Coverage Summary

Mental Health Services and Procedures

Approved by: UnitedHealthcare Medicare Benefit Interpretation Committee  Last Review Date: 03/19/2019

Related Medicare Advantage Policy Guidelines:
- Hemodialysis for Treatment of Schizophrenia (NCD 130.8)
- Hypnotherapy

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The benefit information in this Coverage Summary is based on existing national coverage policy, however, Local Coverage Determinations (LCDs) may exist and compliance with these policies are required where applicable.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG). In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

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I. COVERAGE

Coverage Statement: Mental health services and procedures are covered when Medicare coverage criteria are met.

Guidelines/Notes:
1. Inpatient
   a. Inpatient mental health services are covered in a Medicare certified psychiatric facility when coverage criteria are met.
1) Services must be for "active treatment", which is defined by the following criteria:
   a) Services are provided under an individualized treatment
      Each patient must have an individual comprehensive treatment plan that must be
      based on an inventory of the patient’s strengths and disabilities. The written plan
      must include:
      (1) A substantiated diagnosis;
      (2) Short-term and long-range goals;
      (3) The specific treatment modalities utilized;
      (4) The responsibilities of each member of the treatment team; and
      (5) Adequate documentation to justify the diagnosis and the treatment and
      rehabilitation activities carried out.
   b) Services are reasonably expected to improve the member’s condition or for the
      purpose of diagnosis
   c) Services must be supervised and evaluated by a physician

2) Services are limited to a total of 190 days of psychiatric hospital services during the
   member’s lifetime.
   Note: This limitation applies only to care and services furnished in a psychiatric
   hospital. Psychiatric care provided in an acute care hospital does not count toward
   the 190-day lifetime limit unless the psychiatric care is provided in a psychiatric
   facility/hospital operating as a separate functioning entity (e.g., it is located in a
   separate building, wing, or part of a building and has its own administration and
   maintains separate fiscal records).

3) Examples of inpatient coverage mental health services that are covered include, but
   are not limited to:
   a) Psychotherapy, drug therapy, shock therapy (ECT) and other therapies such as
      occupational, recreational, or milieu therapy, provided the therapeutic activities
      are expected to result in improvement in the patient’s condition
   b) Administration of antidepressants or tranquilizers expected to provide significant
      relief of the member’s psychotic or neurotic symptoms (this alone may not
      constitute active treatment)

   b. Mental health inpatient services are not covered for:
      1) Recreational or diversional activities. If the only activities prescribed for the patient
         are primarily diversional in nature, (i.e., to provide some social or recreational outlet
         for the patient), it would not be regarded as treatment to improve the patient's
         condition.
      2) Inpatient psychiatric services where the member receives medical or surgical care but
         does not meet the criteria described above

For more detailed inpatient psychiatric admission requirements, see the Medicare Benefits

2. Outpatient
   a. Outpatient mental health services are covered when following criteria are met:
      1) Services for outpatient mental health must be incidental to a physician’s service.
         The services or supplies are furnished as an integral, although incidental, part of the
         physician's personal professional services in the course of diagnosis or treatment of
an injury or illness.

2) Services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. At a minimum, the treatment must be designed to reduce or control the patient's psychiatric symptoms so as to prevent relapse or hospitalization and improve or maintain the patient's level of functioning.

3) Services must be prescribed by a physician and provided under an individualized written plan of treatment established by a physician.

4) Services must be supervised and evaluated by a physician to determine the extent to which treatment goals are being realized.

