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®.

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.
Pre-Service Notification
Admissions to an inpatient, residential treatment center, intensive outpatient, or a partial hospital/day treatment program require pre-service notification. Notification of a scheduled admission must occur at least five (5) business days before admission. Notification of an unscheduled admission (including emergency admissions) should occur as soon as is reasonably possible. Benefits may be reduced if Optum is not notified of an admission to these levels of care. Check the member’s specific benefit plan document for the applicable penalty and provision for a grace period before applying a penalty for failure to notify Optum as required.

Available benefits for **Oppositional Defiant 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

**Impulse-Control Disorders (including Intermittent Explosive Disorder, Pyromania, and Kleptomania)** as a principal diagnosis, as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, are typically excluded. Indications for coverage are limited to circumstances where:
- Impulse Control Disorder is a secondary diagnosis; and
- The principal diagnosis is a covered condition; and
- Treatment is primarily focused on the principal diagnosis; or
- Impulse Control Disorders are covered by the member’s benefit plan.

**Conduct Disorder** as a principal diagnosis, as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, is typically excluded. Indications for coverage are limited to circumstances where:
- Conduct Disorder is a secondary diagnosis; and
- The principal diagnosis is a covered condition; and
- Treatment is primarily focused on the principal diagnosis; or
- Conduct Disorder is covered by the member’s benefit plan.

A principal diagnosis is defined as the condition that, after a complete evaluation, is determined to be chiefly responsible for the member seeking treatment, and also becomes the focus of clinical attention during treatment. When a person has multiple diagnoses, the first disorder listed is assumed to be the principal diagnosis, unless the provider specified otherwise (American Psychiatric Association, 2013).

**Available benefits for Disruptive Impulse Control and Conduct Disorders include the following levels of care, procedures, and conditions:**

- **Levels of Care**
  - Inpatient
  - Intensive Outpatient Program
  - Outpatient
  - Partial Hospital Program
  - Residential Treatment Facility

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

- **Conditions**
Indications for Coverage

Oppositional Defiant Disorder

A. Initial evaluation
   - Optum recognizes the American Psychiatric Association’s Practice Guidelines for the Psychiatric Evaluation of Adults (2016):
     o [http://www.psychiatry.org](http://www.psychiatry.org) > Psychiatrists > Practice > Clinical Practice Guidelines
   - Youth with oppositional defiant disorder have been found to have higher rates of comorbid psychiatric disorders, such as attention-deficit/hyperactivity disorder, anxiety disorders, mood disorders, thought disorders, and learning problems (American Academy of Child and Adolescent Psychiatry [AACAP] 2007; 2019).
     o Assessment includes information obtained from the child and parents regarding core symptoms, age of onset, duration of symptoms, and degree of functional impairment (AACAP, 2007).
     o Symptoms occur in multiple settings and may be more pronounced at home or school (AACAP, 2019).
     o It is most common that ODD symptoms are identified by late pre-school or early elementary school; symptoms can also begin in adolescence (Riley et al., 2016).
     o Research evidence shows that many factors are associated with the etiology of ODD such as genetics, nicotine use by parents, prenatal nutritional deficiency, insecure attachment and unresponsive parents (Riley et al., 2016).
   - Diagnostic tools for attention-deficit/hyperactivity disorder, such as the Vanderbilt ADHD Diagnostic Parent Rating Scale and the Conners 3 scales, have comorbidity screening scales that can help in identifying oppositional defiant disorder (Riley et al., 2016).

B. Differential diagnosis for Oppositional Defiant Disorder includes (Diagnostic and Statistical Manual of Mental Disorders 5th ed.; DSM-5; APA, 2013):
   - Conduct disorder;
   - Attention-deficit/hyperactivity disorder;
   - Depressive and bipolar disorders;
   - Disruptive mood dysregulation disorder;
   - Intermittent explosive disorder;
   - Intellectual disability;
   - Language disorder;
   - Social anxiety disorder.

