United Behavioral Health

Coverage Determination Guideline: Bipolar Disorder

Table of Contents

Introduction
Instructions for Use
Benefit Considerations
Coverage Rationale
References
Revision History

INTRODUCTION

Coverage Determination Guidelines are a set of objective and evidence-based behavioral health criteria used by Commercial plans that don't have a provision for medical necessity to standardize coverage determinations, promote evidence-based practices, and support members' recovery, resiliency, and wellbeing for behavioral health benefit plans that are managed by Optum®1.

INSTRUCTIONS FOR USE

This guideline provides assistance in interpreting UnitedHealthcare Commercial benefit plans and is used to make coverage determinations as well as to inform discussions about evidence-based practices and discharge planning for behavioral health benefit plans managed by Optum. When deciding coverage, the member's specific benefits must be referenced.

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member's benefits prior to using this guideline. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this guideline and the member's specific benefit, the member's specific benefit supersedes this guideline. Other clinical criteria may apply. Optum reserves the right, in its sole discretion, to modify its clinical criteria as necessary using the process described in Clinical Criteria.

This guideline is provided for informational purposes. It does not constitute medical advice.

Optum may also use tools developed by third parties that are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Optum may develop clinical criteria or adopt externally-developed clinical criteria that supersede this guideline when required to do so by contract or regulation.

BENEFIT CONSIDERATIONS

Before using this policy, please check the member-specific benefit plan document and any federal or state mandates, if applicable.

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Available benefits for Bipolar Disorder include the following services:

- Diagnostic evaluation, assessment, and treatment planning
- Treatment and/or procedures
- Medication management and other associated treatments
- Individual, family, and group therapy
- Provider-based case management services
- Crisis intervention

**Indications for Coverage**

A. Initial evaluation
   - Optum recognizes the American Psychiatric Association’s Practice Guidelines for the Psychiatric Evaluation of Adults (2016):
     - [http://www.psychiatry.org](http://www.psychiatry.org) > Psychiatrists > Practice > Practice Guidelines

B. Screening and Assessment
   - Early, accurate diagnosis is essential in optimizing treatment outcomes (Bobo, 2017).
     - Accurate diagnosis is dependent upon establishing current or past manic, hypomanic, and depressive episodes. It is imperative to ascertain whether episodes of depression, mania, or hypomania are inclusive of psychotic features (Bobo, 2017).
     - It is helpful for individuals presenting with depression to be asked about past personal and family history of mania and hypomania; 70% of individuals with a bipolar diagnosis have previously been misdiagnosed (Reus, 2020).
   - In the primary care setting, early identification and detection of mental and substance use disorders has shown to enhance quality of life and limit health care costs (Mulvaney-Day et al., 2017).
     - A systematic review and meta-analysis of 10 studies and 3803 participants found that over 3 in 20 patients with depression have unrecognized bipolar disorder in primary care; this can lead to detrimental patient outcomes. Increased awareness of unrecognized bipolar disorder in primary care patients with depression and efficient assessment strategies in primary care are merited (Daveney et al., 2019).
   - Psychiatric assessments for children and adolescents should include screening questions for bipolar disorder (American Academy of Child & Adolescent Psychiatry [AACAP], 2007).
     - The age of onset for bipolar disorder can occur as early as late adolescence (Yatham et al., 2018).
   - Use of a screening instrument, such as the Mood Disorder Questionnaire, can improve recognition of bipolar disorder, particularly among depressed individuals (American Psychiatric Association [APA], 2005; Yatham et al., 2018).
   - A useful screening and diagnostic tool for bipolar disorder is the Composite International Diagnostic Interview (CIDI 3.0), developed by the World Health Organization (Reus, 2020).
   - When assessing suspected bipolar disorder, a corroborative history from a family member or caregiver is encouraged (National Institute for Health and Care Excellence [NICE], 2020).
   - Suspected bipolar disorder must also be carefully evaluated for other associated problems, such as suicidality, comorbid disorders, psychosocial stressors, and other medical problems (AACAP, 2007).
     - Individuals with bipolar disorder are predisposed to other psychiatric disorders at elevated rates, including anxiety disorders, personality disorder, attention-deficit/hyperactivity disorder, and alcohol or drug dependence (Goodwin et al., 2016; National Institute of Mental Health [NIMH], 2020).
     - Research reveals that 30% - 50% of individuals with bipolar disorder will develop a substance use disorder sometime during their lives (Substance Abuse and Mental Health Services Administration [SAMSHA], 2016).
     - Bipolar disorder has the most lethality, the most recurrences, and the most varied clinical presentations of any major psychiatric disorder (SAMSHA, 2016).
C. Differential diagnosis for bipolar disorder includes (APA, 2013):
   - Major depressive disorder;
   - An anxiety disorder;
   - Attention-deficit/hyperactivity disorder;
   - Personality disorder;
   - Disorders with prominent irritability, particularly in children and adolescents.

