Medical Policy

Utilization Management and Clinical Medical Policy

Policy Name:	Policy Number:	Scope:	Origination Date:	Frequently Revision:
Behavioral and Mental Health Management in Home Settings	**MP-EM-FP-04-25**	☒ **MMM MA** ☐ **MMM MultiHealth**	**10/01/2025** **Last Review Date:** **12/12/2025**	**Annual** **Page: 1 of 10**

Service Category:

☐ **Anesthesia**
☐ **Surgery**
☐ **Radiology Procedures**
☐ **Pathology and Laboratory Procedures**
☐ **Medicine Services and Procedures**
☒ **Evaluation and Management Services**
☐ **DME/Prosthetics or Supplies**
☐ **Other:** _____

Service Description:

Mental health home visits are holistic, consumer-centered, and recovery-oriented mental health services provided in group homes or individual residences to homebound adults. These services are provided by physicians, psychiatrists, and/or board-certified mental health professionals with knowledge of mental health conditions. The goal of these visits is to allow patients to manage symptoms, increase functioning, achieve personal goals, maintain recovery, and, when possible, exit the state of home confinement [1]. In addition, these services reduce unmet needs, improve treatment coordination with appropriate referrals, and potentially decrease acute exacerbations that require hospital or emergency room visits [2].

Note: For purposes of this policy, mental-health / behavioral-health specialist refers to licensed and credentialed providers whose scope of practice includes diagnosis and/or treatment of mental health or behavioral disorders (e.g., psychiatrists, clinical psychologists, licensed clinical social workers – LCSW, advanced-practice psychiatric/mental-health nurses and licensed Mental Health Counselors – MHC, among others). The term 'non-participating provider (non-par)' refers to any such specialist who is not under contract with the Plan (outside the network); services rendered by non-par specialists require prior authorization (PA) in accordance with this policy.

Background Information:

The criteria in this document are intended to address those at-risk individuals who, due to psychiatric disorders or mood or behavioral disturbances, are deemed to be in need of home-focused services to assist with specific behavioral impairments in performing activities of daily living (ADLs) or other functional activities [3].

There should be a reasonable expectation that the member's symptoms or level of functioning will stabilize or improve within a reasonable period of time by providing home-based mental health services, the efficacy of which in improving symptoms and functions in this group of patients has been supported in the literature [4-5].

Substance Abuse and Mental Health Services Administration, SAMHSA [6-7]:

Severe mental illness (also known as severe and persistent mental illness): A mental, behavioral, or emotional disorder according to the most recent edition of the DSM, in members over the age of 18, that results in functional impairment that substantially interferes with or limits one or more major life activities (e.g., maintaining interpersonal relationships, ADLs, self-care, etc.). employment, recreation) that have occurred in the last year.

Mental illnesses are disorders that affect a person's thinking, mood, and/or behavior, and can range from mild to severe. According to the National Institute of Mental Health, nearly one in five adult's lives with a mental illness. A mental illness that interferes with a person's life and ability to function is called a serious mental illness (SMI). With the right treatment, people with SMI can live productive and enjoyable lives. There are many types of serious mental illness. The most common include:

- Bipolar disorder is a brain disorder that causes intense changes in mood, energy, and activity levels. People have manic episodes where they feel extremely happy or euphoric, and energized. They also usually have depressive episodes in which they feel deeply sad and have low energy.

- Major depressive disorder (MDD) is one of the most common mental disorders. Symptoms vary from person to person, but can include sadness, hopelessness, anxiety, pessimism, irritability, worthlessness, and fatigue. These symptoms interfere with a person's ability to work, sleep, eat, and enjoy their life.
- Schizophrenia is a chronic and severe mental disorder that causes people to interpret reality abnormally. People may experience hallucinations, delusions, extremely disordered thoughts, and a reduced ability to function in their daily lives.
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LCD Jurisdiction and Reference

For the jurisdiction of Puerto Rico, there is a retired LCD: LCD - Home and E&M Visits (L33817), used as a reference in this policy to define criteria below:

> For these conditions there are services at the outpatient/home visit level, this includes a patient history, examination, problem solving and decision making at various levels, depending on the patient's need and diagnosis. Visits can also be done as counseling or care coordination if medically necessary outside of the office setting and are an integral part of a continuum of care. Patients seen may have chronic conditions, may be disabled, either physically or mentally, making it very difficult to access a traditional office visit, or may have limited support systems. Home or home visiting, in turn, can lead to improved medical care by identifying unmet needs, coordinating treatment with appropriate referrals, and potentially reducing acute exacerbations of medical conditions, resulting in less frequent trips to hospital or emergency rooms [8].
>
> Home health care is expanding rapidly. The growth of home visiting programs in hospitals, early hospital discharge programs, and an increased effort to expand the role of home visiting in medical education have contributed to this expansion. Physicians and qualified non-medical professionals (NPPs) are required to directly supervise or provide progressively more sophisticated home visits. Patients should understand the nature of a pre-arranged visit and consent to treatment at home or home care facility [8].

Documentation requirements

According to LCD L33817 (Home and E/M Visits), each home visit or evaluation must be supported in the medical record as medically necessary and documented on an individual basis. Standing orders for routine visits without specific clinical justification are not accepted. The mere existence of stable chronic conditions does not constitute a medical necessity for a visit. Each encounter must document: (1) motive and relevant history; (2) findings of the physical examination and pertinent diagnostic results; (3) assessment/diagnosis; and (4) care plan. Visits will be considered convenient—and subject to non-coverage—if there is no documented evidence of medical necessity, if the frequency exceeds accepted standards of practice, or if the visit was driven solely by group activities or non-clinical requests.

Drugs

According to the Medicare Benefit Policy Manual, Chapter 15, §50.2, the Medicare program offers limited benefits for outpatient prescription drugs, covering only those that are provided as a result of medical care and are not routinely self-administered by the patient. This normative principle establishes the basis for differentiating between medications or therapies that are the responsibility of the patient and those that, due to their complexity or need for clinical supervision, require coverage and management under medical benefits [9].

Frequency

The frequency and duration of services have no absolute limits; coverage may be continued as long as clinical evidence shows that the patient maintains improvement in accordance with his or her individualized treatment plan and that the intensity/frequency of services is within accepted standards of medical practice. The determination of continuity should be based on documented clinical evaluation and a reasonable expectation that the intervention will continue to produce benefit to the patient. (CMS, *Medicare Benefit Policy Manual*, Pub. 100-02, Chapter 6, §70.1).

No duplication of services

The service must not be one that can be provided by a home health agency under the benefit of *Home Health*. Nor should it duplicate services provided by other professionals [8]

American Psychiatric Association, DSM-5-TR 2022

The diagnosis that qualifies access to these services must be based on the criteria of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5,TR 2022)* and confirmed by a licensed clinician. The DSM-5-TR 2022 provides the diagnostic framework and guides clinical formulation; however, the care decision must be integrated with an exhaustive medical history that considers the patient's biological, psychological, and social factors. Evidence suggests that home-based mental health treatments, when targeted at specific functional impairments (e.g., limitation in activities of daily living, risk of impairment, or hospitalization), may improve symptoms and functioning [11].

Telehealth

In accordance with current CMS regulations, mental and behavioral health services may be provided through in-person visits to the beneficiary's home **or** through telemedicine (real-time interactive technology — audio/video, and for mental/behavioral health including audio-solo), provided that the provider meets the appropriate eligibility, licensing, and credentialing requirements [12,19].

Initial Request

The Initial Request section is included to establish that the first in-home visit request must be initiated only by the beneficiary, their authorized representative with a valid AOR, or the treating provider contracting or not contracting. A delegate cannot make a request unless the member has completed an AOR designating that person as their authorized representative. Although CMS does not mandate this specific process, the plan adopts it to ensure that all requests originate from a legitimately authorized party, prevent inappropriate provider-initiated patient solicitation, and maintain traceability and compliance for audit purposes.

Medical Necessity Guidelines:

Specialized in-home behavioral and mental health services are considered medically necessary when they meet certain clinical and functional criteria. Below are all the requirements that must be met to ensure that care is appropriate, safe, and evidence-based:

A. Initial Request: The first visit must be requested by the patient, or a treating provider contracted or not contracted. The provider cannot make an appointment directly with the patient (e.g., calls, door-to-door visits).

B. Diagnosis: Requires a documented diagnosis according to the criteria of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5 TR 2022)*, issued by a licensed clinician. The diagnosis must be integrated into a clinical formulation (comprehensive case analysis) that considers biological, psychological, and social factors and establishes the relationship between symptoms and functional impairments that warrant intervention at home [11].