C. Treatment planning
   - Optum recognizes the American Psychiatric Association’s Practice Guidelines for the Psychiatric Evaluation of Adults (2016):
     o [http://www.psychiatry.org](http://www.psychiatry.org) > Psychiatrists > Practice > Clinical Practice Guidelines
   - Successful assessment and treatment require establishing therapeutic alliances with both the child and family (American Academy of Child and Adolescent Psychiatry, 2007).
   - Children with oppositional defiant disorder who are not treated are at increased risk for conduct disorder, substance abuse, and delinquency (DSM-5, 2013).
   - Early intervention may help to prevent other disorders (Riley et al., 2016).
   - The most effective treatment plans are customized for both the child and the family (Riley et al., 2016).
   - Psychosocial interventions that are proven and effective include parental management training, school-based training, functional family therapy/ brief strategic family therapy, and cognitive behavior therapy (Ghosh et al., 2017).
     o In school-age children, parent management strategies (e.g., psychoeducational packages targeting social skills, conflict resolution, anger management) are the most empirically supported programs (American Academy of Child and Adolescent Psychiatry, 2016).
Additional psychosocial options include (Ghosh et al., 2017):

- In schools, teachers’ training for behavioral interventions
- Peer groups and peer-mediated interventions
- Social awareness and guidance
- In adolescence, cognitive interventions and skills training, vocational training, and academic preparations appear to reduce disruptive behaviors (AACAP, 2007).
- In children greater than 8 years old, the most beneficial interventions are family-based such as brief strategic family therapy and multicomponent interventions such as multisystemic therapy (Ghosh et al., 2017).
- Medication alone has not been proven effective in treating oppositional defiant disorder, however it may be helpful as an adjunct to treatment packages, for symptomatic treatment, and for treatment of comorbid conditions (AACAP 2018; Ghosh et al., 2017; Riley et al., 2016).

Experts agree that therapies such as boot camps or scare tactics are not effective for children and adolescents with oppositional defiant disorder, and may do more harm than good (AACAP, 2007).

**Impulse-Control Disorders**

**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 > Clinical Practice Guidelines

- The DSM-5 (2013) describes intermittent explosive disorder (IED) as recurrent verbal and physical aggressive outbursts that are not premeditated and cause significant distress.
  - IED has developed as a specific predictor of suicide attempt (Fanning et al., 2016).
  - IED is associated with the following such as substantial comorbidity, particularly posttraumatic stress disorder, predictor for aggressive behavior and lifetime suicide attempts (Fanning et al., 2016).
  - Tools such as the screening questionnaire for DSM-5 intermittent explosive disorder (IED-SQ) have been developed to identify intermittent explosive disorder (Coccaro et al., 2017).
  - The Minnesota Impulse Control Disorders Interview (MIDI) can be used to screen impulse control disorders including IED (Chamberlain & Grant, 2018).

- The DSM-5 (2013) describes pyromania as deliberate and intentional firesetting on more than one occasion.
  - The Minnesota Impulse Control Disorders Interview (MIDI) can be used to screen impulse control disorders including pyromania/firesetting behaviors (Chamberlain & Grant, 2018).
  - Mental health issues are contributing factors to firesetting behaviors such as substance misuse, impulse control problems, increased aggression, history of abuse and/or emotional neglect (Porth et al., 2018).

- The DSM-5 (2013) defines kleptomania as recurrent, impulsive stealing behavior of objects that are not needed for personal or monetary use.
  - The Structured Clinical Interview for Kleptomania (SCI-K) can be used to diagnose kleptomania (Grant & Chamberlain, 2018).
  - Currently there is limited data regarding the etiology of kleptomania, in addition, there is no robust research regarding effective psychosocial interventions and overall treatment options (Grant & Chamberlain, 2018).

**B. Differential diagnosis for Impulse-Control Disorders includes (DSM-5, 2013):**

- Disruptive mood dysregulation disorder;
- Antisocial personality disorder or borderline personality disorder;
- Substance intoxication or withdrawal;
- Attention-deficit/hyperactivity disorder;
- Autism spectrum disorder;
Oppositional defiant disorder or conduct disorder.

