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.

COVERAGE RATIONALE

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**
Conditions classified in the current edition of the *International Classification of Diseases* section on Mental and Behavioral Disorders or *Diagnostic and Statistical Manual of the American Psychiatric Association* that are not excluded from coverage.

**Indications for Coverage**

**Oppositional Defiant Disorder**

A. Initial evaluation and best practices

- 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)

- 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, and substance abuse (American Academy of Child and Adolescent Psychiatry, 2007).
  - Assessment includes information obtained from the child and parents regarding core symptoms, age of onset, duration of symptoms, and degree of functional impairment (American Academy of Child and Adolescent Psychiatry, 2007).

- 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 (American Psychiatric Association, 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 and best practices

- 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)

- 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 (American Academy of Child and Adolescent Psychiatry, 2009).

- Early intervention may help to prevent other disorders (Riley et al., 2016).

- The most effective treatment plans are tailored to the needs and behavioral symptoms of each child (American Academy of Child and Adolescent Psychiatry, 2009).

- Treatment often consists of a combination of therapies, including behavioral therapy, parent training, and family therapy. (American Academy of Child and Adolescent Psychiatry, 2009)
  - 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 2007; Riley et al., 2016).
  - In adolescence, cognitive interventions and skills training, vocational training, and academic preparations appear to reduce disruptive behaviors (American Academy of Child and Adolescent Psychiatry, 2007).
  - 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 (American Academy of Child and Adolescent Psychiatry 2009; 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 (American Academy of Child and Adolescent Psychiatry, 2009).

Impulse-Control Disorders

A. Initial evaluation and best practices

- 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
- Intermittent explosive disorder (IED) has emerged as a specific predictor of suicide attempt (Fanning et al., 2016).
- IED is associated with substantial comorbidity, particularly posttraumatic stress disorder, and its presence should be assessed when evaluating individuals with trauma exposure (Reardon et al., 2014).
- Tools such as the screening questionnaire for DSM-5 intermittent explosive disorder (IED-SQ) can be useful to identify the presence of intermittent explosive disorder (Coccaro et al., 2017).
- Conduct disorder and attention-deficit/hyperactivity disorder have been associated with juvenile firesetting in some studies (Peters & Freeman, 2016).
- The adult literature has suggested an association between psychiatric illness and firesetting behavior, particularly affective disorders and substance use disorders (Peters & Freeman, 2016).

B. Differential diagnosis for Impulse-Control Disorders includes (American Psychiatric Association, 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 and best practices

- Treatment for intermittent explosive disorder often includes multicomponent cognitive-behavioral therapy (e.g., McCloskey et al., 2008) and/or SSRI antidepressants (e.g., Coccaro et al., 2009).
- In general, interventions for juvenile firesetting have included educational programs and interventions based in cognitive behavior therapy (CBT) (Peters & Freeman, 2016).
  - Little is known about short-term and long-term effectiveness and efficacies of the available treatments for arsonists (Horley & Bowlby, 2011).

Conduct Disorder

A. Initial evaluation and best practices

- 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
- Many children with a conduct disorder may have coexisting conditions, such as mood or anxiety disorder, posttraumatic stress disorder, substance abuse, attention-deficit/hyperactivity disorder, and learning problems (American Academy of Child and Adolescent Psychiatry 2013; Morcillo et al., 2012; Silberg et al., 2015; Tandon & Giedinghagen, 2017).
  - Higher severity of conduct disorder increases risk of comorbid disorders (Morcillo et al., 2012).
• Child-onset Conduct Disorder predicts later educational and legal issues (Tandon & Giedinghagen, 2017).
• Assessment should be multifaceted, including information from the school and other agencies, the carers, and the child (Baker, 2016).

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

C. Treatment planning and best practices
• Optum recognizes the American Psychiatric Association’s Practice Guidelines for the Psychiatric Evaluation of Adults (2016):
  o 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 (American Academy of Child and Adolescent Psychiatry, 2013).
• Engagement of the family is important, because dropout from treatment is high (National Collaborating Center for Mental Health, 2013).
• Treatment of conduct disorder can be complex and challenging, especially if long-standing (Baker, 2016). Behavior therapy and psychotherapy are usually necessary to help the child appropriately express and control anger (American Academy of Child and Adolescent Psychiatry, 2013). A multimodal approach is likely to see greater changes (National Collaborating Center for Mental Health, 2013).
  o For young children, parent management training has the strongest support (Baker, 2016; Tandon & Giedinghagen, 2017).
  o Multisystemic therapy is the most promising intervention for adolescents with serious conduct disorders (Baker, 2016).
• Early treatment offers a better chance for improvement (American Academy of Child and Adolescent Psychiatry, 2013; Tandon & Giedinghagen, 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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<tr>
<td>F91.3</td>
<td>Oppositional Defiant Disorder</td>
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<tr>
<td>F63.81</td>
<td>Intermittent Explosive Disorder</td>
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<tr>
<td>F91.1</td>
<td>Conduct Disorder: Childhood-onset type</td>
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<td>F91.2</td>
<td>Conduct Disorder: Adolescent-onset type</td>
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<td>F63.1</td>
<td>Pyromania</td>
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<td>F63.2</td>
<td>Kleptomania</td>
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<th>Procedure Codes</th>
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<tr>
<td>90785</td>
<td>Interactive complexity (list separately in addition to the code for primary procedure)</td>
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<td>90791</td>
<td>Psychiatric diagnostic evaluation</td>
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<td>90792</td>
<td>Psychiatric diagnostic evaluation with medical services</td>
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<tr>
<td>90832</td>
<td>Psychotherapy, 30 minutes with patient</td>
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<td>Procedure Code</td>
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<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>
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<td>Psychotherapy, 45 minutes with patient</td>
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<td>90836</td>
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<td>90837</td>
<td>Psychotherapy, 60 minutes with patient</td>
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<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>
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<td>90839</td>
<td>Psychotherapy for crisis; first 60 minutes</td>
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<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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<td>90846</td>
<td>Family psychotherapy (without the patient present), 50 minutes</td>
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<td>90847</td>
<td>Family psychotherapy (conjoint psychotherapy) (with the patient present), 50 minutes</td>
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<td>90849</td>
<td>Multiple-family group psychotherapy</td>
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<tr>
<td>90853</td>
<td>Group psychotherapy (other than of a multiple-family group)</td>
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<tr>
<td>90863</td>
<td>Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure)</td>
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</table>
S9482 Family stabilization services, per 15 minutes
S9484 Crisis intervention mental health services, per hour
S9485 Crisis intervention mental health services, per diem

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REFERENCES


**REVISION HISTORY**

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