UHA
HEALTH INSURANCE

Outpatient Psychotherapy Services

I. Policy

University Health Alliance (UHA) will reimburse for outpatient psychotherapy services when they are medically or psychologically necessary and when they meet criteria guidelines (subject to limitations and exclusions) indicated below.

II. Criteria/Guidelines

A. Outpatient psychotherapy services can be delivered as individual, family, or group therapy.

B. All psychotherapy must be rendered by a licensed physician or other qualified health care professional. Qualified medical professionals for psychotherapy include: Psychologist, MFT, MHC, LCSW, APRN, MD, DO, and PA.

   1. The type of therapy a clinician provides cannot be assumed based on discipline. If asked by a patient or referring physician, therapists should provide information about the type of therapy they provide and training they have received.

   2. Primary care clinicians with psychotherapy training: Because primary care clinicians are subject to competing demands and time constraints, psychotherapy should be limited to patient subgroups that can be effectively treated with briefer versions of evidence-based psychotherapies (shorter session lengths and fewer sessions). Patients with more severe, complex, or refractory conditions may be better suited for referral to mental health specialty care. In such instances, systematic communication and coordination between primary care and mental health clinicians are encouraged.

C. The patient must be diagnosed with a condition listed in the current version of Diagnostic and Statistical Manual of the American Psychiatric Association. Conditions such as epilepsy, senility, intellectual or developmental disabilities, and use of intoxicating substances, do not in and of themselves constitute a mental disorder.

D. All services must be provided under an individualized treatment plan subject to review and approval by UHA or our designee.

E. All services must be medically or psychologically necessary and coded at the appropriate level of care.

   1. There is often no clear distinction between psychotherapy and E&M services, so UHA will not require strict temporal reconciliation between E&M codes and psychotherapy add-on codes. However, please bear in mind that E&M codes are based both on medical necessity and on the required elements of history, examination, and complexity of decision-making.

   2. As general medical necessity guidelines, we offer the following examples:

      a. 99212: A brief visit simply continuing previous medications with no new side effects.

      b. 99213: Documentation of minor side effects, dosage adjustments, updating general medical conditions and medications, mention of interaction with other drugs or medical conditions, discussion of long-term risks, etc. A 99213 requires that medical issues were addressed but does not necessarily require that an Rx be written at that visit.

      c. 99214: Documentation of more serious side effects or drug interactions, or extensive discussion of interactions with other drugs or medical conditions, or switching to a different medication with discussion of risks, benefits, side effects, etc. This should be a relatively infrequent E&M code, justified by medical necessity.

d. 99215: Complex or difficult medical issues combined with more extensive evaluation, with all the required elements of history, examination, and complexity of decision-making for level five codes.

3. UHA may require submission of medical records to assess medical necessity for use of 99215 codes as well as for frequent use of 99214 codes for routine psychiatric visits.

4. UHA expects that most psychotherapy visits will be for about 30 or 45 minutes (psychotherapy add-on codes 90833, 90836). Extended psychotherapy codes (90837 without E&M, or 90838 as add-on to E&M) should generally be used for patients who present particular difficulties or complexities, such as crisis or family psychotherapy, and not for routine individual psychotherapy. UHA may require submission of medical records to assess medical necessity for all 90837 and 90838 codes.

NOTE:

This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine, and it should not deter a provider from expressing his/her judgment.

Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member's individual benefit plans may apply, and this policy is not a guarantee of payment. UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries.

UHA understands that opinions about and approaches to clinical problems may vary. Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may request that UHA reconsider the application of the medical necessity criteria considering any supporting documentation.

III. Limitations/Exclusions

A. Counseling services, unless part of substance abuse treatment, are not covered. These noncovered services include: bereavement counseling; clergy counseling; family, marriage, or couples counseling; parent or other training services; educational programs or other services performed by mutual self-help groups.

1. Referral by provider or judicial system does not determine or change coverage.

B. Psychiatric diagnostic evaluation is a covered benefit (90791/90792) and is defined as an integrated bio-psychosocial assessment including history, mental status evaluation, and recommendations.

