Telemental Health Services

Guideline Number: BHCDG832016
Effective Date: May, 2013
Revision Date: March, 2016

Table of Contents:
- Instructions for Use.................................1
- Key Points.............................................2
- Benefits..............................................2
- Level of Care Criteria.........................4
- Best Practices.................................7
- Additional Resources.....................12
- Definitions.................................12
- References.................................13
- Coding........................................13
- History.........................................14

Related Coverage Determination Guidelines:
All Coverage Determination Guidelines

Related Medical Policies:
Level of Care Guidelines

INSTRUCTIONS FOR USE

This Coverage Determination Guideline provides assistance in interpreting behavioral health benefit plans that are managed by Optum. This Coverage Determination Guideline is also applicable to behavioral health benefit plans managed by Pacificare Behavioral Health and U.S. Behavioral Health Plan, California (doing business as Optum California (“Optum-CA”). When deciding coverage, the enrollee specific document must be referenced. The terms of an enrollee’s document (e.g., Certificates of Coverage (COCs), Schedules of Benefits (SOBs), or Summary Plan Descriptions (SPDs) may differ greatly from the standard benefit plans upon which this guideline is based. 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 document and the COC/SPD, the enrollee’s specific benefit document supersedes these guidelines.

All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements that supersede the COC/SPD and the plan benefit coverage prior to use of this guideline. Other coverage determination guidelines and clinical guideline may apply.

Optum reserves the right, in its sole discretion, to modify its coverage determination guidelines and clinical guidelines as necessary.

While this Coverage Determination Guideline does reflect Optum’s understanding of current best practices in care, it does not constitute medical advice.
Key Points

- Telemental Health services are behavioral health services provided by a qualified behavioral health professional from a distant site equipped with a secure two-way, real time interactive telecommunication system to a member in a qualifying originating site.

- The course of treatment provided via Telemental Health is focused on addressing the “why now” factors that precipitated admission (e.g., changes in the member’s signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the “why now” factors that precipitated admission no longer require treatment.

- Benefits are available for covered services that are not otherwise limited or excluded based on the relevant Level of Care (LOC) Guidelines, the Coverage Determination Guidelines (CDGs) and/or the Psychological and Neuropsychological Testing Guidelines.

- Services should be consistent with evidence-based interventions and clinical best practices as described in Part III, and should be of sufficient intensity to address the member’s needs (UnitedHealthcare Certificate of Coverage, 2007, 2009 & 2011).

PART I: BENEFITS

Before using this guideline, please check enrollee’s specific plan document and any federal or state mandates, if applicable.

Benefits

Benefits include the following services:

- Diagnostic evaluation and assessment
- Treatment planning
- Referral services
- Medication management
- Individual, family, therapeutic group and provider-based case management services
- Crisis intervention

Covered Services

Covered Health Service(s) – 2001

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.
**Covered Health Service(s) – 2007 and 2009**

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 this Certificate of Coverage under Section 1: Covered Health Services and in the Schedule of Benefits.
- Not otherwise excluded in this 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.

**Pre-Service Notification**

Admissions to an inpatient, residential treatment center, 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.

**Limitations and Exclusions**

The requested service or procedure for the treatment of a mental health condition must be reviewed against the language in the enrollee's benefit document. When the requested service or procedure is limited or excluded from the enrollee’s benefit document, or is otherwise defined differently, it is the terms of the enrollee's benefit document that prevails.

Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and are therefore considered experimental.
- Not consistent with the Mental Health/Substance Use Disorder Designee’s level of care guidelines or best practice guidelines as modified from time to time.
- Not clinically appropriate for the member’s Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.

Additional Information

The lack of a specific exclusion that excludes coverage for a service does not imply that the service is covered.

The following are examples of services that are inconsistent with the Level of Care Guidelines and Best Practice Guidelines (not an all inclusive list):

- Services that deviate from the indications for coverage; Phone-based services including phone counseling, email, texting, voicemail, or facsimile;
- Use of remote medical monitoring devices; or
- Use of virtual reality devices.
- Store-and-forward transmissions of case information;
- Group or family psychotherapy which is co-led by providers at different sites.

Please refer to the enrollee’s benefit document for ASO plans with benefit language other than the generic benefit document language.

