INSTRUCTIONS FOR USE

This Coverage Determination Guideline provides assistance in interpreting behavioral health benefit plans that are managed by Optum. This Coverage Determination Guideline is also applicable to behavioral health benefit plans managed by Pacificare Behavioral Health and U.S. Behavioral Health Plan, California (doing business as Optum California ("Optum-CA"). When deciding coverage, the enrollee specific document must be referenced. The terms of an enrollee’s document (e.g., Certificates of Coverage (COCs), Schedules of Benefits (SOBs), or Summary Plan Descriptions (SPDs) may differ greatly from the standard benefit plans upon which this guideline is based. 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 document and the COC/SPD, the enrollee’s specific benefit document supersedes these guidelines.

All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements that supersede the COC/SPD and the plan benefit coverage prior to use of this guideline. Other coverage determination guidelines and clinical guideline may apply.

Optum reserves the right, in its sole discretion, to modify its coverage determination guidelines and clinical guidelines as necessary.

While this Coverage Determination Guideline does reflect Optum’s understanding of current best practices in care, it does not constitute medical advice.
Key Points

- According to the DSM, the essential feature of Adjustment Disorders is the development of clinically significant emotional or behavioral symptoms in response to an identifiable psychosocial stressor or stressors occurring within 3 months of the onset of the stressor. These symptoms may be characterized by marked distress, in excess of what would be expected from exposure to the stressor, and significant impairment in social or occupational functioning. Triggering stressors may include family or marital conflict, academic or work problems, financial difficulties, major life changes and health problems (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (Diagnostic and Statistical Manual of Mental Disorders, 5th ed.; DSM-5; American Psychiatric Association (DSM-5), 2013).

- Subtypes include Adjustment Disorder with depressed mood, anxiety, mixed anxiety and depressed mood, disturbance of conduct, mixed disturbance of emotions and conduct, and unspecified (DSM-5, 2013).

- Benefits are available for covered services that are not otherwise limited or excluded.

- Pre-notification is required for inpatient, residential treatment center, intensive outpatient, or partial hospital/day treatment programs.

- Services should be consistent with evidence-based interventions and clinical best practices as described in Part II, and should be of sufficient intensity to address the member's needs (Certificate of Coverage, 2007, 2009 & 2011).

PART I: BENEFITS

Before using this guideline, please check enrollee’s specific plan document and any federal or state mandates, if applicable.

Benefits

Benefits include the following services:

- Diagnostic evaluation and assessment
- Treatment planning
- Referral services
- Medication management
- Individual, family, therapeutic group and provider-based case management services
- Crisis intervention

Covered Services

Covered Health Service(s) – 2001

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.
Covered Health Service(s) – 2007, 2009 and 2011

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 this Certificate of Coverage under Section 1: Covered Health Services and in the Schedule of Benefits.
- Not otherwise excluded in this 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.

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.

Limitations and Exclusions

The requested service or procedure for the treatment of a mental health condition must be reviewed against the language in the enrollee's benefit document. When the requested service or procedure is limited or excluded from the enrollee’s benefit document, or is otherwise defined differently, it is the terms of the enrollee’s benefit document that prevails.

Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and are therefore considered experimental.
- Not consistent with the Mental Health/Substance Use Disorder Designee’s level of care guidelines or best practice guidelines as modified from time to time.
- Not clinically appropriate for the member’s Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.

Additional Information

The lack of a specific exclusion that excludes coverage for a service does not imply that the service is covered. The following are examples of services that are inconsistent with the Level of Care Guidelines and Best Practice Guidelines (not an all inclusive list):

- Services that deviate from the indications for coverage summarized earlier in this document.
- Admission to an inpatient, residential treatment, partial hospital/day treatment program or intensive outpatient program without evidence-based treatment of acute symptoms.
- Admission to an inpatient, residential treatment, partial hospital/day treatment program or intensive outpatient program for the sole purpose of awaiting placement in a long-term facility.
- Admission to an inpatient, residential treatment, partial hospital/day treatment program or intensive outpatient program that does not provide adequate nursing care and monitoring, or physician coverage.
- The use of psychological or neuropsychological testing when a diagnostic or treatment planning question can be answered by means of a standard interview and behavior rating scale assessment.