See the Medicare Benefits Policy Manual, Chapter 6, §70 – Outpatient Hospital Psychiatric Services. (Accessed July 9, 2018)

b. Examples of outpatient mental health services that are covered include but are not limited to:

1) Individual and group therapy with physicians, psychologists or other mental health professionals authorized by the State; see the Medicare Benefits Policy Manual, Chapter 6, §70.1.C – Application of Criteria. (Accessed July 5, 2018)

2) Services of social workers, trained psychiatric nurses and other trained staff to work with psychiatric members; see the Medicare Benefits Policy Manual, Chapter 6, §70.1.C – Application of Criteria. (Accessed July 5, 2018)

Note: Home health psychiatric nurse visits are only be covered if part of a treatment plan established by and reviewed by a physician; see the Medicare Benefit Policy Manual, Chapter 7, §40.1.2.15 - Psychiatric Evaluation, Therapy, and Teaching. (Accessed July 5, 2018)

3) Drugs and biologicals furnished for therapeutic purposes and only if they are of a type that cannot be self-administered; see the Medicare Benefits Policy Manual, Chapter 6, §70.1.C – Application of Criteria. (Accessed July 5, 2018)

4) Activity therapies but only those that are individualized and essential for the treatment of the patient's condition. The treatment plan must clearly justify the need for each particular therapy utilized and explain how it fits into the patient's treatment; see the Medicare Benefits Policy Manual, Chapter 6, §70.1.C – Application of Criteria. (Accessed July 5, 2018)

5) Counseling services with members of the family only when the primary purpose is the treatment of the member’s psychiatric condition; see the Medicare Benefits Policy Manual, Chapter 6, §70.1.C – Application of Criteria. (Accessed July 5, 2018)

6) Occupational therapy, if required, must be related to the member’s psychiatric condition and a component of the physician's treatment plan; see the Medicare Benefits Policy Manual, Chapter 6, §70.1.C – Application of Criteria. (Accessed July 5, 2018)

7) Patient education programs where the educational activities are closely related to the member’s care and treatment of his/her diagnosed psychiatric condition; see the Medicare Benefits Policy Manual, Chapter 6, §70.1.C – Application of Criteria. (Accessed July 5, 2018)

8) Diagnostic services for the purpose of diagnosing those individuals for whom an extended or direct observation is necessary to determine functioning and interactions, to identify problem areas, and to formulate a treatment plan; see the
Hypnotherapy (CPT Code 90880)

- Medicare does not have a National Coverage Determination (NCD) for hypnotherapy.
- Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these LDS is required where applicable. For state-specific LCDs/LCAs, see the LCD Availability Grid (Attachment A).
- For states with no LCDs/LCAs, see the Wisconsin LCD for Psychiatry and Psychology Services (L34616) for coverage guidelines. (IMPORTANT NOTE: After checking the LCD Availability Grid and searching the Medicare Coverage Database, if no state LCD or LCA is found, then use the above referenced policy.)
- Committee approval date: July 17, 2018
- Accessed May 1, 2019

3. Partial hospitalization:
   a. Partial hospitalization is covered for members meeting one of the following criteria:
      1) The member discharged from an inpatient hospital treatment program, and the partial hospitalization program is in lieu of continued inpatient treatment. When partial hospitalization is used to shorten an inpatient stay and transition the member to a less intense level of care, there must be evidence of the need for the acute, intense, structured combination of services provided by a partial hospitalization program.
      2) The member who, in the absence of partial hospitalization, would be at reasonable risk of requiring inpatient hospitalization
   b. Partial hospitalization visits do not count against inpatient days. A partial hospitalization visit is considered as an outpatient visit when provided by a hospital outpatient department or a Medicare-certified Community Health Care Centers (CMHC).

See the Medicare Benefits Policy Manual, Chapter 6, §70.3 – Partial Hospitalization Services. (Accessed July 5, 2018)

Medicare certification and compliance information regarding CMHC can be found at https://www.cms.gov/CertificationandCompliance/03_CommunityHealthCenters.asp. (Accessed July 5, 2018)

4. Vagus nerve stimulation (VNS) for Intractable Depression

Effective February 15, 2019, The Centers for Medicare & Medicaid Services (CMS) issued a decision memo stating it will finalize its proposal to cover FDA approved vagus nerve stimulation (VNS) devices for treatment resistant depression (TRD) through Coverage with Evidence Development (CED).

