United Behavioral Health

Coverage Determination Guideline: Substance Related 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.

1 Optum is a brand used by United Behavioral Health and its affiliates.
Available benefits for Substance-Related Disorders include the following levels of care, procedures, and conditions:

- **Levels of Care**
  - Inpatient
  - Intensive Outpatient Program
  - Outpatient
  - Partial Hospital Program
  - Residential Treatment Facility

- **Procedures**
  - Diagnosis, evaluation, assessment, and treatment planning
  - Treatment and/or procedures
  - Medication management and other associated treatments
  - Individual, family, and group therapy
  - Provider-based case management
  - Crisis intervention

- **Conditions**
  - Depressive Disorders classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association* (APA) that are not excluded from coverage.

**Gambling Disorder** as a principal diagnosis, as defined in the current edition of the *Diagnostic and Statistical Manual* of the American Psychiatric Association, is typically excluded. In this instance, indications for coverage are limited to circumstances where:

- Gambling Disorder is a secondary diagnosis; and
- The principal diagnosis is a covered condition; and
- Treatment is primarily focused on the principal diagnosis; and
  - OR
- Gambling Disorder is covered by the member’s benefit plan.

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 (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.

Per the specific requirements of the plan, health care services or supplies may not be covered when inconsistent with generally accepted standards and clinical guidelines.

**Indications for Coverage**

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.

Per the specific requirements of the plan, health care services or supplies may not be covered when inconsistent with generally accepted standards and clinical guidelines.

A. Initial evaluation common criteria and best practices
   - Optum recognizes the American Psychiatric Association’s Practice Guidelines for the Psychiatric Evaluation of Adults (2016):
     - [http://www.psychiatry.org](http://www.psychiatry.org) > Psychiatrists > Practice > Clinical Practice Guidelines
The American Society of Addiction Medicine (ASAM) uses six dimensions of assessment for service planning and treatment across all services and levels of care (American Society of Addiction Medicine, 2013):

1) Acute intoxication and/or withdrawal potential, exploring the individual’s past and current experiences of substance use and withdrawal;
2) Biomedical conditions and complications, exploring health history and current physical condition;
3) Emotional, behavioral, or cognitive conditions or complications, exploring an individual’s thoughts, emotions, and mental health issues;
4) Readiness to change, exploring an individual’s readiness and interest in changing;
5) Relapse, continued use, or continued problem potential, exploring an individual’s unique relationship with relapse or continued use or problems;
6) Recovery/living environment, exploring an individual’s recovery or living situation, and the surrounding people, places, and things.

The results from the evaluation should determine the member’s diagnosis, level of risk, treatment setting, and treatment planning goals (American Society of Addiction Medicine, 2013).

B. Screening and Assessment Tools for Substance Use Disorders

The National Institute of Drug Abuse (NIDA) has identified the following evidence-based/validated pre-screen and full-screen tools, where applicable (NIDA, 2018):

- Screening tools:
  - Screening to Brief Intervention (S2BI);
  - Brief Screener for Alcohol, Tobacco, and other Drugs (BSTAD);
  - NIDA-Modified ASSIST Screening Tool (NM-ASSIST);
  - Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS);
  - Alcohol Use Disorders Identification Test (AUDIT) and Alcohol Use Disorders Identification Test-Consumption (AUDIT-C);
  - Opioid Risk Tool;
  - CAGE and CAGE-AID;
  - Alcohol Screening and Brief Intervention for Youth: A Practitioner’s Guide (NIAAA).

- Additional frequently used assessment tools include, but are not limited to:
  - CRAFFT 2.1 Tool specific for ages 12-21 years old (NIDA, 2018);
  - Drug Abuse Screen Test (DAST-10; DAST-20) (NIDA, 2018);
  - Clinical Opiate Withdrawal Scale (COWS) (NIDA, 2018);
  - Clinical Institute Withdrawal Assessment (CIWA-Ar) (Mirijello, 2015; VA/DOD, 2015).

C. Laboratory Testing (NIDA, 2017; VA/DOD, 2015):

- As indicated, testing to assess and/or monitor drug use is an important component of a treatment regimen;
- Feedback about laboratory assessments may improve the individual’s motivation to change and serve as a baseline to monitor treatment progress.
- See the related coverage determination guideline on drug testing: http://www.providerexpress.com > Clinical Resources > Coverage Determination Guidelines

D. Treatment Planning

- 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
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4) Readiness to change, exploring an individual’s readiness and interest in changing;
5) Relapse, continued use, or continued problem potential, exploring an individual’s unique relationship with relapse or continued use or problems;
6) Recovery/living environment, exploring an individual’s recovery or living situation, and the surrounding people, places, and things.