Please refer to the enrollee’s benefit document for ASO plans with benefit language other than the generic benefit document language.

PART II: CLINICAL BEST PRACTICES

Evaluation and Treatment Planning

1. The initial evaluation:
1.1. Gathers information about the presenting issues from the member's perspective, and includes the member’s understanding of the factors that lead to requesting services (i.e., the “why now” factors).

1.2. Focuses on the member’s specific needs.

1.3. Identifies the member’s goals and expectations.

1.4. Is completed in a timeframe commensurate with the member’s needs, or otherwise in accordance with clinical best practices.

1.5. The provider collects information from the member and other sources, and completes an initial evaluation of the following:

1.5.1.1. The member’s chief complaint;
1.5.1.2. The history of the presenting illness;
1.5.1.3. The “why now” factors leading to the request for service;
1.5.1.4. The member’s mental status;
1.5.1.5. The member’s current level of functioning;
1.5.1.6. Urgent needs including those related to the risk of harm to self, others, or property;
1.5.1.7. The member’s use of alcohol, tobacco, or drugs;
1.5.1.8. Co-occurring behavioral health and physical conditions;
1.5.1.9. The history of behavioral health services;
1.5.1.10. The history of trauma;
1.5.1.11. The member’s medical history and current physical health status;
1.5.1.12. The member’s developmental history;
1.5.1.13. Pertinent current and historical life information including the member’s:
   1.5.1.13.1. Age;
   1.5.1.13.2. Gender, sexual orientation;
   1.5.1.13.3. Culture;
   1.5.1.13.4. Spiritual beliefs;
   1.5.1.13.5. Educational history;
   1.5.1.13.6. Employment history;
   1.5.1.13.7. Living situation;
   1.5.1.13.8. Legal involvement;
   1.5.1.13.9. Family history;
1.5.1.13.10. Relationships with family and other natural resources;
1.5.1.14. The member's strengths;
1.5.1.15. Barriers to care;
1.5.1.16. The member's instructions for treatment, or appointment of a representative to make decisions about treatment;
1.5.1.17. The member's broader recovery, resiliency and wellbeing goals.

1.6. The provider uses the findings of the evaluation to assign a DSM/ICD diagnosis.

2. Evaluation of Adjustment Disorder

2.1. If the standard evaluation suggests Adjustment Disorder, clinicians should complete an evaluation focused on the following areas:

2.1.1. Identification of specific stressors causing impairment (Psychopharmacology Treatment Planner, Adjustment Disorder, 2007).

2.1.2. Assessment of current symptoms. Common symptoms of Adjustment Disorder include (Frank, 2014):

2.1.2.1. Sadness
2.1.2.2. Anxiety
2.1.2.3. Insomnia
2.1.2.4. Poor concentration
2.1.2.5. Loss of self-esteem, isolated, hopeless
2.1.2.6. Children often exhibit depressed or irritable mood, sleep disturbances and poor performance in school.

2.1.3. The use of measurement tools such as the Adjustment Disorder New Module -20 (ADNM-20) (Glaesmer, 2015), Beck Depression Inventory (BDI), Hamilton Depression Rating Scale (HDRS), Montgomery Asberg Depression Rating Scale (MADRS), GAD-7, Hamilton Anxiety Rating Scale (HARS), and Structured Clinical Interview for DSM disorders (SCID) (Osborne, Raetz & Kost, 2014) that are indicated for Adjustment Disorder (Psychopharmacology Treatment Planner, 2007).
2.2. Acute stress from a loss, event, or new medical diagnosis is the most common trigger of Adjustment Disorder. Limited coping skills may also result in a higher degree of distress. (Osborne, Raetz & Kost, 2014)

2.3. Though the course of Adjustment Disorders is usually brief, the symptoms can be quite severe and may include suicidal ideation; when compared to patients with Major Depression, individuals with Adjustment Disorders have a shorter interval between the appearance of their first symptoms and the time of a suicide attempt (Powell, 2015). Assessment of suicidality should be included as part of the evaluation to include (APA Psychiatric Evaluation, 2016):