PART II: COVERAGE CRITERIA

1. Admission Criteria
   1.1. The member is eligible for benefits.
   AND
   1.2. The member’s condition and proposed services are covered by the benefit plan.
AND

1.3. Services are within the scope of the provider’s professional training and licensure.

AND

1.4. The member’s current condition cannot be safely, efficiently, and effectively assessed and/or treated in a less intensive level of care due to acute changes in the member’s signs and symptoms and/or psychosocial and environmental factors (i.e., the “why now” factors leading to admission).

1.4.1. Failure of treatment in a less intensive level of care is not a prerequisite for authorizing coverage.

AND

1.5. The member’s current condition can be safely, efficiently, and effectively assessed and/or treated in the proposed level of care. Assessment and/or treatment of acute changes in the member’s signs and symptoms and/or psychosocial and environmental factors (i.e., the “why now” factors leading to admission) require the intensity of services provided in the proposed level of care.

AND

1.6. Co-occurring behavioral health and medical conditions can be safely managed.

AND

1.7. Services are:

1.7.1. Consistent with generally accepted standards of clinical practice;

1.7.2. Consistent with services backed by credible research soundly demonstrating that the services will have a measurable and beneficial health outcome, and are therefore not considered experimental;

1.7.3. Consistent with Optum’s best practice guidelines;

1.7.4. Clinically appropriate for the member’s behavioral health conditions based on generally accepted standards of clinical practice and benchmarks.

AND

1.8. There is a reasonable expectation that services will improve the member’s presenting problems within a reasonable period of time.

1.8.1. Improvement of the member’s condition is indicated by the reduction or control of the acute signs and symptoms that necessitated treatment in a level of care.
1.8.2. Improvement in this context is measured by weighing the effectiveness of treatment against evidence that the member’s signs and symptoms will deteriorate if treatment in the current level of care ends. Improvement must also be understood within the broader framework of the member’s recovery, resiliency and wellbeing.

AND

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

AND

1.10. Acute changes in the member’s signs and symptoms, and/or psychosocial and environmental factors (i.e., the “why now” factors leading to admission) have occurred, and the member’s current condition can be safely, efficiently, and effectively assessed and/or treated in this setting.

AND

1.11. A secure two-way, real time interactive telecommunication system is available to facilitate interaction between the member and the provider.

2. Continued Service Criteria

2.1. The admission criteria continue to be met and active treatment is being provided. For treatment to be considered “active” services must be:

2.1.1. Supervised and evaluated by the admitting provider;

2.1.2. Provided under an individualized treatment plan that is focused on addressing the “why now” factors, and makes use of clinical best practices;

2.1.3. Reasonably expected to improve the member’s presenting problems within a reasonable period of time.

AND

2.2. The “why now” factors leading to admission have been identified and are integrated into the treatment and discharge plans.

AND

2.3. Clinical best practices are being provided with sufficient intensity to address the member’s treatment needs.

AND

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

3. Discharge Criteria

3.1. The continued stay criteria are no longer met. Examples include:
3.1.1. The “why now” factors which led to admission have been addressed to the extent that the member can be safely transitioned to a less intensive level of care, or no longer requires care.

3.1.2. The “why now” factors which led to admission cannot be addressed, and the member must be transitioned to a more intensive level of care.

3.1.3. Treatment is primarily for the purpose of providing social, custodial, recreational, or respite care.

3.1.4. The member requires medical-surgical treatment.

3.1.5. The member is unwilling or unable to participate in treatment and involuntary treatment or guardianship is not being pursued.