C. Treatment planning
- 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 > Clinical Practice Guidelines

- Treatment for intermittent explosive disorder often includes multicomponent cognitive-behavioral therapy and/or SSRI antidepressants (McCloskey et al., 2011).
- In general, interventions for juvenile firesetting have included educational programs and interventions based in cognitive behavior therapy (CBT) (Porth et al., 2018).
  - Programs for dangerous firesetting behaviors are limited as well as the available research. There is also a lack of consensus among professionals in education, healthcare, and community, making treatment planning more difficult (Porth et al., 2018).
  - Fear as a tactic to resolve firesetting behaviors is considered ineffective as the brain is not being fully developed in youth (Porth et al., 2018).

Conduct Disorder

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 > Clinical Practice Guidelines

- Many children with a conduct disorder (CD) may have coexisting conditions, such as mood or anxiety disorder, posttraumatic stress disorder, substance abuse, attention-deficit/hyperactivity disorder, and learning problems (AACAP, 2018).
  - Comorbid diagnoses such as ADHD and oppositional defiant disorder are common in individuals diagnosed with CD; these comorbid diagnoses make early intervention essential in preventing problematic outcomes in adulthood (AACAP, 2018; DSM-5, 2013).
- Research reveals that children and adolescents diagnosed with conduct disorder are more likely to experience negative outcomes in adulthood such as criminal behavior, social dysfunction, substance misuse, and psychopathology (McGonigal et al., 2019).
- Assessment should be multifaceted, including information from the school and other agencies, the carers, parents, peer groups, and the child (National Institute for Health and Care Excellence [NICE], 2017).

B. Differential diagnosis for conduct disorder includes (DSM-5, 2013):
- Oppositional defiant disorder;
- Attention-deficit/hyperactivity disorder;
- Depressive and bipolar disorders;
- Intermittent explosive disorder;
- Adjustment disorders.

C. Treatment planning
- 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 > Clinical Practice Guidelines

- In developing a comprehensive treatment plan, information from the child, family, teachers, and other medical specialties is used to understand the causes of the disorder and any coexisting conditions (NICE, 2017).
- Parent training programs are recommended either group or individual settings to improve parenting skills (NICE, 2017).
- Treatment of conduct disorder can be complex and challenging, and is dependent on the severity of symptoms (AACAP, 2018).
• Behavior therapy and psychotherapy are typically required to help the child appropriately express and control anger (AACAP, 2018).
• A multimodal approach is recommended for young people ages 11-17 years old (NICE, 2018).
  o For young children, parent management training is recommended (NICE, 2017).
  o Multisystemic therapy is an effective intervention for both adolescents and the family with serious conduct disorders (AACAP, 2018).
• Early treatment offers a better chance for improvement (AACAP, 2018).
• Pharmacology intervention is not recommended routinely; medication administration is focused on severely aggressive behavior, explosive anger, and for those individuals who have not responded to psychosocial interventions (NICE, 2017).

**APPLICABLE CODES**

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member-specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other clinical criteria may apply.

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>F63.1</td>
<td>Pyromania</td>
</tr>
<tr>
<td>F63.2</td>
<td>Kleptomania</td>
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<tr>
<td>F63.81</td>
<td>Intermittent Explosive Disorder</td>
</tr>
<tr>
<td>F91.1</td>
<td>Conduct Disorder: Childhood-onset type</td>
</tr>
<tr>
<td>F91.2</td>
<td>Conduct Disorder: Adolescent-onset type</td>
</tr>
<tr>
<td>F91.3</td>
<td>Oppositional Defiant Disorder</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>90785</td>
<td>Interactive complexity (list separately in addition to the code for primary psychiatric procedure)</td>
</tr>
<tr>
<td>90791</td>
<td>Psychiatric diagnostic evaluation</td>
</tr>
<tr>
<td>90792</td>
<td>Psychiatric diagnostic evaluation with medical services</td>
</tr>
<tr>
<td>90832</td>
<td>Psychotherapy, 30 minutes with patient</td>
</tr>
<tr>
<td>90833</td>
<td>Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)</td>
</tr>
<tr>
<td>90834</td>
<td>Psychotherapy, 45 minutes with patient</td>
</tr>
<tr>
<td>90836</td>
<td>Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)</td>
</tr>
<tr>
<td>90837</td>
<td>Psychotherapy, 60 minutes with patient</td>
</tr>
<tr>
<td>90838</td>
<td>Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)</td>
</tr>
<tr>
<td>90839</td>
<td>Psychotherapy for crisis; first 60 minutes</td>
</tr>
<tr>
<td>90840</td>
<td>Psychotherapy for crisis; each additional 30 minutes (list separately in addition to the code for primary service)</td>
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<tr>
<td>90846</td>
<td>Family psychotherapy (without the patient present), 50 minutes</td>
</tr>
<tr>
<td>90847</td>
<td>Family psychotherapy (conjoint psychotherapy) (with the patient present), 50 minutes</td>
</tr>
<tr>
<td>90849</td>
<td>Multiple-family group psychotherapy</td>
</tr>
<tr>
<td>90853</td>
<td>Group psychotherapy (other than of a multiple-family group)</td>
</tr>
<tr>
<td>90863</td>
<td>Pharmacologic management, including prescription and review of medication,</td>
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when performed with psychotherapy services (List separately in addition to the code for primary procedure)