Refer to the Decision Memo for Vagus Nerve Stimulation (VNS) for Treatment Resistant Depression (TRD) (CAG-00313R2) issued on February 15, 2019. (Accessed March 14, 2019)

5. The following outpatient mental health services are not covered:
   b. Vocational training services solely related to specific employment opportunities, work skills or work settings; see the Medicare Benefits Policy Manual, Chapter 6, §70.1.C.2 – Noncovered Services. (Accessed July 9, 2018)
   c. Psychosocial programs (e.g., community support groups in nonmedical settings for chronically mentally ill persons for the purpose of social interaction); see the Medicare Benefits Policy Manual, Chapter 6, §70.1.C.2 – Noncovered Services. (Accessed July 9, 2018)
   d. Activity therapies, group activities or other services/programs which are solely recreational or diversional activities; see the Medicare Benefits Policy Manual, Chapter 6, §70.1.C.2 – Noncovered Services. (Accessed July 9, 2018)
   e. Geriatric day care; see the Medicare Benefits Policy Manual, Chapter 6, §70.1.C.2 – Noncovered Services. (Accessed July 9, 2018)
   f. Outpatient psychosocial activities; see the Medicare Benefits Policy Manual, Chapter 6, §70.3 – Partial Hospitalization Service. (Accessed July 9, 2018)
   g. Partial hospitalization for the member who are otherwise psychiatrically stable or require medication management only; see the Medicare Benefits Policy Manual, Chapter 6, §70.3 – Partial Hospitalization Service. (Accessed July 9, 2018)
   h. Lightbox for the treatment of seasonal affective disorder (SAD) (HCPCS Code E0203 – listed as noncovered by Medicare). Other devices and equipment used for environmental control or to enhance the environmental setting in which the beneficiary is placed are not considered covered DME.


6. Examples of services and procedures that are not covered for a mental health diagnosis include, but are not limited to:
   a. Hemodialysis for schizophrenia; see the NCD for Hemodialysis for Treatment of Schizophrenia (130.8). (Accessed July 5, 2018)
   b. Multiple seizure electroconvulsive therapy; see the NCD for Multiple Electroconvulsive Therapy (160.25). (Accessed July 5, 2018)
   c. Intensive Behavioral Therapy for the Treatment of Autism (CPT Codes 0364T - 0370T)
      • Medicare does not have a National Coverage Determination (NCD) for intensive behavioral therapy for the treatment of autism.
      • Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For state-specific LCDs/LCAs, see the LCD Availability Grid (Attachment B).
      • For coverage guidelines, see the Novitas LCD for Services That Are Not Reasonable and Necessary (L35094). (IMPORTANT NOTE: After checking the LCD Availability Grid and searching the Medicare Coverage Database, if no state LCD or LCA is found, then use the above referenced policy).
      • Committee approval date: July 17, 2018
NOTE: For the following preventive services, refer to the Coverage Summary for Preventive Health Services and Procedures.

- Intensive Behavioral Therapy for Obesity
- Alcohol Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse
- Intensive Behavioral Therapy for Cardiovascular Disease
- Screening for Sexually Transmitted Infections (STIs) and High-Intensity Behavioral Counseling (HIBC) to Prevent STIs
- Screening for Depression in Adults

II. DEFINITIONS

**Inpatient Hospital Psychiatric Services:** Inpatient hospital services furnished to a patient of an inpatient psychiatric facility. *Medicare Benefits Policy Manual, Chapter 2 - Inpatient Psychiatric Hospital Service.* (Accessed July 9, 2018)

**Outpatient Hospital Psychiatric Services:** Refers to a wide range of services and programs that a hospital may provide to its outpatients who need psychiatric care, ranging from a few individual services to comprehensive, full-day programs; from intensive treatment programs to those that provide primarily supportive. *Medicare Benefits Policy Manual, Chapter 6, §70 - Outpatient Hospital Psychiatric Services, 70.1. -Coverage Criteria.* (Accessed July 9, 2018)

