



HOME-BASED OUTPATIENT TREATMENT

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BENEFIT CONSIDERATIONS

Before using this guideline, please check the member’s specific benefit plan requirements and any federal or state mandates, if applicable.

COVERAGE RATIONALE

Assessment and diagnostic services, and active behavioral health treatment provided in the member’s home are assessed and stabilized to the point that the member’s condition can be safely, efficiently and effectively treated in an ambulatory setting, or it is determined that treatment is no longer required.

Home-based assessment and treatment are separate services, and the findings of a home-based assessment may or may not support the need for home-based treatment.

Providers delivering home-based outpatient services must do so within the scope of their professional training and licensure which is equivalent to the professional training and licensure required to deliver office-based outpatient services (Certificate of Coverage, 2007, 2009 & 2011):

- Diagnostic evaluation and assessment
- Treatment planning
- Referral services
- Medication management
- Psychotherapy
- Case Management
- Crisis intervention

Treatment should not be primarily for the purpose of providing social, custodial, recreational, or respite care.

The member should not be in imminent or current risk of harm to self, others, and/or property.

A member is determined to be homebound when (CMS LCD, 2018):

- A physical condition restricts the member’s ability to leave his/her residence except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person; or if leaving home is medically contraindicated.
- A patient with a psychiatric disorder is considered to be homebound "...if his/her illness is manifested in part by a refusal to leave the home, or is of such a nature that it would not be considered safe for him/her to leave home unattended even if he/she has no physical limitations." The following are examples of conditions supporting the homebound determination:
 - Agoraphobia or Panic Disorder;

- Disorders of thought processes wherein the severity of delusions, hallucinations, agitation and/or impairments of thoughts/cognition grossly affect the member's judgment and decision making, and therefore the member's safety;
- Acute depression with severe vegetative symptoms;
- Psychiatric problems associated with medical problems that render the member homebound.
- If a member does in fact leave the home, the member may nevertheless be considered homebound if the absence(s) from the home are infrequent or for relatively short duration, or are attributable to the need to receive medical treatment.

Home-based outpatient assessment may be covered when:

- An assessment of the acute changes in the member's signs and symptoms, and/or psychosocial and environmental factors is required to determine if behavioral health services are needed.
- An assessment of psychosocial and environmental factors conducted in an ambulatory setting was inconclusive.

Home-based outpatient treatment may be covered when:

- The member's signs and symptoms are primarily or exclusively experienced at home.
- The factors leading to the admission undermine the member's participation in treatment at an ambulatory setting.

Applied Behavior Analysis for Autism Spectrum Disorder is typically performed in the member's natural home environment. Home-based assessment and treatment provides the member and parents/guardians the opportunity to directly apply and practice management skills with the goal of producing naturalized behavioral improvements.

The member's family and other natural resources are engaged to participate in the member's treatment, as clinically indicated.

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.

LEVEL OF CARE GUIDELINES

Optum / OptumHealth Behavioral Solutions of California Level of Care Guidelines are available at: <https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html>

The Level of Care Guidelines are a set of objective and evidence-based behavioral health guidelines used to standardize coverage determinations, promote evidence-based practices, and support members' recovery, resiliency, and wellbeing.

UNITEDHEALTHCARE BENEFIT PLAN DEFINITIONS

For plans using 2001 and 2004 generic UnitedHealthcare COC/SPD, unless otherwise specified

Covered Health Service(s)

Those health services provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance abuse, or their symptoms.

A Covered Health Service is a health care service or supply described in *Section 1: What's Covered--Benefits as a Covered Health Service*, which is not excluded under *Section 2: What's Not Covered--Exclusions*.

For plans using 2007 and 2009 generic UnitedHealthcare COC/SPD, unless otherwise specified

Covered Health Service(s)

Those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance abuse, or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Described in the *Certificate of Coverage* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in the *Certificate of Coverage* under *Section 2: Exclusions and Limitations*.

In applying the above definition, "scientific evidence" and "prevailing medical standards" shall have the following meanings:

- "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
- "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

For plans using 2011 and more recent generic UnitedHealthcare COC/SPD, unless otherwise specified

Covered Health Care Service(s) - health care services, including supplies or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Care Service in the *Certificate* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
- Not excluded in the *Certificate* under *Section 2: Exclusions and Limitations*.

Medically Necessary - health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following as determined by us or our designee.

- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Doctor specialty society recommendations or professional standards of care may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Doctor specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

We develop and maintain clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services.

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 Policies and Coverage Determination Guidelines may apply.

CPT Code	Description
90785	Interactive complexity (list separately in addition to the code for primary procedure)
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
90832	Psychotherapy, 30 minutes with patient
90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service(list separately in addition to the code for primary procedure)
90834	Psychotherapy, 45 minutes with patient

CPT Code	Description
90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)
90837	Psychotherapy, 60 minutes with patient
90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)
90839	Psychotherapy for crisis; first 60 minutes
90840	Psychotherapy for crisis; each additional 30 minutes (list separately in addition to the code for primary service)
90846	Family psychotherapy (without the patient present), 50 minutes
90847	Family psychotherapy (conjoint psychotherapy) (with the patient present), 50 minutes
90849	Multiple-family group psychotherapy
90853	Group psychotherapy (other than of a multiple-family group)

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*Additional reference materials can be found in the reference section(s) of the applicable Level of Care Guidelines

HISTORY/REVISION INFORMATION

Date	Action/Description
05/09/2017	<ul style="list-style-type: none"> Version 1 – Annual Review
05/09/2018	<ul style="list-style-type: none"> Annual Update: Updates to formatting, codes, references checked