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>G0177</td>
<td>Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)</td>
</tr>
<tr>
<td>G0410</td>
<td>Group psychotherapy other than of a multiple-family group, in a partial hospitalization setting, approximately 45 to 50 minutes</td>
</tr>
<tr>
<td>G0411</td>
<td>Interactive group psychotherapy, in a partial hospitalization setting, approximately 45 to 50 minutes</td>
</tr>
<tr>
<td>H0004</td>
<td>Behavioral health counseling and therapy, per 15 minutes</td>
</tr>
<tr>
<td>H0017</td>
<td>Behavioral health; residential (hospital residential treatment program), without room and board, per diem</td>
</tr>
<tr>
<td>H0018</td>
<td>Behavioral health; short-term residential (nonhospital residential treatment program), without room and board, per diem</td>
</tr>
<tr>
<td>H0019</td>
<td>Behavioral health; long-term residential (nonmedical, nonacute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem</td>
</tr>
<tr>
<td>H0025</td>
<td>Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)</td>
</tr>
<tr>
<td>H0035</td>
<td>Mental health partial hospitalization, treatment, less than 24 hours</td>
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<tr>
<td>H2001</td>
<td>Rehabilitation program, per 1/2 day</td>
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<tr>
<td>H2011</td>
<td>Crisis intervention service, per 15 minutes</td>
</tr>
<tr>
<td>H2012</td>
<td>Behavioral health day treatment, per hour</td>
</tr>
<tr>
<td>H2013</td>
<td>Psychiatric health facility service, per diem</td>
</tr>
<tr>
<td>H2017</td>
<td>Psychosocial rehabilitation services, per 15 minutes</td>
</tr>
<tr>
<td>H2018</td>
<td>Psychosocial rehabilitation services, per diem</td>
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<tr>
<td>H2019</td>
<td>Therapeutic behavioral services, per 15 minutes</td>
</tr>
<tr>
<td>H2020</td>
<td>Therapeutic behavioral services, per diem</td>
</tr>
<tr>
<td>H2033</td>
<td>Multisystemic therapy for juveniles, per 15 minutes</td>
</tr>
<tr>
<td>S0201</td>
<td>Partial hospitalization services, less than 24 hours, per diem</td>
</tr>
<tr>
<td>S9480</td>
<td>Intensive outpatient psychiatric services, per diem</td>
</tr>
<tr>
<td>S9482</td>
<td>Family stabilization services, per 15 minutes</td>
</tr>
<tr>
<td>S9484</td>
<td>Crisis intervention mental health services, per hour</td>
</tr>
<tr>
<td>S9485</td>
<td>Crisis intervention mental health services, per diem</td>
</tr>
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REFERENCES


### REVISION HISTORY

<table>
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<tr>
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<td>02/14/2017</td>
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<tr>
<td>03/14/2018</td>
<td>Annual Update: Updates to formatting and references</td>
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<tr>
<td>05/20/2019</td>
<td>Annual Update: Updates to formatting and references</td>
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<td>03/16/2020</td>
<td>Annual Review and update</td>
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