

Hypnotherapy

Policy Number	HYP09262012RP	Approved By	UnitedHealthcare Medicare Reimbursement Policy Committee	Current Approval Date	05/14/2014
----------------------	---------------	--------------------	--	------------------------------	------------

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

This policy is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare reimbursement policies use Current Procedural Terminology (CPT®*), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms (CMS 1450). Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy. This information is intended to serve only as a general resource regarding UnitedHealthcare’s reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, and/or the enrollee’s benefit coverage documents. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare due to programming or other constraints; however, UnitedHealthcare strives to minimize these variations.

UnitedHealthcare may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

*CPT copyright 2010 (or such other date of publication of CPT) American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.

Proprietary information of UnitedHealthcare. Copyright 2014 United HealthCare Services, Inc.

Table of Contents

Application	1
Summary	2
Overview	2
Reimbursement Guidelines	2
General Coding Guidelines for Psychiatry and Psychology Services	2
Documentation Guidelines	2
CPT/HCPCS Codes	3
References Included (but not limited to):	3
CMS LCD(s)	3
CMS Article(s)	4
CMS Benefit Policy Manual	4
UnitedHealthcare Medicare Advantage Coverage Summaries	4
Others	4
History	4

Application

This reimbursement policy applies to services reported using the Health Insurance Claim Form CMS-1500 or its electronic equivalent or its successor form, and services reported using facility claim form CMS-1450 or its electronic equivalent or its successor form. This policy applies to all products, all network and non-network physicians, and other health care professionals.

The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits. This policy does not take

Hypnotherapy

precedence over CCI edits. Please refer to the CCI for correct coding guidelines and specific applicable code combinations prior to billing UnitedHealthcare. It is not enough to link the procedure code to a correct, payable ICD-9-CM diagnosis code. The diagnosis must be present for the procedure to be paid. Compliance with the provisions in this policy is subject to monitoring by pre-payment review and/or post-payment data analysis and subsequent medical review. The effective date of changes/additions/deletions to this policy is the committee meeting date unless otherwise indicated. CPT codes and descriptions are copyright 2010 American Medical Association (or such other date of publication of CPT). All rights reserved. CPT is a registered trademark of the American Medical Association. Applicable FARS/DFARS restrictions apply to Government use. Fee schedules, relative value units, conversion factors, and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. Current Dental Terminology (CDT), including procedure codes, nomenclature, descriptors, and other data contained therein, is copyright by the American Dental Association, 2002, 2004. All rights reserved. CDT is a registered trademark of the American Dental Association. Applicable FARS/DFARS apply.

Summary

Overview

Hypnosis is an artificially induced alteration of consciousness in which the patient is in a state of increased suggestibility. The therapist induces an altered state of consciousness, or focused attention, in the patient. While patients are in this relaxed state of heightened awareness and suggestibility, they can experience changes in the way they feel, think, and behave in response to suggestions directed to them by the hypnotherapist. This modality for psychiatric services helps the therapist to achieve an alteration in the patient's thought and behavior patterns.

Reimbursement Guidelines

Hypnosis may be used for diagnostic or therapeutic purposes. When used therapeutically to enhance psychotherapy or provided in conjunction with psychotherapy in the same session, only CPT code 90880 or the psychotherapy CPT code should be reported.

Individual psychotherapy codes should be used only when the focus of treatment involves individual psychotherapy. These codes should not be used as generic psychiatric service codes when other codes such as an evaluation and management (E/M) service or pharmacological codes would be more appropriate. Psychological services are covered in Comprehensive Outpatient Rehabilitation Facilities (CORFs). If the CORF treatment services rendered are for both a psychiatric condition and one or more non-psychiatric conditions, separate the charges for the psychiatric aspects of treatment from the charges for the non-psychiatric aspects.

General Coding Guidelines for Psychiatry and Psychology Services

Charges for certain psychiatric services provided by hospital outpatient departments are submitted to the Part A MAC. Services of physicians, clinical psychologists, physician assistants, nurse practitioners, and clinical nurse specialists are billed to the Part B MAC. Services furnished incident to the professional services of clinical psychologists to hospital patients remain bundled with the facility services for payment purposes, with payment made to the hospital for such "incident to" services.

Under certain circumstances, facilities may component bill the services of physicians, clinical psychologists, clinical social workers, and clinical nurse specialists and submit the facility fee services to the Part A MAC with the appropriate revenue and HCPCS codes. Hospitals should be advised that facility fee charges submitted to the Part A MAC must meet the same medical necessity and documentation standards as described elsewhere in the LCDs for Psychiatry and Psychology Services.