PART III: BEST PRACTICES

1. The Initial Evaluation:
   1.1. Gathers information about the presenting issues from the member’s perspective, and includes the member’s understanding of the factors that lead to requesting services (i.e., the “why now” factors).
   1.2. Focuses on the member’s specific needs.
   1.3. Identifies the member’s goals and expectations.
   1.4. Is completed in a timeframe commensurate with the member’s needs, or otherwise in accordance with clinical best practices.
   1.5. The provider collects information from the member and other sources, and completes an initial evaluation of the following:
       1.5.1. The member’s chief complaint;
       1.5.2. The history of the presenting illness;
       1.5.3. The “why now” factors leading to the request for service;
       1.5.4. The member’s mental status;
       1.5.5. The member’s current level of functioning;
       1.5.6. Urgent needs including those related to the risk of harm to self, others, or property;
       1.5.7. The member’s use of alcohol, tobacco, or drugs;
       1.5.8. Co-occurring behavioral health and physical conditions;
       1.5.9. The history of behavioral health services;
       1.5.10. The history of trauma;
       1.5.11. The member’s medical history and current physical health status;
1.5.12. The member’s developmental history;
1.5.13. Pertinent current and historical life information including the member’s:
   1.5.13.1.1. Age;
   1.5.13.1.2. Gender, sexual orientation;
   1.5.13.1.3. Culture;
   1.5.13.1.4. Spiritual beliefs;
   1.5.13.1.5. Educational history;
   1.5.13.1.6. Employment history;
   1.5.13.1.7. Living situation;
   1.5.13.1.8. Legal involvement;
   1.5.13.1.9. Family history;
   1.5.13.1.10. Relationships with family and other natural resources;
1.5.14. The member’s strengths;
1.5.15. Barriers to care;
1.5.16. The member’s instructions for treatment, or appointment of a representative to make decisions about treatment;
1.5.17. The member’s broader recovery, resiliency and wellbeing goals.

1.6. The provider uses the findings of the evaluation to assign a DSM/ICD diagnosis.

2. Treatment Planning

2.1. The provider and, whenever possible, the member use the findings of the initial evaluation and the diagnosis to develop a treatment plan. The treatment plan addresses:
   2.1.1. The short- and long-term goals of treatment;
   2.1.2. The type, amount, frequency and duration of treatment;
   2.1.3. The expected outcome for each problem to be addressed expressed in terms that are measurable, functional, time-framed and directly related to the “why now” factors;
   2.1.4. How the member’s family and other natural resources will participate in treatment when clinically indicated;
   2.1.5. How treatment will be coordinated with other providers as well as with agencies or programs with which the member is involved.
2.2. As needed, the treatment plan also includes interventions that enhance the member’s motivation, promote informed decisions, and support the member’s recovery, resiliency, and wellbeing.

2.2.1. Examples include psychoeducation, motivational interviewing, recovery and resiliency planning, advance directive planning, and facilitating involvement with self-help and wraparound services.

2.3. The provider informs the member of safe and effective treatment alternatives, as well as the potential risks and benefits of the proposed treatment. The member gives informed consent acknowledging willingness and ability to participate in treatment and abide by safety precautions.

2.4. Treatment focuses on addressing the “why now” factors to the point that the member’s condition can be safely, efficiently, and effectively treated in a less intensive level of care, or the member no longer requires care.

2.5. The treatment plan and level of care are reassessed when the member’s condition improves, worsens or does not respond to treatment.

2.5.1. When the member’s condition has improved, the provider determines if the treatment plan should be altered, or if treatment is no longer required.

2.5.2. When the member’s condition has worsened or not responded to treatment, the provider verifies the diagnosis, alters the treatment plan, or determines if the member’s condition should be treated in another level of care.

2.6. In the event that all information is unavailable at the time of the evaluation, there must be enough information to provide a basis for the diagnosis, guide the development of the treatment plan, and support the need for treatment in the proposed level of care.

3. Telemental Health Protocol

3.1. Asynchronous store and forward technologies (i.e., the transmission of a member’s clinical record, lab results or other clinical information from an originating site to the physician or practitioner at the distant site) is not considered part of the standard of care for telemental health.

3.2. The following are not considered telemental health because they don’t utilize a secure two-way, real time interactive telecommunication system:

3.2.1. Phone-based services including phone counseling, email, texting, voicemail, or facsimile;

3.2.2. Remote medical monitoring devices;
3.2.3. Virtual reality devices;
3.2.4. Internet-based services including internet-based phone calls.

3.3. A qualified provider at the distant site is licensed in the state where the member resides.

3.4. Delivery of group and family psychotherapy to members at different locations (i.e., multipoint videoconferencing) may be covered when all members are in the state where the provider is licensed, and all locations provide secure two-way, real-time interactive telecommunication systems.

3.4.1. Group or family psychotherapy which is co-led by providers at different sites is not part of the standard of care.

3.5. Services are delivered in a manner consistent with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable privacy and security regulations and standards.

