Optum
Coverage Determination Guideline

DISRUPTIVE, IMPULSE-CONTROL & CONDUCT DISORDERS

Policy Number: BH727DICCD_032018 **Effective Date**: March 14, 2018

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Relevant Diagnoses

- Oppositional Defiant Disorder
- Intermittent Explosive Disorder
- Conduct Disorder
- Pyromania
- Kleptomania

Related Behavioral Clinical Policies & Guidelines:

- Neurodevelopmental Disorders
- Anxiety Disorders
- Personality Disorders
- Other Specified and Unspecified Disorders

BENEFIT CONSIDERATIONS

Before using this document, please check the member's specific benefit plan requirements 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).

EVIDENCE-BASED CLINICAL GUIDELINES

Oppositional Defiant Disorder

A. Initial evaluation
- See "*Common Criteria and Best Practices for All Levels of Care*", available at: **https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html**
- 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
- 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
- See "*Common Criteria and Best Practices for All Levels of Care*", available at: **https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html**
- 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
- 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 deliquency (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 symtoms of each child (American Academy of Child and Adolescent Psychiatry 2009).

D. Treatment of oppositional defiant disorder
- 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 (Riley et al 2016; American Academy of Child and Adolescent Psychiatry 2007).
    - 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 (Riley et al 2016; American Academy of Child and Adolescent Psychiatry 2009; 2007).
- 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).

E. Discharge planning
- see "*Common Criteria and Best Practices for All Levels of Care*": **https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html**

Impulse-Control Disorders

This section is applicable in the event that the member's Impulse-Control Disorder (e.g., Intermittent Explosive Disorder, Pyromania, Kleptomania) or its treatments are covered:

A. Initial evaluation
- See "*Common Criteria and Best Practices for All Levels of Care*", available at: **https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html**
- 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
- See "*Common Criteria and Best Practices for All Levels of Care*", available at: **https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html**
- 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

D. Treatment of impulse-control disorders
- 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).

E. Discharge planning
- See "*Common Criteria and Best Practices for All Levels of Care*": **https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html**

Conduct Disorder

This section is applicable in the event that the member's Conduct Disorder or its treatments are covered:

A. Initial evaluation
- See "Common Criteria and Best Practices for All Levels of Care", available at: **https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html**
- 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 (Silberg et al 2015; American Academy of Child and Adolescent Psychiatry 2013; Morcillo et al 2012).
    - Higher severity of conduct disorder increases risk of comorbid disorders (Morcillo et al 2012).
- 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
- See "*Common Criteria and Best Practices for All Levels of Care*", available at: **https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html**
- 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
- 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)

D. Treatment of conduct disorder
- 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 moltimodal approach is likely to see greater changes (National Collaborating Center for Mental Health 2013).
    - For young children, parent management training has the strongest support (Baker 2016).
    - 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).

F. Discharge planning

- See "*Common Criteria and Best Practices for All Levels of Care*": **https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html**

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 guideline 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 policies and guidelines may apply.

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

HCPCS Code	Description
G0177	Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)
G0410	Group psychotherapy other than of a multiple-family group, in a partial hospitalization setting, approximately 45 to 50 minutes
G0411	Interactive group psychotherapy, in a partial hospitalization setting, approximately 45 to 50 minutes
H0004	Behavioral health counseling and therapy, per 15 minutes
H0017	Behavioral health; residential (hospital residential treatment program), without room and board, per diem
H0018	Behavioral health; short-term residential (nonhospital residential treatment program), without room and board, per diem
H0019	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
H0025	Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)

HCPCS Code	Description
H0035	Mental health partial hospitalization, treatment, less than 24 hours
H2001	Rehabilitation program, per 1/2 day
H2011	Crisis intervention service, per 15 minutes
H2012	Behavioral health day treatment, per hour
H2013	Psychiatric health facility service, per diem
H2017	Psychosocial rehabilitation services, per 15 minutes
H2018	Psychosocial rehabilitation services, per diem
H2019	Therapeutic behavioral services, per 15 minutes
H2020	Therapeutic behavioral services, per diem
H2033	Multisystemic therapy for juveniles, per 15 minutes
S0201	Partial hospitalization services, less than 24 hours, per diem
S9480	Intensive outpatient psychiatric services, per diem
S9482	Family stabilization services, per 15 minutes
S9484	Crisis intervention mental health services, per hour
S9485	Crisis intervention mental health services, per diem

ICD-10 Diagnosis Code	ICD-10 CM Description
F91.3	Oppositional Defiant Disorder
F63.81	Intermittent Explosive Disorder
F91.1	Conduct Disorder: Childhood-onset type
F91.2	Conduct Disorder: Adolescent-onset type
F63.1	Pyromania
F63.2	Kleptomania

LEVEL OF CARE GUIDELINES

Optum / OptumHealth Behavioral Solutions of California Level of Care Guidelines are available at: https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html

The Level of Care Guidelines are a set of objective and evidence-based behavioral health guidelines used to standardize coverage determinations, promote evidence-based practices, and support members' recovery, resiliency, and wellbeing.

UNITEDHEALTHCARE BENEFIT PLAN DEFINITIONS

For plans using 2001 and 2004 generic UnitedHealthcare COC/SPD, unless otherwise specified
Covered Health Service(s)
Those health services provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance abuse, or their symptoms.

A Covered Health Service is a health care service or supply described in *Section 1: What's Covered--Benefits as a Covered Health Service*, which is not excluded under *Section 2: What's Not Covered--Exclusions*.

For plans using 2007 and 2009 generic UnitedHealthcare COC/SPD, unless otherwise specified
Covered Health Service(s)
Those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance abuse, or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Described in the *Certificate of Coverage* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.

- Not otherwise excluded in the *Certificate of Coverage* under *Section 2: Exclusions and Limitations*.

In applying the above definition, "scientific evidence" and "prevailing medical standards" shall have the following meanings:

- "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
- "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

For plans using 2011 and more recent generic UnitedHealthcare COC/SPD, unless otherwise specified
Covered Health Care Service(s) - health care services, including supplies or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Care Service in the *Certificate* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
- Not excluded in the *Certificate* under *Section 2: Exclusions and Limitations.*

Medically Necessary **-** health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following as determined by us or our designee.

- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Doctor specialty society recommendations or professional standards of care may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Doctor specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

We develop and maintain clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services.

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*Additional reference materials can be found in the reference section(s) of the applicable Level of Care Guidelines

HISTORY/REVISION INFORMATION

Date	Action/Description
02/14/2017	• Version 1
3/14/2018	• Annual Update: Updates to formatting and references