1. It can be used more than once when separate evaluations are conducted with the patient and an informant on different days.
2. It cannot be reported on the same day as psychotherapy or crisis psychotherapy.
3. It can be used for reassessments when required.

C. Interactive Complexity Add-on Code in addition to initial evaluation or psychotherapy (+90785) is covered provided the increased intensity of the work provided is documented and one of the following situations exist:

1. Maladaptive or difficult (i.e., third party involvement) communication complicating delivery of care
2. Emotional or behavioral conditions inhibiting initiation of treatment plan
3. Inadequate language expression or different language between client and provider
4. Mandated (i.e., abuse or neglect) reporting

D. If services would be covered by another entity by legal obligation (federal, state, territorial, municipal, or other government instrumentality or agency) and if in the absence of UHA insurance coverage the member would not be charged, services are not covered.

E. Biofeedback and neurofeedback (a form of biofeedback) are not covered benefits. Low Energy Neurofeedback System (LENS) is not covered.

F. Wilderness Camps – These programs are not covered under residential programs, but the psychotherapy sessions conducted within these programs are covered provided that the therapists are licensed as described above in the state where care is provided.

1. Sessions are limited to 1 hour per day per type of therapy (i.e., 1 hour family therapy, 1 hour individual therapy, and 1 hour group therapy maximum per day).
2. The program will be responsible for creating the invoice/claim including (but not limited to) patient's name, date of birth, address, date and time of service, type of therapy with CPT code/description and length of session, diagnosis code, therapist's name and business license of the camp where services are being provided.
3. All claims for this level of care in wilderness camps are paid at the NON-PARTICIPATING PROVIDER benefit level.
4. Claims must be submitted monthly with attached clinical documentation for review.

IV. Administrative Guidelines

A. Prior Authorization is not required.

B. UHA reserves the right to perform retrospective review using the above criteria to validate that services rendered met payment determination.

C. Each family psychotherapy session may only be billed to one family member, even if the provider is seeing multiple members of the same family. Coverage will be provided for family psychotherapy without the patient present when coded appropriately (CPT 90846).

D. Psychotherapy and E&M Codes.

1. **To report both E&M and psychotherapy, the two services must be significant and separately identifiable.**
2. **In most cases, Level 4-5 E&M codes would rarely (if ever) be appropriate in the context of a psychotherapy session.**
3. When E&M codes are used, the medical service must reflect the E&M criteria of history/exam/medical decision, not time.
    a. Time may not be used as the basis of E&M code selection.
    b. Prolonged services (99354, 99355, 99358, and 99359) are not covered.

E. Psychotherapy may be provided via telehealth when **face to face therapy is genuinely impractical** and provided under the statutory indications outlined in the UHA Medical Benefits Guide, Hawaii State Law 453-1.3, and UHA Telehealth payment policy guidelines and limitations.

1. Standard telephone contacts, facsimile transmissions, or email text, in combination or by itself do not constitute telehealth services.
2. Out of State telehealth services for psychotherapy require strict adherence to UHA benefits, UHA Telehealth payment policy, and State of Hawaii legal guidelines; and members and providers are encouraged to familiarize themselves with these guidelines before conducting services.

F. **Psychotherapy for crisis (90839, 90840) are reserved for crisis and emergency management.**

1. Notes must support the existence of a crisis state of a patient in high distress with complex or life-threatening circumstances that require urgent or immediate attention. This includes a history, mental status examination, mobilization of resources, and implementation treatment. A session scheduled outside a regular appointment does not in itself constitute crisis psychotherapy.
2. Notes that do not substantiate this level of service will be downcoded to a non-crisis code 90837.
3. Notes are required with claims submission for crisis codes.

G. The patient and therapist should set realistic goals for treatment and periodically evaluate whether these goals are being met. If improvement does not occur within the planned duration of treatment, the intervention should be reassessed, and other clinical options should be considered.

V. Policy History

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