2.3.1. Current suicidal ideas, suicide plans, and suicide intent, including active or passive thoughts of suicide or death

2.3.2. Prior suicidal ideas, suicide plans, and suicide attempts, including attempts that were aborted or interrupted

2.3.3. Prior intentional self-injury in which there was no suicide intent

2.3.4. Anxiety symptoms, including panic attacks

2.3.5. Hopelessness

2.3.6. Impulsivity

2.3.7. History of psychiatric hospitalization and emergency department visits for psychiatric issues

2.3.8. Current or recent substance use disorder or change in use of alcohol or other substances

2.3.9. Presence of psychosocial stressors (e.g., financial, housing, legal, school/occupational or interpersonal/relationship problems; lack of social support; painful, disfiguring, or terminal medical illness)

2.3.10. Current aggressive or psychotic ideas, including thoughts of physical or sexual aggression or homicide

2.3.11. Mood, level of anxiety, thought content and process, and perception and cognition

2.3.12. Past and current psychiatric diagnoses

2.3.13. Trauma history
2.4. The DSM-5 notes that symptoms may persist for longer than 6 months if they occur in response to a chronic stressor or to a stressor that has enduring consequences.

3. Differential Diagnosis

3.1. Differential diagnoses may include a normal stress response, acute stress reaction that develops within 3 days of the stressor and resolves by 1 month, depression that does not fit the diagnostic criteria of Major Depressive Disorder, bereavement, Personality Disorders, Anxiety, and PTSD. Hypothyroidism should also be considered (Osborne, Raetz & Kost, 2014).

3.2. Comorbidities and symptom overlap with other conditions are often present with Adjustment Disorder. The differential diagnosis should take into account the possible presence of the following conditions prior to confirming Adjustment Disorder (Psychopharmacology Treatment Planner, 2007):

3.3. Post-Traumatic Stress Disorder
3.4. Anxiety Disorders
3.5. Substance Use Disorders
3.6. Medical Conditions

4. Treatment Planning

4.1. The provider and, whenever possible, the member use the findings of the initial evaluation and the diagnosis to develop a treatment plan. The treatment plan addresses:

4.1.1. The short- and long-term goals of treatment;

4.1.2. The type, amount, frequency and duration of treatment;

4.1.3. The expected outcome for each problem to be addressed expressed in terms that are measurable, functional, time-framed and directly related to the “why now” factors;

4.1.4. How the member’s family and other natural resources will participate in treatment when clinically indicated;

4.1.5. How treatment will be coordinated with other providers as well as with agencies or programs with which the member is involved.

4.2. As needed, the treatment plan also includes interventions that enhance the member’s motivation, promote informed decisions, and support the member’s recovery, resiliency, and wellbeing.
4.2.1. Examples include psychoeducation, motivational interviewing, recovery and resiliency planning, advance directive planning, and facilitating involvement with self-help and wraparound services.

4.3. The provider informs the member of safe and effective treatment alternatives, as well as the potential risks and benefits of the proposed treatment. The member gives informed consent acknowledging willingness and ability to participate in treatment and abide by safety precautions.

4.4. Treatment focuses on addressing the “why now” factors to the point that the member’s condition can be safely, efficiently, and effectively treated in a less intensive level of care, or the member no longer requires care.

4.5. The treatment plan and level of care are reassessed when the member’s condition improves, worsens or does not respond to treatment.

4.5.1. When the member’s condition has improved, the provider determines if the treatment plan should be altered, or if treatment is no longer required.

4.5.2. When the member’s condition has worsened or not responded to treatment, the provider verifies the diagnosis, alters the treatment plan, or determines if the member’s condition should be treated in another level of care.

4.5.3. In the event that all information is unavailable at the time of the evaluation, there must be enough information to provide a basis for the diagnosis, guide the development of the treatment plan, and support the need for treatment in the proposed level of care.

**Treatment Interventions** The predominant mood accompanying Adjustment Disorder (e.g., depression or anxiety) is a major consideration for both pharmacologic and supportive therapy. Clinicians should consider both psychotherapy and pharmacotherapy for patients who have Adjustment Disorder with depressed or anxious mood (Frank, 2014).