3.6. The frequency and duration of outpatient visits allows for safe, efficient, and effective achievement of treatment goals, and supports the member’s recovery and resiliency. Initially, the frequency of visits varies from weekly in routine cases to several times a week. As the member’s functional status improves, the frequency of visits decreases to meet the member’s current needs and treatment goals. Factors that may impact frequency and duration include:

3.6.1. The goals of treatment;
3.6.2. The member’s preferences;
3.6.3. Evidence from clinical best practices which supports frequency and duration;
3.6.4. The need to monitor and manage imminent risk of harm to self, others, and/or property.

3.7. The provider informs the member of the process to be followed in the event of an after-hours emergency such as the availability of on-call services. The process is not solely reliant on the Emergency Room.

4. Discharge Planning

4.1. The provider and, whenever possible, the member develops an initial discharge plan at the time of admission, and estimates the length of treatment.

4.2. The provider and, whenever possible, the member updates the initial discharge plan during the admission ensuring that:

4.2.1. An appropriate discharge plan is in place prior to discharge;
4.2.2. The discharge plan is designed to mitigate the risk that the “why now” factors which precipitated admission will reoccur;
4.2.3. The member agrees with the discharge plan.

4.3. For members continuing treatment, the discharge plan includes:
   4.3.1. The discharge date;
   4.3.2. The post-discharge level of care, and the recommended forms and frequency of treatment;
   4.3.3. The names of the providers who will deliver treatment;
   4.3.4. The date of the first appointment including the date of the first medication management visit;
   4.3.5. The name, dose and frequency of each medication;
   4.3.6. A prescription sufficient to last until the first medication management visit is provided;
   4.3.7. An appointment for necessary lab tests is provided;
   4.3.8. Resources to assist the member with overcoming barriers to care such as lack of transportation of child care;
   4.3.9. Recommended self-help and community support services;
   4.3.10. Information about what the member should do in the event of a crisis prior to the first appointment.

4.4. The first treatment appointment and medication management visit are scheduled to occur within a timeframe that is commensurate with the risk that the “why now” factors which led to admission will reoccur.

4.5. The provider shares the discharge plan and all pertinent clinical information with the providers at the next level of care prior to discharge.

4.6. The provider shares the discharge plan and all pertinent clinical information with the Care Advocate to ensure that necessary prior authorizations or notifications are completed prior to discharge.

4.7. Notification of the Care Advocate that the member is discontinuing treatment may trigger outreach and assistance to the member.

4.8. The provider coordinates discharge with agencies and programs such as the school or court system with which the member is involved.

4.9. For members not continuing treatment, the discharge plan includes:
   4.9.1. The discharge date;
   4.9.2. Recommended self-help and community support services;
   4.9.3. Information about what the member should do in the event of a crisis or to resume services.
4.9.4. The provider explains the risk of discontinuing treatment when the member refuses treatment or repeatedly does not adhere with the treatment plan.

**ADDITIONAL RESOURCES**

**Clinical Protocols**
Optum maintains clinical protocols that include the Level of Care Guidelines and Best Practice Guidelines which describe the scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding treatment. These clinical protocols are available to Covered Persons upon request, and to Physicians and other behavioral health care professionals on ubhonline.

**Peer Review**
Optum will offer a peer review to the provider when services do not appear to conform to this guideline. The purpose of a peer review is to allow the provider the opportunity to share additional or new information about the case to assist the Peer Reviewer in making a determination including, when necessary, to clarify a diagnosis.

**Second Opinion Evaluations**
Optum facilitates obtaining a second opinion evaluation when requested by an enrollee, provider, or when Optum otherwise determines that a second opinion is necessary to make a determination, clarify a diagnosis or improve treatment planning and care for the member.

**Referral Assistance**
Optum provides assistance with accessing care when the provider and/or enrollee determine that there is not an appropriate match with the enrollee’s clinical needs and goals, or if additional providers should be involved in delivering treatment.

**DEFINITIONS**

**Distant Site** The site where the practitioner providing the professional service is located at the time the service is provided via a telecommunications system.

**Interactive Telecommunications System** Multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner.

**Originating Site** The location of an eligible member at the time the service being furnished via a telecommunications system occurs.