Individual psychotherapy codes should be used only when the focus of the treatment encounter involves psychotherapy. Psychotherapy codes should not be used as generic psychiatric service codes when another code, such as an E/M or pharmacological management code, would be more appropriate.

Documentation Guidelines

The patient's medical record must contain documentation that fully supports the medical necessity for services included within this policy. This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) has imposed specific restrictions on access to psychotherapy notes. These restrictions are outlined in the Code of Federal Regulations (CFR), 45 CFR, parts 160 and 164 (The Privacy Rule). Providers are exempt from submitting psychotherapy notes

Hypnotherapy

without patient authorization when the notes in question fit the Privacy Rule definition in 45 CFR Section 164.501. This section defines psychotherapy notes as "notes recorded by a mental health professional (in any medium) which document or analyze the contents of a counseling session and that are separated from the rest of a medical record."

45 CFR § 164.501 states that "the provider is responsible for extracting information required to perform a review for medical necessity." The provider, therefore, is expected to document information potentially necessary for review in a manner that will allow submission if this information without release of psychotherapy details that are protected by the Privacy Rule.

This following information is excluded from the protected information in 45 CFR §164.501, and must be included in all psychiatric medical record documentation and made available upon request:

- Name of beneficiary and date of service
- Type of service (individual, group, family, interactive, etc.)
- Time element, where duration of the face-to-face contact is the determining factor for coding the service rendered
- Modalities and frequency of treatment furnished
- A clinical note for each encounter, where in the aggregate, summarizes the following items: diagnosis, symptoms, functional status, focused mental status examination, treatment plan, prognosis, and progress to date. Elements such as treatment plans, functional status and prognostic assessment are expected to be documented, updated and available for review, but do not need to be delineated for each individual date of service
- Identity and professional credentials of the person performing service

For interactive therapy, the medical record should indicate the adaptations utilized in the session and the rationale for employing these non-verbal interactive techniques

For psychotherapy services that include a medical evaluation and management component, documentation of the medical evaluation or management component of the treatment, including prescriptions, monitoring of medication effects, co-morbid medical conditions evaluated, and results of clinical tests.

Group therapy session notes must be prepared within a reasonable time period after the rendering of professional services consistent with accepted practice, and can be organized according to the general session note guidelines for individual therapy or the clinician may elect to use the following group note format:

- One portion of the note that is common to all patients, documenting date, length of time for the session, along with key issues presented. Names of the patients in the group should not appear in this group note.
- A second portion of the note, for each patient's record, commenting on that particular patient's participation in the group process and any significant changes in patient status. As outlined in HIPAA regulations referenced above, the note should exclude sensitive content of the patients' conversation.

While there are no specific limitations on the frequency or length of time that outpatient psychiatric services may be covered, there are many factors, including the nature of the illness, prior history, goals of treatment, and the patient's response, that affect the outcome of treatment. When outpatient psychiatric services are provided at a high frequency or long duration, the plan of treatment, progress notes, and condition of the patient should justify the intensity of the services rendered.

For psychotherapy services, there should be documentation of the patient's capacity to participate in and benefit from psychotherapy, especially if the patient is in any way cognitively impaired. The medical record should document the target symptoms, goals of therapy and methods of monitoring outcome. There should be documentation in the medical record of how the treatment is expected to improve the health status or function of the patient.

Those hospitals that provide services at off-campus locations must clearly document in the medical record the location of the billed services, and that the services were properly supervised.

CPT/HCPCS Codes

Code	Description
90880	Hypnotherapy

References Included (but not limited to):

CMS LCD(s)

Numerous LCDs

Hypnotherapy

CMS Article(s)

Numerous Articles

CMS Benefit Policy Manual

Chapter 15; § 80.2 Psychological and Neuropsychological Tests

UnitedHealthcare Medicare Advantage Coverage Summaries

Mental Health Services and Procedures

Others

Mental Health Services; ICN 903195; September 2013

History

Date	Revisions
05/14/2014	<ul style="list-style-type: none"> • Re-review presented to MRPC for approval • Administrative update
05/22/2013	Re-review presented to MRPC for approval
09/26/2012	Reimbursement Policy presented to MRP Committee and approved
09/14/2012	Reimbursement Policy created