- Treatment plans should be reviewed often, modified, and individualized to fit the changing needs (NIDA, 2019; VA/DOD, 2015).
- Whenever a medication is to be used, the treatment plan should include steps that will promote medication adherence, depending on the needs of the individual (Substance Abuse and Mental Health Services Administration [SAMSHA], 2015).
- Adolescents’ drug use and treatment needs differ from those of adults; treatment should be tailored to the unique needs of the adolescent (NIDA, 2014).

E. General Treatment
- Successful treatment may have several steps, including (NIDA, 2019):
  - Detoxification;
  - Behavioral Counseling;
  - Medication;
  - Evaluation and treatment for co-occurring mental health issues;
  - Long-term follow-up to prevent relapse.
- The earlier treatment is offered in the disease process, the greater the likelihood of positive outcomes (NIDA, 2018).
- Matching treatment settings, interventions, and services to an individual’s particular problems and needs is critical to his or her ultimate success in returning to productive functioning (NIDA, 2018).
- Successful treatment addresses the individual’s drug abuse and any related medical, psychological, social, vocational, and legal problems (NIDA, 2018).
- All parties involved in the individual’s treatment should establish close linkages and open communications (SAMHSA, 2015).
- Because individuals often leave treatment prematurely, programs should include strategies to engage and keep people in treatment (NIDA, 2018).
  - A majority of individuals with a substance use disorder require a minimum of 3 months in treatment to substantially decrease or discontinue substance use; the most beneficial outcomes occur with longer durations of treatment (NIDA, 2018).
- The following principles should be considered fundamental to the engagement/re-engagement process for individuals with substance use disorders (VA/DOD, 2015):
  - Indicate to the individual and significant others that treatment is more effective than no treatment (i.e., “treatment works”);
  - Consider the individual’s prior treatment experience and respect the preference for the initial intervention approach(es), since no single intervention approach has emerged as the treatment of choice;
  - Regardless of the particular psychosocial intervention chosen, use motivational interviewing style during therapeutic encounters with individuals and emphasize the common elements of effective interventions including improving self-efficacy for change, promoting a therapeutic relationship, strengthening coping skills, changing reinforcement contingencies for recovery, and enhancing social support for recovery;
  - Emphasize that the most consistent predictors of successful outcome are retention in formal treatment and/or active involvement with community support for recovery;
  - Use strategies demonstrated to be efficacious to promote active involvement in available mutual help programs (e.g., 12-Step facilitation such as Alcoholics Anonymous and Narcotics Anonymous, Peer linkage, Network support);
Coordinate addiction-focused psychosocial interventions with evidence-based intervention(s) for other biopsychosocial problems to address identified concurrent problems consistent with the individual’s priorities;

- Provide intervention in the least restrictive setting necessary to promote access to care, safety, and effectiveness;
- If an individual drops out of treatment, the treatment team should make efforts to contact the person and re-engage him/her in treatment;
- If the individual remains unwilling to engage in any addiction-focused care, determine whether treatment for medical and psychiatric problems can be effectively and safely provided while looking for windows of opportunity to engage the person in addiction treatment.

- Recovery support services designed to initiate, support and enhance recovery should be implemented alongside treatment services (e.g., helping member access supportive living environment, participation in peer support services, involvement in wraparound services that may influence the treatment success) (American Society of Addiction Medicine, 2013).

- Some individuals may respond to psychosocial interventions and others to medication therapy alone, but most individuals benefit from a combination of these approaches (SAMHSA, 2015).

F. Psychosocial Interventions

- Behavioral therapies help individuals modify their attitudes and behaviors related to drug use and increase healthy life and relapse prevention skills (NIDA, 2018).
- Psychosocial approaches to treatment can be provided at the individual or group level. Some common therapies include (NIDA, 2018; VA/DOD, 2015):
  - Cognitive behavioral-therapy, which teaches the individual to recognize and stop negative thinking and behavior patterns;
  - Contingency management, such as providing incentives to reinforce positive behaviors;
  - Motivational enhancement therapy, which is often used early in the process to build motivation and commit to specific plans to engage in treatment and seek recovery;
  - Peer support group programs, including 12-step programs such as Alcoholics Anonymous or Narcotics Anonymous;
  - Family behavior therapy includes the individual plus at least one significant other; the goal is to address co-occurring problems.