**Originating Site Facility Fee** The fee paid to the originating site for services provided directly to a patient (non-consultative services).
**Store-and-Forward** The asynchronous transmission of medical information to be reviewed at a later time by a practitioner at the distant site. Medical information may include, but not be limited to, video clips, still images, x-rays, MRIs, EKGs, laboratory results, audio clips and text.

**Telecommunications System** The technological equipment and transmittal mechanisms used to facilitate the provision of telepsychiatry services. The system must provide two-way interactive communication, both auditory and visual.

**REFERENCES**


**CODING**

The Current Procedural Terminology (CPT) codes and HCPCS codes listed in this guideline are for reference purposes only. Listing of a service code in this guideline does not imply that the service described by this code is a covered or non-covered health service. Coverage is determined by the benefit document.

<table>
<thead>
<tr>
<th>Limited to specific CPT and HCPCS codes?</th>
<th>X Yes □ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q3014</td>
<td>Site originating fee</td>
</tr>
</tbody>
</table>

*All of the following CPT codes must include GT Modifier for Telepsychiatry Services*

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90791</td>
<td>Psychiatric diagnostic evaluation</td>
</tr>
<tr>
<td>90791 plus interactive add-on code (90875)</td>
<td>Psychiatric diagnostic evaluation (interactive)</td>
</tr>
<tr>
<td>90832</td>
<td>Psychotherapy, 30 minutes with patient and/or family</td>
</tr>
<tr>
<td>90832 plus interactive add-on code (90875)</td>
<td>Psychotherapy, 30 minutes with patient and/or family (interactive)</td>
</tr>
<tr>
<td>90832 plus pharmacological add-on code (90863)</td>
<td>Psychotherapy, 30 minutes with patient and/or family (pharmacological management)</td>
</tr>
<tr>
<td>90834</td>
<td>Psychotherapy, 45 minutes with patient and/or family member</td>
</tr>
<tr>
<td>90834 plus interactive add-on code (90875)</td>
<td>Psychotherapy, 45 minutes with patient and/or family member (interactive)</td>
</tr>
<tr>
<td>90834 plus pharmacological add-on code (90863)</td>
<td>Psychotherapy, 45 minutes with patient and/or family member (pharmacological management)</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>90837</td>
<td>Psychotherapy, 60 minutes with patient and/or family member</td>
</tr>
<tr>
<td>90837 plus interactive add-on code (90875)</td>
<td>Psychotherapy, 60 minutes with patient and/or family member (interactive)</td>
</tr>
<tr>
<td>90837 plus pharmacological add-on code (90863)</td>
<td>Psychotherapy, 60 minutes with patient and/or family member (pharmacological management)</td>
</tr>
<tr>
<td>90839</td>
<td>Psychotherapy for crisis, first 60 minutes</td>
</tr>
<tr>
<td>90839 plus interactive add-on code (90875)</td>
<td>Psychotherapy for crisis, first 60 minutes (interactive)</td>
</tr>
<tr>
<td>90846</td>
<td>Family psychotherapy without the patient present</td>
</tr>
<tr>
<td>90847</td>
<td>Family psychotherapy, conjoint psychotherapy with the patient present</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>
</tr>
<tr>
<td>90853 plus interactive add-on code (90875)</td>
<td>Group psychotherapy (other than of a multiple-family group) (interactive)</td>
</tr>
<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>
</tr>
<tr>
<td>G0411</td>
<td>Interactive group psychotherapy, in a partial hospitalization setting, approximately 45 to 50 minutes</td>
</tr>
</tbody>
</table>

**Limited to specific diagnosis codes?** □ Yes X No

**Limited to place of service (POS)?** □ Yes X No

**Limited to specific provider type?** □ Yes X No

**Limited to specific revenue codes?** □ Yes X No

**PART VIII: HISTORY**

<table>
<thead>
<tr>
<th>Revision Date</th>
<th>Name</th>
<th>Revision Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/2013</td>
<td>L. Urban</td>
<td>Version 1-Final</td>
</tr>
<tr>
<td>10/2014</td>
<td>G. Niewenhous</td>
<td>Version 2-Final</td>
</tr>
<tr>
<td>3/2015</td>
<td>L. Urban</td>
<td>Version 3-Final</td>
</tr>
<tr>
<td>3/2016</td>
<td>G. Niewenhous</td>
<td>Version 4-Final</td>
</tr>
</tbody>
</table>