C. Homebound Patient: The patient is homebound: they cannot safely leave their residence and must meet one of two criteria [13]:

Criterion 1 (At least one of the following conditions must be met):

- Due to illness or injury, the patient requires the use of assistive devices (crutches, cane, wheelchair, walker), the use of specialized transportation, or the assistance of another person to leave their residence.

Or;

- The patient has a medical condition that makes leaving home medically contraindicated.

Criterion 2 (Both requirements must be met together):

- The patient demonstrates a normal inability to leave his or her home.
- Leaving your home requires considerable and exhausting effort.

D. Clinical Need by Condition: There is a specific clinical need that requires home intervention for the patient's condition and that meets one or more of the interventions corresponding to the diagnosis. These interventions should target documented symptoms or functional limitations, align with the clinical formulation of the case, and integrate with the patient's updated medical assessment [8,10].

Diagnostic	Source	Interventions (1 or more)
Major Depressive Disorder ORG: B-008-HC (HC)	[14]	• Abnormal Involuntary Motion Scale (AIMS) Test for Tardive Dyskinesia (TD) for Patient Taking Neuroleptic Medications • Assessment of caregiver burden of care, with possible referral to respite care • Coordination of care with the case management program (i.e., condition management, transition of care) • Home Safety Assessment • Medication Management, Adherence Instruction, and Side Effect Assessment • Mental status examination • Nutrition and hydration management • Psychosocial assessment, management and referral • Rehabilitation therapy or team coordination

		• Significant exacerbation of chronic condition with need for clinical intervention and monitoring • Establishing Telehealth Services
Bipolar Disorders **ORG: B-004-HC**	[15]	▪ Abnormal involuntary movement scale (AIMS) test for tardive dyskinesia (TD) for patient taking neuroleptic medication ▪ Burden of care assessment of caregiver, with potential referral to respite care ▪ Coordination of care with case management program (ie, condition management, care transition) ▪ Home safety assessment ▪ Injection of long-acting antipsychotic medication (such as haloperidol decanoate, fluphenazine decanoate) ▪ Medication management, adherence instruction, and side effects assessment ▪ Mental status examination ▪ Nutrition and hydration management ▪ Psychosocial assessment, management, and referrals ▪ Rehabilitation therapy or equipment coordination ▪ Significant chronic condition exacerbation with need for clinical intervention and monitoring ▪ Telehealth services establishment
Dementia **ORG: B-007-HC**	[16]	▪ Abnormal involuntary movement scale (AIMS) test for tardive dyskinesia (TD) for patient taking neuroleptic medication ▪ Burden of care assessment of caregiver, with potential referral to respite care ▪ Coordination of care with case management program (ie, condition management, care transition) ▪ Electrolyte management ▪ Gastrointestinal status assessment ▪ Genitourinary status assessment ▪ Home safety assessment ▪ Injection of long-acting antipsychotic medication (such as haloperidol decanoate, fluphenazine decanoate) ▪ Medication management, adherence instruction, and side effects assessment ▪ Mental status examination ▪ Neurologic status assessment ▪ Nutrition and hydration management ▪ Pain management ▪ Psychosocial assessment, management, and referrals ▪ Rehabilitation therapy or equipment coordination ▪ Significant chronic condition exacerbation with need for clinical intervention and monitoring ▪ Skin integrity assessment ▪ Telehealth services establishment

Schizophrenia Spectrum Disorders B-014-HC	[17]	▪ Abnormal involuntary movement scale (AIMS) test for tardive dyskinesia (TD) for patient taking neuroleptic medication ▪ Burden of care assessment of caregiver, with potential referral to respite care ▪ Coordination of care with case management program (ie, condition management, care transition) ▪ Home safety assessment ▪ Injection of long-acting antipsychotic medication (such as haloperidol decanoate, fluphenazine decanoate) ▪ Medication management, adherence instruction, and side effects assessment ▪ Mental status examination ▪ Nutrition and hydration management ▪ Psychosocial assessment, management, and referrals ▪ Rehabilitation therapy or equipment coordination ▪ Significant chronic condition exacerbation with need for clinical intervention and monitoring ▪ Telehealth services establishment

E. Person-centered treatment plan: A person-centered treatment plan has been developed that includes all the following (1 to 4):

1. It identifies specific behavioral impairments or symptoms (psychological, family, community) that interfere with normal functions [10].