- There is sizable evidence from psychotherapy research that general factors such as therapist skill, the strength of the therapeutic alliance, and the structure provided by regular clinical contact can have a powerful effect on engagement (VA/DOD, 2015).

G. General Pharmacotherapy

- Medications are often an important aspect of treatment, especially when combined with counseling and other behavioral therapies (NIDA, 2018; VA/DOD, 2015). Pharmacotherapy as part of the individual’s treatment and recovery may be used to (NIDA, 2018):
  - Re-establish normal brain function and decrease cravings and/or;
  - Treat co-occurring medical and/or psychiatric conditions.

- Medication Assisted Treatment (MAT) or Medication Assisted Recovery (MAR) approaches may involve pharmacotherapy to support recovery and treatment interventions (SAMHSA, 2019):
  - Individuals with moderate or severe alcohol use disorder, including those who have physiologic dependence or who are experiencing cravings and have not improved in response to psychosocial approaches alone, are particularly strong candidates for medication-assisted treatment. Disulfiram, acamprosate, naltrexone are commonly used medications regarding alcohol misuse disorders.
  - Individuals with opioid use disorder may benefit from MAT with medications that decrease withdrawal symptoms and psychological cravings, such as methadone, buprenorphine, and naltrexone.
  - In addition to factors specific to each medication, the clinician should consider the individual’s past experience with particular medication-assisted treatment.
medications; beliefs and opinions about which pharmacotherapy may be most helpful; level of motivation for abstinence; medical status and contraindications for each medication; and history of medication adherence.

- See the related Coverage Determination Guideline on Office-Based Treatment Of Opioid Dependence: http://www.providerexpress.com > Clinical Resources > Coverage Determination Guidelines

H. Withdrawal Management/Detoxification
- Individuals requiring medically supervised detoxification may need to be referred to an addiction specialist or addiction treatment program that can provide medically monitored withdrawal treatment (SAMSHA, 2015).
- In assessing the likelihood and potential severity of withdrawal, the most useful clinical factors are the person’s previous withdrawal experience, co-morbid medical conditions, inability to tolerate oral medications, and the number of previous withdrawals (VA/DOD, 2015).
- Withdrawal management/detoxification medications help suppress withdrawal symptoms during detoxification (SAMSHA, 2019).
  - Currently, benzodiazepines are considered first line in the treatment of alcohol withdrawal. The various options for administration routes demonstrates an advantage for use of benzodiazepines (Mirijello et al., 2015).
  - Benzodiazepines have proven efficacy in reducing seizure activity associated with complex withdrawal symptoms (Mirijello et al., 2015).
- Detoxification is not in itself "treatment", but only a first step in the process; individuals not receiving any further treatment after detoxification are likely to resume their drug use (NIDA, 2018).
  - Individuals should be encouraged to continue drug addiction treatment following detoxification (NIDA, 2018).
- Specific attention should be given to the medication evaluation and management of members with active psychiatric and/or medical symptoms (American Society of Addiction Medicine, 2013).

I. Monitoring Progress
- An individual’s treatment and services plan must be assessed continually and modified as necessary to ensure that it meets his or her changing needs (NIDA, 2018).
- Drug use during treatment must be monitored continuously, as lapses during treatment do occur (NIDA, 2018):
  - For some individuals the knowledge that their drug use is being monitored can be a meaningful incentive to resist drug use.
  - Monitoring also provides an early indication of a return to drug use, signaling a possible need to adjust an individual's treatment plan to better meet his or her needs.
- Monitoring progress for treatment of alcohol use disorder is an ongoing process, during which the diagnosed individual is assessed on three dimensions (SAMSHA, 2015):
  - Adherence to the treatment plan;
  - Ability to sustain abstinence or reduced drinking, duration of periods of abstinence or reduced drinking, and levels of craving;
  - Overall health status and social functioning.
- If an individual begins to experience problems with adherence, the clinician should assess for underlying medical, psychiatric, or social factors and revisit the treatment plan to determine whether different strategies or treatment modalities may be useful. Adding to the frequency of monitoring visits or counseling may improve the ability of the individual to manage relapse risks and stressors (SAMSHA, 2015).

