>F98.29</td>
<td>Other feeding disorders of infancy and early childhood</td>
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<td>F98.3</td>
<td>Pica of infancy and childhood</td>
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<tr>
<td>R11.10</td>
<td>Vomiting, unspecified</td>
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</table>

<table>
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<tr>
<th>Procedures Codes</th>
<th>Description</th>
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<td>90785</td>
<td>Interactive complexity (list separately in addition to the code for primary psychiatric procedure)</td>
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<td>90791</td>
<td>Psychiatric diagnostic evaluation</td>
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<td>90792</td>
<td>Psychiatric diagnostic evaluation with medical services</td>
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<td>90832</td>
<td>Psychotherapy, 30 minutes with patient</td>
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<tr>
<td>90833</td>
<td>Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)</td>
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<td>90834</td>
<td>Psychotherapy, 45 minutes with patient</td>
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<td>Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)</td>
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<td>90837</td>
<td>Psychotherapy, 60 minutes with patient</td>
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<td>Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)</td>
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<td>Psychotherapy for crisis; first 60 minutes</td>
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<td>Psychotherapy for crisis; each additional 30 minutes (list separately in addition to the code for primary service)</td>
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<td>Family psychotherapy (without the patient present), 50 minutes</td>
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<td>90847</td>
<td>Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes</td>
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<td>90849</td>
<td>Multiple-family group psychotherapy</td>
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<td>90853</td>
<td>Group psychotherapy (other than of a multiple-family group)</td>
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<td>90863</td>
<td>Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (list separately in addition to the code for primary procedure)</td>
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<td>H0019</td>
<td>Behavioral health; long-term residential (nonmedical, non-acute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem</td>
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<td>H0025</td>
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<td>H0035</td>
<td>Mental health partial hospitalization, treatment, less than 24 hours</td>
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<td>H2001</td>
<td>Rehabilitation program, per 1/2 day</td>
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<td>H2011</td>
<td>Crisis intervention service, per 15 minutes</td>
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<tr>
<td>H2012</td>
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<td>H2013</td>
<td>Psychiatric health facility service, per diem</td>
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<td>H2017</td>
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<td>H2018</td>
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<td>Crisis intervention mental health services, per hour</td>
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<tr>
<td>S9485</td>
<td>Crisis intervention mental health services, per diem</td>
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<tr>
<td>H2011</td>
<td>Crisis intervention service, per 15 minutes</td>
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<tr>
<td>H2012</td>
<td>Behavioral health day treatment, per hour</td>
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REFERENCES


**REVISION HISTORY**

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<th>Action/Description</th>
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<tr>
<td>12/20/2017</td>
<td>Annual review performed. Formatting updated: instructions for use removed, benefit considerations condensed, plan definitions removed, links to common criteria removed, DSM classification removed and additional resources section removed. Coding and references updated. No substantive changes to clinical content.</td>
</tr>
<tr>
<td>6/13/2018</td>
<td>Revised CDG to reflect the inclusion of Feeding disorders.</td>
</tr>
<tr>
<td>06/17/2019</td>
<td>Annual Update: Updates to formatting, codes, references</td>
</tr>
<tr>
<td>05/18/2020</td>
<td>Annual review and update</td>
</tr>
</tbody>
</table>