1. **Psychotherapy**

   1.1. Although based on consensus opinion rather than on controlled trials, interventions for Adjustment Disorder should be aimed at reducing the stressor(s), improving coping ability, and creating an emotional state and support system to enhance adaptation and coping (Carta, Balestrieri, Murru & Hardoy, 2009).
1.2. The most commonly agreed upon forms of therapy include cognitive behavioral therapy (CBT), interpersonal psychotherapy, brief dynamic therapy, and brief supportive therapy (Optum BHS Brief Review, 2013).

1.3. Brief problem-solving therapy that combines interpersonal therapy with solution-focused goals may also help members with adjustment disorder (Osborne, Raetz & Kost, 2014).

1.4. Regardless of the chosen method, the goals of psychotherapy include (Ali, 2007):

1.4.1. Identifying stressors and determining whether they can be eliminated or minimized

1.4.2. Clarifying and reframing the meaning of the stressors

1.4.3. Identifying strategies to reduce stressors

1.4.4. Maximizing the patient’s coping skills

1.4.5. Assisting the patient manage stressors and engaging a support network that may include the participation in support groups.

1.5. Individual therapy can help the patient identify his or her maladaptive responses to the stressor, maximize the use of his or her strengths, and provide support. Group psychotherapy can be particularly helpful for individuals who share a common stressor (Powell, 2015).

1.6. Improvement should be measured on an ongoing basis to include the use of measurement tools such as A Collaborative Outcomes Resource Network (ACORN) and the Session Rating Scale/Outcomes Rating Scale, which are available to clinicians free of cost at www.psychoutcomes.org and www.talkingcure.com (Carta, et al, 2009).

2. Pharmacotherapy

2.1. Psychopharmacological treatment of may be necessary if the symptoms are severe, but use of medications should be brief and be accompanied by psychotherapy. Judicious use of antianxiety or antidepressant agents may be helpful to a patient who suffers from symptoms of anxiety or a mood disorder. Rarely, antipsychotic medications may be indicated for patients who decompensate (Powell, 2015).

2.2. The use of pharmacotherapy for the treatment of AD is debated and not well supported by the literature (O’Conner, et al., 2009). Currently, antidepressants and anxiolytics are prescribed for AD, due to the overlapping of symptoms AD has with other psychiatric disorders (e.g., anxiety and mood disorders). This leads treatment to be driven by methods used to treat other disorders of similar symptoms (Optum BHS Brief Review, 2012).
2.3. If medication is indicated, medication choices for Adjustment Disorders must be made jointly with patients, with consideration of patient preference, prior response to medication, safety, tolerability, anticipated side effects, co-occurring conditions and cost.

2.4. Anxiolytics or hypnotics may be used to help the patient with sleep disturbance and alleviate excessive daytime anxiety (Psychopharmacology Treatment Planner, 2007).

2.5. Benzodiazepines should be avoided in combination with certain medications and if substance abuse is of concern. If these agents are chosen, the prescriber should:
   
   2.5.1. Titrate to the minimum effective dose for treatment of the patient’s symptoms.
   
   2.5.2. Monitor the patient for the development of side effects, response to medication, adherence and abuse of the medication.
   
   2.5.3. Reassess symptoms experienced by the patient such as excessive worry, decreased sleep or appetite.

2.6. Antidepressant medications may be prescribed to help alleviate depressive symptoms (Psychopharmacology Treatment Planner. The prescriber should:
   
   2.6.1. Titrate an antidepressant to the minimum effective dose for treatment the patient’s symptoms.
   
   
   2.6.3. Increase the dose every 4-6 weeks as tolerated until a satisfactory response has been reached.

2.7. Rating scales should be repeated for assessment of the patient’s depression and/or anxiety related symptoms (Psychopharmacology Treatment Planner, 2007).

2.8. The patient should maintain on the chosen medication until the stressor(s) have resolved and/or the patient is able to develop coping skills in therapy to reduce symptoms without medication (Psychopharmacology Treatment Planner, 2007).