**Partial Hospitalization:** Partial hospitalization is active treatment pursuant to an individualized treatment plan, prescribed and signed by a physician, which identifies treatment goals, describes a coordination of services, is structured to meet the particular needs of the patient, and includes a multidisciplinary team approach to patient care under the direction of a physician. *Medicare Benefits Policy Manual, Chapter 6, §70.3 (A) – Partial Hospitalization Services - Program Criteria.* (Accessed July 9, 2018)

III. REFERENCES

See above

IV. REVISION HISTORY

04/01/2019 Updated policy introduction; added language to clarify:

- There are instances where [the Coverage Summary] may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG)
- In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (*Medicare IOM Pub. No. 100-16, Ch. 4, §90.5*)

03/19/2019 Re-review with the following updates:

Guideline 4 (Vagus nerve stimulation (VNS) for Intractable Depression) – Added following language:

“Effective February 15, 2019, The Centers for Medicare & Medicaid Services (CMS) issued a decision memo stating it will finalize its proposal to cover FDA approved vagus nerve stimulation (VNS) devices for treatment resistant depression (TRD) through Coverage with..."
Evidence Development (CED).

Refer to the Decision Memo for Vagus Nerve Stimulation (VNS) for Treatment Resistant Depression (TRD) (CAG-00313R2) issued on February 15, 2019.


Also see the Coverage Summary for Experimental Procedures and Items, Investigational Devices and Clinical Trials.”

Guideline 5.b [Examples of services and procedures that are not covered for a mental health diagnosis include, but are not limited to: (Vagus Nerve Stimulation)] – Removed Vagus Nerve Stimulation reference and reference to the replacement of the battery-powered generator for VNS for the treatment of resistant depression from this guideline.

09/18/2018 Updated Local Coverage Determination (LCD) Availability Grids; removed instruction to “use the applicable LCD based on member’s residence/place and type of service” (this note only applies when selecting the appropriate DME LCD Policy)

7/17/2018 Annual review with the following updates:

Guideline 1 (Inpatient)

- Deleted the following language:

  Inpatient mental health services are covered in a Medicare certified psychiatric facility when the member has a serious mental illness that significantly impacts their thought perception of reality, emotional process or judgment or grossly impairs behavior as demonstrated by recent disturbed behavior

  Replaced with:

  Inpatient mental health services are covered in a Medicare certified psychiatric facility when coverage criteria are met.

- Updated the reference note to read: “For more detailed inpatient psychiatric admission requirements, see the Medicare Benefits Policy Manual, Chapter 2 - Inpatient Psychiatric Hospital Service.

Guideline 2.b (Examples of outpatient mental health services that are covered)

- Updated the reference link to the specific section of the Medicare Benefit Policy Manual, i.e., Medicare Benefits Policy Manual, Chapter 6, §70.1.C – Application of Criteria.

- Deleted “ Individualized activity therapies that are not primarily recreational or diversionary “; replaced with “Activity therapies but only those that are individualized and essential for the treatment of the patient’s condition. The treatment plan must clearly justify the need for each particular therapy utilized and explain how it fits into the patient's treatment”

Guideline 3 (Partial Hospitalization) – updated the reference link to the Medicare Policy Benefit Manual; deleted the reference link to section 70.1.B – Partial Hospitalization.

Guideline 4 (Outpatient mental health services are not covered) – updated the reference link to the Medicare Policy Benefit Manual; deleted the reference to section 70.1.B – Partial Hospitalization.

07/17/2017 Annual review with the following update:
Guideline 5.d [(Intensive Behavioral Therapy for the Treatment of Autism (CPT Codes 0364T - 0370T) – replaced the default policy for states with no LCDs from UnitedHealthcare Medical Policy for Intensive Behavioral Therapy for Autism Spectrum Disorder to Novitas LCD for Services That Are Not Reasonable and Necessary (L35094). The United Healthcare Medical Policy was retired; Novitas L35094 has the most geographic coverage; all available LCDs align (not covered).

