

HEALTH CARE BENEFITS FOR CHILDREN OF VIETNAM VETERANS

CHAPTER: 2
SECTION: 4
TITLE: MENTAL HEALTH

AUTHORITY: 38 CFR 17.900-17.902

I. PROCEDURE CODE(S)

90801, 90802, 90804-90857, 90862-90871, 90875-90876, 90901-90911

II. POLICY

A. Mental health benefits are authorized for services and supplies that are medically or psychologically necessary when:

1. The services are related to the covered condition(s).
2. The services are rendered by persons who are furnishing services within their licensure and qualifications for their respective disciplines (whether the person is an individual professional provider or is employed by another authorized provider).
3. The mental disorder is one of those listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-R) and is of a severity not only to cause the patient distress, but also to interfere with the patient's ability to carry out his or her usual activities. This does not mean that the person must be unable to function. Rather, because of a mental disorder, the person experiences more than average problems in carrying out the normal activities associated with the roles and responsibilities of persons of similar age and circumstances.

B. Mental health services must be preauthorized (see [Chapter 2, Section 1, Preauthorization](#)).

1. Admissions resulting from a psychiatric emergency should be reported within 24 hours of admission or the next business day after admission, but must be reported no later than 72 hours from the time of admission.
2. A psychiatric emergency exists when, based on a psychiatric evaluation performed by a physician (or other qualified mental health care professional with hospital admission authority), the patient is at immediate risk of serious harm to self or others as a result of a mental disorder and requires immediate continuous skilled observation at the acute level of care.

C. All requests for mental health services must include:

1. a report of evaluation,
2. a proposed treatment plan which includes diagnosis, modalities to be used, length of sessions and estimated length of treatment (frequency and number of visits), and
3. the relationship of the mental health condition to the covered condition(s).

III. POLICY CONSIDERATIONS

A. Qualified providers of mental health services are:

1. psychiatrists, medical doctors (MDs), and doctors of osteopathy (DOs),
2. clinical psychologists,
3. certified psychiatric nurse specialists,
4. licensed/clinical social workers (Master's Level), and
5. certified marriage and family therapists.

B. Providers who require a physician referral and supervision are:

1. marriage and family counselors,
2. mental health counselors, and
2. pastoral counselors.

C. It may be assumed that all professional staff in an authorized institution meet regulatory criteria. Any evidence to the contrary is to be brought to the attention of the Health Administration Center immediately.

D. Mental health services other than individual and group therapy, which are provided as an incidental part of an inpatient treatment plan, may be covered although not reimbursed separately. This would include miscellaneous ancillary therapy modalities such as:

1. recreational therapy,
2. art therapy,
3. dance therapy, and
4. play therapy.

- E. Electroconvulsive treatment (ECT) is covered.
- F. Biofeedback is covered.

IV. EXCLUSIONS

- A. Outpatient psychotherapy when the patient is an inpatient at an institution.
- B. Leisure time programs, outings, and movies.

END OF POLICY