Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines:

Outpatient Psychotherapy

Effective: January 1, 2026

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request to the FAX numbers below.	Yes ☐ No ☒
Notification Required IF REQUIRED, concurrent review may apply	Yes ☐ No ☒

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products; 800-232-0816
☒ Tufts Health Plan Commercial products; 617-972-9409

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); 888-415-9055
☒ Tufts Health Together – MassHealth Accountable Care Partnership Plans; 888-415-9055
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; 857-304-6404
☒ Tufts Health One Care-- A dual-eligible product; 857-304-6304

Senior Products

☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); 617-972-9409
☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); 617-972-9409
☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); 617-972-9409

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

Overview

Medically Necessary Outpatient psychotherapy services are covered for the diagnosis and treatment of mental health and substance use disorders specified in the most recent Diagnostic and Statistical Manual (DSM)™ or with the most recent International Classification of Diseases (ICD). The reported diagnosis should support the current symptom presentation and should be the focus of treatment.

Clinical Guideline Coverage Criteria

The Plan considers outpatient psychotherapy services, delivered by a provider licensed in a recognized discipline, as reasonable and medically necessary when **EITHER** of the following are met:

1. Must meet either A or B
   a. Meet **ALL** of the following:
      i. When clinical data provide clear evidence of signs and symptoms consistent with a mental health or substance use disorder as defined in the most recent DSM or ICD; **and**
      ii. And when there is a treatment plan, with measurable goals and approaches, that address the signs and symptoms of the patient's mental health or substance use disorder and that is consistent with current professional practice standards; **and**
      iii. And when there is no less intensive or more appropriate level of service that can be safely and effectively provided; **or**

b. When clinical data indicate that the Member's condition has stabilized and continued treatment at a less frequent maintenance level is needed to sustain the current level of functioning.

Limitations

The Plan considers outpatient psychotherapy as not reasonable or medically necessary for **ANY** of the following:

1. Regardless of medical necessity, services listed as exclusions, or not listed as covered benefits, in the Member's benefit document; **or**
2. Services that could safely and effectively be provided at a lesser frequency or intensity; **or**
3. Therapy visits more than once a week except in situations of acute crisis for a brief period of time. For example, situations when there is a risk of hospitalization, severe symptoms and/or severe functional impairments; **or**
4. When services are not documented in a medical record containing contemporaneous progress notes.

Codes

The following code(s) are associated with this service:

Table 1: CPT/HCPCS Codes

Ancillary providers may bill the following procedure codes:

Procedure Codes for All Clinicians

Code	Description
90791[1]	Psychiatric diagnostic evaluation (no medical services)
90785	Interactive complexity (add on code)
90832	Psychotherapy, 30 minutes with patient or family member
90834	Psychotherapy, 45 minutes with patient or family member
90837	Psychotherapy, 60 minutes with patient or family member
90839	Psychotherapy for crisis, first 60 minutes
90840	Psychotherapy for crisis, each additional 30 minutes (add on code)
90846	Family Psychotherapy (without patient present)
90847	Family Psychotherapy (with patient present)
90849	Multiple-family group psychotherapy
90853	Group Psychotherapy

Additional Codes for Prescribing Clinicians – (Psychiatrists, prescribing nurse clinical specialists and MH clinics)

Code	Description
99202	New patient, office or outpatient visit, expanded problem-focused
99203	New patient, office or outpatient visit, low complexity
99204	New patient, office or outpatient visit, moderate complexity
99205	New patient, office or outpatient visit, high complexity
99211	Established patient, office or outpatient visit, 5 minutes are spent
99212[2]	Established patient, office or outpatient visit, 10 minutes are spent
99213[2]	Established patient, office or outpatient visit, low complexity
99214	Established patient, office or outpatient visit, moderate complexity
99215	Established patient, office or outpatient visit, high complexity
90792[1]	Psychiatric diagnostic evaluation with medical services
90833	Psychotherapy, 30 minutes with patient or family member with an evaluation & management service

[1] Billing is limited to two 90791 and 90792 procedure codes per provider, per Member, per calendar year
[2] Billing 99211, 99212, or 99213 alone or with 90785 does not require prior authorization. These medical management services do not decrement the Member's mental health benefit.

Code	Description
90836	Psychotherapy, 45 minutes with patient or family member with an evaluation & management service
90838	Psychotherapy, 60 minutes with patient or family member with an evaluation & management service

References:

1. Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents With Major and Persistent Depressive Disorders, The American Academy of Child and Adolescent Psychiatry. https://www.jaacap.org/action/showPdf?pii=S0890-8567%2822%2901852-4. Accessed on August 1, 2023.
2. Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents With Anxiety Disorders. The American Academy of Child and Adolescent Psychiatry. https://www.jaacap.org/action/showPdf?pii=S0890-8567%2820%2930280-X Accessed on August 1, 2023.
3. The American Psychiatric Association Practice Guideline for the Treatment of Patients With Eating Disorders. Published Online:1 Feb 2023https://doi.org/10.1176/appi.ajp.23180001. Accessed on October 21, 2024.
4. National Institute of Mental Health. Mental Health Information: Anxiety Disorders 2016. Retrieved from: https://www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml. Accessed on October 21, 2024.

Approval And Revision History

October 21, 2020: Reviewed by IMPAC, renewed without changes.
Subsequent endorsement date(s) and changes:

- November 4, 2020: Fax number for Unify updated.
- November 18, 2020: Reviewed by IMPAC, language requiring notification removed from Overview section, effective January 1, 2021.
- March 17, 2021: Reviewed by IMPAC, Added Tufts Health Direct, Tufts Health Together and Tufts Health RITogether to applicable products for MNG effective April 1, 2021. Addition of code 90849 to MNG. Fax number for Tufts Health Direct and Tufts Health updated. Addition of Unify Product to guideline effective January 1, 2022.
- September 15, 2021: Reviewed by IMPAC, renewed without changes.
- February 1, 2022: Template Updated.
- September 21, 2022: Reviewed by Medical Policy Approval Committee (MPAC), renewed without changes.
- August 16, 2023: Reviewed by MPAC, renewed without changes, template updated effective November 1, 2023
- November 2023: Removed 99201 from policy as it was end dated January 1, 2021. Rebranded Unify to One Care effective January 1, 2024
- September 19, 2024: Reviewed by MPAC, renewed without changes effective November 1, 2024
- November 19, 2025: Reviewed by MPAC for annual review, renewed without changes effective January 1, 2026
- December 2025: Administrative updates effective January 1, 2026
- December 8, 2025: Reviewed by UM Committee for annual review, renewed without changes effective January 1, 2026

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members

under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.