2.9. Medications should be reduced gradually over several weeks with close monitoring for recurrence of symptoms and/or withdrawal (Psychopharmacology Treatment Planner, 2007).

**Discharge Planning**

1. The provider and, whenever possible, the member develops an initial discharge plan at the time of admission, and estimates the length of treatment.
1.1. The provider and, whenever possible, the member updates the initial discharge plan during the admission ensuring that:

1.1.1. An appropriate discharge plan is in place prior to discharge;

1.1.2. The discharge plan is designed to mitigate the risk that the “why now” factors which precipitated admission will reoccur;

1.1.3. The member agrees with the discharge plan.

1.2. For members continuing treatment, the discharge plan includes:

1.2.1. The discharge date;

1.2.2. The post-discharge level of care, and the recommended forms and frequency of treatment;

1.2.3. The names of the providers who will deliver treatment;

1.2.4. The date of the first appointment including the date of the first medication management visit;

1.2.5. The name, dose and frequency of each medication;

1.2.6. A prescription sufficient to last until the first medication management visit is provided;

1.2.7. An appointment for necessary lab tests is provided;

1.2.8. Resources to assist the member with overcoming barriers to care such as lack of transportation of child care;

1.2.9. Recommended self-help and community support services;

1.2.10. Information about what the member should do in the event of a crisis prior to the first appointment.

1.2.11. The first treatment appointment and medication management visit are scheduled to occur within a timeframe that is commensurate with the risk that the “why now” factors which led to admission will reoccur.

1.2.12. The provider shares the discharge plan and all pertinent clinical information with the providers at the next level of care prior to discharge.

1.2.13. The provider shares the discharge plan and all pertinent clinical information with the Care Advocate to ensure that necessary prior authorizations or notifications are completed prior to discharge.
1.2.14. Notification of the Care Advocate that the member is discontinuing treatment may trigger outreach and assistance to the member.

1.2.15. The provider coordinates discharge with agencies and programs such as the school or court system with which the member is involved.

1.3. For members not continuing treatment, the discharge plan includes:

1.3.1. The discharge date;

1.3.2. Recommended self-help and community support services;

1.3.3. Information about what the member should do in the event of a crisis or to resume services.

1.3.4. The provider explains the risk of discontinuing treatment when the member refuses treatment or repeatedly does not adhere with the treatment plan.

**PART III: LEVEL OF CARE CRITERIA**

**Common Admission Criteria for All Levels of Care**

1. Admission Criteria

1.1. The member is eligible for benefits.

    **AND**

1.2. The member’s condition and proposed services are covered by the benefit plan.

    **AND**

1.3. Services are within the scope of the provider’s professional training and licensure.

    **AND**

1.4. The member’s current condition cannot be safely, efficiently, and effectively assessed and/or treated in a less intensive level of care due to acute changes in the member’s signs and symptoms and/or psychosocial and environmental factors (i.e., the “why now” factors leading to admission).

    1.4.1. Failure of treatment in a less intensive level of care is **not** a prerequisite for authorizing coverage.

    **AND**
1.5. The member’s current condition can be safely, efficiently, and effectively assessed and/or treated in the proposed level of care. Assessment and/or treatment of acute changes in the member’s signs and symptoms and/or psychosocial and environmental factors (i.e., the “why now” factors leading to admission) require the intensity of services provided in the proposed level of care.

AND

1.6. Co-occurring behavioral health and medical conditions can be safely managed.

AND

1.7. Services are:

1.7.1. Consistent with generally accepted standards of clinical practice;

1.7.2. Consistent with services backed by credible research soundly demonstrating that the services will have a measurable and beneficial health outcome, and are therefore not considered experimental;

1.7.3. Consistent with Optum’s best practice guidelines;

1.7.4. Clinically appropriate for the member’s behavioral health conditions based on generally accepted standards of clinical practice and benchmarks.

AND

1.8. There is a reasonable expectation that services will improve the member’s presenting problems within a reasonable period of time.

1.8.1. Improvement of the member’s condition is indicated by the reduction or control of the acute signs and symptoms that necessitated treatment in a level of care.