J. Managing Relapse
- Relapse does not indicate that treatment has failed, but signals that it may need to be adjusted, reinstated, or modified in order to move toward recovery (NIDA, 2018).
- Sizeable evidence shows that brief counseling sessions combined with use of a medication is an effective treatment for many individuals in early recovery (SAMSHA, 2015).
Counseling sessions typically focus on encouraging abstinence, adherence to the medication regimen, and participation in mutual-help groups and other peer support programs (SAMSHA, 2015; VA/DOD, 2015).

- If individuals are receiving treatment for alcohol use disorder relapse, the provider should consider several options, including (SAMSHA, 2015):
  - Examining social, medical, or behavioral factors that contribute to the individual’s alcohol consumption;
  - Increased monitoring;
  - Adjusting the dose of medication;
  - Increasing or changing the intensity of psychosocial services;
  - Referring the individual for specialty care.

K. Gambling Disorder Assessment and Treatment

- According to the DSM-5 (APA, 2013), significant symptoms of impairment or distress regarding gambling must occur within a 12-month time frame.
- Gambling can affect individuals in varying ways, and certain approaches may work better for certain people (APA, 2018):
  - Cognitive behavioral therapy, psychodynamic therapy, group therapy and family therapy are utilized to treat gambling disorder.
  - Fewer than 10 percent of people with gambling disorder pursue treatment.
- The South Oaks Gambling Screen (SOGS) is a 16-item instrument used to “rule in” or “rule out” an individual as someone with problem-gambling. If the individual is “ruled in”, the next step would be to perform a comprehensive diagnostic assessment (American Society of Addiction Medicine, 2013).
- Assessment of the member’s gambling behavior includes (American Society of Addiction Medicine, 2013):
  - Initiation;
  - Progression;
  - Current frequency, severity, types of games played, maintaining factors, and features of dependence;
  - Consequences (financial, interpersonal, vocational, etc);
  - Reasons for consultation and motivation to change;
  - Assessment of suicide risk;
  - Comorbidities;
  - Confirmation of the diagnosis;
- Pathological gambling can be highly comorbid with substance use, mood, anxiety, and personality disorders (American Society of Addiction Medicine, 2013).
- Individuals with gambling disorder are at increased risk of suicide (APA, 2018).
- Once a diagnosis is confirmed, determining the severity of the illness can be used to guide the intensity of the intervention(s) developed as part of the treatment plan (American Society of Addiction Medicine, 2013).

### 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>
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</thead>
<tbody>
<tr>
<td>F10.10, F10.20</td>
<td>Alcohol Use Disorder (mild, moderate, severe)</td>
</tr>
<tr>
<td>F10.120-F10.129; F10.220-F10.229; F10.920-F10.929</td>
<td>Alcohol intoxication</td>
</tr>
<tr>
<td>F10.230-F10.239</td>
<td>Alcohol Withdrawal</td>
</tr>
</tbody>
</table>
F15.920-F15.929 Caffeine/Stimulant/Other Stimulant Intoxication
F15.23, F15.93 Caffeine/Stimulant/Other Stimulant Withdrawal
F12.10, F12.20 Cannabis Use Disorder (mild, moderate, severe)
F12.120-F12.129; F12.220-F12.229; F12.920-F12.929 Cannabis Intoxication
F12.23, F12.93 Cannabis Withdrawal
F16.10, F16.20 Phencyclidine/Hallucinogen/Other Hallucinogen Use Disorder (mild, moderate, severe)
F16.120-F16.129; F16.220-F16.229; F16.920-F16.929 Phencyclidine/Hallucinogen/Other Hallucinogen Intoxication
F18.10, F18.20 Inhalant Use Disorder (mild, moderate, severe)
F18.120-F18.129; F18.220-F18.229; F18.920-F18.929 Inhalant Intoxication
F11.10, F11.20 Opioid Use Disorder (mild, moderate, severe)
F11.120-F11.129; F11.220-F11.229; F11.920-F11.929 Opioid Intoxication
F11.23, F11.93 Opioid Withdrawal
F13.10, F13.20 Sedative, Hypnotic, or Anxiolytic Use Disorder (mild, moderate, severe)
F13.120-F13.129; F13.220-F13.229; F13.920-F13.929 Sedative, Hypnotic, or Anxiolytic Intoxication
F13.230-F13.239; F13.930-F13.939 Sedative, Hypnotic, or Anxiolytic Withdrawal
Z72.0, F17.200, F17.210 Tobacco/Nicotine Use Disorder
F17.203, F17.213 Tobacco/Nicotine Withdrawal
F63.0 Gambling Disorder

