United Behavioral Health

Coverage Determination Guideline: Home-Based Outpatient Treatment

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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.
Indications for Coverage
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, and 2018):

- 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 L34561, 2019):

- 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 member 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.

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.

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>Procedure Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>90785</td>
<td>Interactive complexity (list separately in addition to the code for primary psychiatric 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>
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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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<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>
</tr>
<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>
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<tr>
<td>90839</td>
<td>Psychotherapy for crisis; first 60 minutes</td>
</tr>
<tr>
<td>90840</td>
<td>Psychotherapy for crisis; each additional 30 minutes (list separately in addition to the code for primary service)</td>
</tr>
<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>
</tr>
<tr>
<td>90853</td>
<td>Group psychotherapy (other than of a multiple-family group)</td>
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**REFERENCES**


# REVISION HISTORY

<table>
<thead>
<tr>
<th>Date</th>
<th>Action/Description</th>
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<tbody>
<tr>
<td>05/09/2017</td>
<td>Version 1 – Annual Review</td>
</tr>
<tr>
<td>05/09/2018</td>
<td>Annual Update: Updates to formatting, codes, references</td>
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<tr>
<td>06/17/2019</td>
<td>Annual Update: Updates to formatting, codes, references</td>
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<tr>
<td>05/18/2020</td>
<td>Annual review and update</td>
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