08/16/2016 Guideline 1.b.1 – added the following verbiage: “If the only activities prescribed for the patient are primarily diversional in nature, (i.e., to provide some social or recreational outlet for the patient), it would not be regarded as treatment to improve the patient’s condition.”

Guideline 1.b.3 – deleted the following verbiage: “Board and care”/convalescent/custodial services provided in a psychiatric hospital after the active treatment ends (e.g., the member remains confused or is at risk for wandering and is unable to be safely discharged back home or the family is no longer able to take care of the member". - no CMS reference available.

Guideline 4.h – Added the following verbiage “Other devices and equipment used for environmental control or to enhance the environmental setting in which the beneficiary is placed are not considered covered DME.” Also added reference to the Medicare Benefit Policy Manual, Chapter 15, Section 110.1 (B)(2) Equipment Presumptively Nonmedical.

Guideline 5.d – Added “(CPT Codes 0364T - 0370T)” to title. Also added reference to available LCDs and LCD Availability Grid (Attachment B).

01/15/2016 Updated reference link(s) of the applicable LCDs to reflect the new condensed LCD link(s).

08/18/2015 Annual review with the following updates:
• Guideline #9 [Hypnotherapy (CPT Code 90880)] – Changed default for states without LCDs from NGS LCD for Psychiatry and Psychology Services (L26895) to Wisconsin LCD for Psychiatry and Psychology Services (L30489). Wisconsin LCD has larger geographical coverage.

• Guideline #5.d (Intensive Behavioral Therapy for the Treatment of Autism) – Continue to default to UnitedHealthcare Medical Policy for Intensive Behavioral Therapy for the Treatment of Autism Spectrum Disorders (There are no available NCDs, LCDs or MCGs).

04/21/2015 Re-review with the following updates:
• NCD 160.4 Sterotactic Cingulotomy as a Means of Psychosurgery retired; all references to this NCD deleted.

08/19/2014 Annual review with the following updates:
Definitions:
• Mental Health Services - Deleted; unable to find CMS reference.
• Inpatient Hospital Psychiatric Services - Added definition.
• Outpatient Hospital Psychiatric Services – Added definition.
• Partial Hospitalization – Added CMS reference to Medicare Benefits Policy Manual, Chapter 6 - Hospital Services Covered Under Part B, §70.3 (A) – Partial Hospitalization Services - Program Criteria.
12/17/2013  Guideline #2.a.9 (Hypnotherapy) - Changed default guideline for states without LCDs from NHIC LCD for Psychiatry and Psychology Services (L29834) to National Government Services LCD for Psychiatry and Psychology Services (L26895).

Guideline #5.b (Vagus Nerve Stimulation) - Added language to indicate that replacement of the battery-powered generator for VNS for the treatment of resistant depression provided prior to May 4, 2007, if needed, will be covered.

08/20/2013  Annual review; no updates.

10/31/2012  Updated to include Guidelines #9 – Hypnotherapy.

08/20/2012  Annual review with the following updates:
- Guidelines #1.a.1 updated to include additional benefit language pertaining to individualized treatment based on the Medicare Benefits Policy Manual, Chapter 6 - Hospital Services Covered Under Part B §70 - Outpatient Hospital Psychiatric Services.
- Guidelines #1.a.3 updated to better clarify the examples of covered inpatient mental health services
- Coverage Summary was updated to include the reference to the Coverage Summary for Preventive Health Services and Procedures for screening services related to mental health.

08/29/2011  Annual review; no updates.

02/02/2011  Updated the link to the UnitedHealthcare Medical Policy for Intensive Behavioral Therapy for the Treatment of Autism Spectrum Disorders.

V. ATTACHMENT(S)

Attachment A - LCD Availability Grid

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### Attachment A - LCD Availability Grid

**Hypnotherapy**

**(CPT code 90880)**

CMS website accessed May 1, 2019

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End of Attachment A

### Attachment B - LCD Availability Grid

**Intensive Behavioral Therapy for the Treatment of Autism**

**(CPT codes 0364T - 0370T)**

CMS website accessed May 1, 2019

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End of Attachment B