D. Treatment planning
   - Optum recognizes the American Psychiatric Association’s Practice Guidelines for the Psychiatric Evaluation of Adults (2016):
     - [http://www.psychiatry.org > Psychiatrists > Practice > Clinical Practice Guidelines](http://www.psychiatry.org)
   - Acute mood episodes increase safety risks for individuals and others, requiring a risk assessment; this may compel third party information for an accurate risk assessment (Goodwin et al., 2016).
     - According to the Agency for Healthcare Research and Quality (AHRQ, 2018), approximately 25% of individuals diagnosed with bipolar disorder will attempt suicide.
     - Individuals at risk for suicide or violence require urgent intervention such as hospital admission or other psychiatric services (Goodwin et al., 2016).
     - Treatment planning that closely monitors rapid cycling (greater than three episodes per year) and mixed states are recommended. These episodes are associated with a poorer prognosis, a longer disease course, more treatment resistance, more substance use comorbidity, and increased suicidal risk (Reus, 2020).
   - Treatment generally consists of 2 phases; the acute-phase is focused on the management of the acute mood episode, while the maintenance-phase is focused on preventing recurrences (Bobo, 2017).
   - The relapsing and remitting aspects of bipolar disorder necessitate a long-term multidisciplinary management approach that combines pharmacotherapy and psychoeducation (Yatham et al., 2018).
     - Relapse awareness includes monitoring of stressors and sleep disturbance (Goodwin et al., 2016).

E. Psychosocial Interventions
   - Psychotherapeutic interventions are an important component of a comprehensive treatment plan for early-onset bipolar disorder (AACAP, 2007).
   - When done in combination with medication, psychotherapy, such as cognitive behavioral therapy, family-focused therapy, interpersonal therapy, and psychoeducation, can be an effective treatment for bipolar disorder (NIMH, 2020).
     - Psychoeducation for individuals that experience episodes of mania and depression has shown moderate to strong clinical efficacy. This approach includes instruction about the early warning signs for episodes, and common triggers for mania and depression. Psychoeducation interventions are most often conducted in a group setting with the best tested approach comprising approximately 21 group sessions (Society of Clinical Psychology, 2016).
     - Psychotherapies combined with bipolar medications can reduce rates of recurrence by 50% or more (Bobo, 2017).
     - Psychosocial interventions may prove valuable for acute depressive episodes associated with bipolar disorder, in addition to maintenance treatment to prevent relapse and to restore quality of life to the individual and family (Yatham et al., 2018).

F. General Pharmacotherapy
   - Medications generally used to treat bipolar disorder include mood stabilizers, atypical antipsychotics, and antidepressants (NIMH, 2020).
Lithium, valproate, and several atypical antipsychotics are generally considered to be first-line treatments for acute mania in both adults and younger individuals (AACAP, 2007; APA, 2002; Yatham et al., 2018).

- Choice of medication should be based on evidence of efficacy, the phase of the illness, presence of any confounding presentations, the agent’s side effect spectrum and safety, the patient’s history of medication response, and the preferences of the patient and his or her family (AACAP, 2007).
- Regular safety medication monitoring is vital for medication side effects such as weight changes and extrapyramidal symptoms (Yatham et al., 2018).
- Evidence shows that on average about 20% more individuals have a better response to combination therapy when compared to mood stabilizer monotherapy (Yatham et al., 2018).

G. Other Treatments
- Electroconvulsive therapy (ECT) may provide relief for those with severe bipolar disorder who have not been able to recover with other treatments (NIMH, 2020).
  - For severely impaired adolescents with manic or depressive episodes in bipolar I disorder, electroconvulsive therapy (ECT) may be indicated if medications are either not helpful or cannot be tolerated (AACAP, 2007).

**REFERENCES**


**REVISION HISTORY**

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<thead>
<tr>
<th>Date</th>
<th>Action/Description</th>
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<tbody>
<tr>
<td>05/09/2017</td>
<td>• Version 1 – Annual Update</td>
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<tr>
<td>05/09/2018</td>
<td>• Annual Update: Updates to formatting, codes, checked references</td>
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<tr>
<td>06/17/2019</td>
<td>• Annual Update: Updates to formatting, codes, references</td>
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<tr>
<td>09/21/2020</td>
<td>• Annual Update: updates to references, removal of coding grids</td>
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