2. Measurable, age-appropriate individual goals based on standardized assessments and linked to symptoms/behaviors [13].

3. Specific schedule: intensity (number of visits/week and hours/visit), duration (minimum 1 month, maximum 6 months), and periodic medical reevaluation [10,13].

4. Services provided by licensed/certified providers in their field of practice [10].

Not medically necessary:

In-home behavioral health services are considered **non-medically necessary** when the above criteria are not met or when a reevaluation by a duly mental-health / behavioral-health specialist has determined (A, B or C):

A. No measurable improvement in symptoms or functional impairments has been documented; **or**

B. The individual's condition (symptoms or ability to function) has deteriorated and now warrants a more intensive level of care (e.g., more intensive supervised inpatient or outpatient behavioral health care (example: Level of Care IOP, PHP).

C. Services will be considered non-medically necessary when the requested intervention is not directly related to the documented DSM-5 TR 2022 diagnosis or identified functional limitations, consistent with CMS standards of reasonableness and necessity.

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Limits or Restrictions:

1. The following providers requires going through the service authorization process:
   - Psychologists (participating/non-participating)
   - Clinical Social Workers (participating/non-participating)
   - Psychiatrists/General Practitioners (only when non-participating)
2. For services that require an applicable diagnosis but are not individually itemized within this medical policy, coverage determinations will be made based on medical necessity, supporting clinical documentation, and alignment with applicable regulatory and evidence-based standards. The absence of a diagnosis in the policy's listing does not constitute non-coverage; instead, each request will be evaluated on its individual clinical merits**.**
3. Training of domiciliary staff is not considered medically necessary [8].
4. Each page of the record must be legible and include appropriate patient identification information (e.g., full name, dates of service).
5. The documentation must include the legible signature of the physician or non-medical professional responsible for and providing the patient care [18].
6. A specialist in mental and/or behavioral health may visit multiple patients on the same day, but each visit must respond to individual medical needs and be documented [18].
7. Home services should not unnecessarily duplicate those already provided by other professionals, regardless of whether they are in the office, center, or home [18].
8. Visits for the same diagnosis, condition, or episode that is already being treated by another professional may be considered concurrent or duplicate [18].
9. If documentation does not demonstrate medical necessity, services may be considered non-medically necessary [18].

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Codes Information:

ICD-10 Diagnostic Codes:

Codes	Description
F32.x	Depressive episode (mild, moderate, or severe)
F33.x	Recurrent Major Depressive Disorder
F31.x	Bipolar disorder (with manic, depressive, or mixed episodes)
F20.x	Schizophrenia
F25.x	Schizoaffective disorders
F21	Schizotypal disorder
F03	Unspecified dementia
F01.x	Vascular dementia
G30.x	Alzheimer's disease

HCPCS Codes:

Codes	Description
-	-

CPT Codes:

Codes	Description
99344	HOME/RES VST NEW MOD MDM
99345	HOME/RES VST NEW HIGH MDM
99347	HOME/RES VST EST SF MDM
99348	HOME/RES VST EST LOW MDM
99349	HOME/RES VST EST MOD MDM
99350	HOME/RES VST EST HIGH MDM
98968	HC PRO PHONE CALL 21-30 MIN

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Policy History:

Type of Review	Summary of Changes	P&T Approval Date	UM/CMPC Approval Date
Superseded	Medical Policy MP-EM-FP-04-25 – Behavioral and Mental Health Management in Home Settings was implemented to supersede Medical Policy MP-EM-FP-01-23 – Home Visits – Mental Health. This policy represents a comprehensive revision, including updates to clinical criteria, service descriptions, background information, medical necessity requirements, applicable CPT and ICD-10 coding, and limitations and restrictions. The policy was updated to ensure alignment with applicable CMS regulatory and coverage requirements for home-based and telehealth behavioral and mental health services, including clarification of eligible provider types, implementation of preauthorization requirements, revised service delivery modalities (in-person and telehealth), and enhanced documentation, monitoring, and care-planning standards. This policy constitutes the current internal governing policy for these services, subject to applicable CMS National and Local Coverage Determinations (NCDs/LCDs) and associated Articles, where applicable.	**Not applicable**	**12/12/2025**