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Description</th>
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<tr>
<td>90785</td>
<td>Interactive complexity (list separately in addition to the code for primary psychiatry procedure)</td>
</tr>
<tr>
<td>90791</td>
<td>Psychiatric diagnostic evaluation</td>
</tr>
<tr>
<td>90792</td>
<td>Psychiatric diagnostic evaluation with medical services</td>
</tr>
<tr>
<td>90832</td>
<td>Psychotherapy, 30 minutes with patient</td>
</tr>
<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>
</tr>
<tr>
<td>90834</td>
<td>Psychotherapy, 45 minutes with patient</td>
</tr>
<tr>
<td>90836</td>
<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>
</tr>
<tr>
<td>90837</td>
<td>Psychotherapy, 60 minutes with patient</td>
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<tr>
<td>90838</td>
<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>
</tr>
<tr>
<td>90839</td>
<td>Psychotherapy for crisis; first 60 minutes</td>
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<tr>
<td>Code</td>
<td>Description</td>
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<td>-------</td>
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<tr>
<td>90840</td>
<td>Psychotherapy for crisis; each additional 30 minutes (list separately in addition to the code for primary service)</td>
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<tr>
<td>90846</td>
<td>Family psychotherapy (without the patient present), 50 minutes</td>
</tr>
<tr>
<td>90847</td>
<td>Family psychotherapy (conjoint psychotherapy) (with the patient present), 50 minutes</td>
</tr>
<tr>
<td>90849</td>
<td>Multiple-family group psychotherapy</td>
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<tr>
<td>90853</td>
<td>Group psychotherapy (other than of a multiple-family group)</td>
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<tr>
<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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<tr>
<td>G0177</td>
<td>Training and educational services related to the care and treatment of patient’s disabling mental health problems per session (45 minutes or more)</td>
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<tr>
<td>G0410</td>
<td>Group psychotherapy other than of a multiple-family group, in a partial hospitalization setting, approximately 45 to 50 minutes</td>
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<tr>
<td>G0411</td>
<td>Interactive group psychotherapy, in a partial hospitalization setting, approximately 45 to 50 minutes</td>
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<tr>
<td>H0004</td>
<td>Behavioral health counseling and therapy, per 15 minutes</td>
</tr>
<tr>
<td>H0015</td>
<td>Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling, crisis intervention, and activity therapies or education</td>
</tr>
<tr>
<td>H0017</td>
<td>Behavioral health; residential (hospital residential treatment program), without room and board, per diem</td>
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<tr>
<td>H0018</td>
<td>Behavioral health; short-term residential (nonhospital residential treatment program), without room and board, per diem</td>
</tr>
<tr>
<td>H0019</td>
<td>Behavioral health; long-term residential (nonmedical, nonacute 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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<tr>
<td>H0025</td>
<td>Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)</td>
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<tr>
<td>H0035</td>
<td>Mental health partial hospitalization, treatment, less than 24 hours</td>
</tr>
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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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<td>H2012</td>
<td>Behavioral health day treatment, per hour</td>
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<td>H2013</td>
<td>Psychiatric health facility service, per diem</td>
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<td>H2017</td>
<td>Psychosocial rehabilitation services, per 15 minutes</td>
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<tr>
<td>H2018</td>
<td>Psychosocial rehabilitation services, per diem</td>
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<td>H2019</td>
<td>Therapeutic behavioral services, per 15 minutes</td>
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<td>H2020</td>
<td>Therapeutic behavioral services, per diem</td>
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<td>H2033</td>
<td>Multisystemic therapy for juveniles, per 15 minutes</td>
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<td>S0201</td>
<td>Partial hospitalization services, less than 24 hours, per diem</td>
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<tr>
<td>S9480</td>
<td>Intensive outpatient psychiatric services, per diem</td>
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<td>S9482</td>
<td>Family stabilization services, per 15 minutes</td>
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<tr>
<td>S9484</td>
<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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REFERENCES


REVISION HISTORY

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<th>Action/Description</th>
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<td>02/2019</td>
<td>• Version 3</td>
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<tr>
<td>02/17/2020</td>
<td>• Version 4; Annual review</td>
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