1.8.2. Improvement in this context is measured by weighing the effectiveness of treatment against evidence that the member’s signs and symptoms will deteriorate if treatment in the current level of care ends. Improvement must also be understood within the broader framework of the member’s recovery, resiliency and wellbeing.

AND

1.9. Treatment is not primarily for the purpose of providing social, custodial, recreational, or respite care.
2. **Common Continued Service Criteria for All Levels of Care**

   2.1. The admission criteria continue to be met and active treatment is being provided. For treatment to be considered “active” services must be:

   2.1.1. Supervised and evaluated by the admitting provider;

   2.1.2. Provided under an individualized treatment plan that is focused on addressing the “why now” factors, and makes use of clinical best practices;

   2.1.3. Reasonably expected to improve the member’s presenting problems within a reasonable period of time.

   **AND**

   2.2. The “why now” factors leading to admission have been identified and are integrated into the treatment and discharge plans.

   **AND**

   2.3. Clinical best practices are being provided with sufficient intensity to address the member’s treatment needs.

   **AND**

   2.4. The member’s family and other natural resources are engaged to participate in the member’s treatment as clinically indicated.

3. **Common Discharge Criteria for All Levels of Care**

   3.1. The continued stay criteria are no longer met. Examples include:

   3.1.1. The “why now” factors which led to admission have been addressed to the extent that the member can be safely transitioned to a less intensive level of care, or no longer requires care.

   3.1.2. The “why now” factors which led to admission cannot be addressed, and the member must be transitioned to a more intensive level of care.

   3.1.3. Treatment is primarily for the purpose of providing social, custodial, recreational, or respite care.

   3.1.4. The member requires medical-surgical treatment.

   3.1.5. The member is unwilling or unable to participate in treatment and involuntary treatment or guardianship is not being pursued.
Assessment and diagnosis and active behavioral health treatments that are provided in an ambulatory setting. The course of treatment in Outpatient is focused on addressing the “why now” factors that precipitated admission (e.g., changes in the member’s signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the “why now” factors that precipitated admission no longer require treatment.

1. Admission Criteria
   1.1. (See Common Criteria for All Levels of Care)

   AND

   1.2. The member is not in imminent or current risk of harm to self, others, and/or property.

   AND

   1.3. Acute changes in the member’s signs and symptoms, and/or psychosocial and environmental factors (i.e., the “why now” factors leading to admission) have occurred, and the member’s current condition can be safely, efficiently, and effectively assessed and/or treated in this setting.

2. Continued Service Criteria
   2.1. (See Common Criteria for All Levels of Care)

3. Discharge Criteria
   3.1. (See Common Criteria for All Levels of Care)

4. Clinical Best Practices
   4.1. Evaluation & Treatment Planning

   4.1.1. (See Common Clinical Best Practices for All Levels of Care)

   4.1.2. The frequency and duration of outpatient visits allows for safe, efficient, and effective achievement of treatment goals, and supports the member’s recovery and resiliency. Initially, the frequency of visits varies from weekly in routine cases to several times a week. As the member’s functional status improves, the frequency of visits decreases to meet the member’s current needs and treatment goals. Factors that may impact frequency and duration include:

   4.1.2.1. The goals of treatment;

   4.1.2.2. The member’s preferences;

   4.1.2.3. Evidence from clinical best practices which supports frequency and duration;
4.1.2.4. The need to monitor and manage imminent risk of harm to self, others, and/or property.

4.1.3. The provider informs the member of the process to be followed in the event of an after-hours emergency such as the availability of on-call services. The process is not solely reliant on the Emergency Room.

4.2. Discharge Planning

4.2.1. (See Common Clinical Best Practices for All Levels of Care)
Intensive Outpatient Program

A structured program that maintains hours of service for at least 9 hours per week for adults and 6 hours per week for children/adolescents during which assessment and diagnostic services, and active behavioral health treatment are provided to members who are experiencing moderate signs and symptoms that result in significant personal distress and/or significant psychosocial and environmental issues. The purpose of services is to monitor and maintain stability, decreasing moderate signs and symptoms, increase functioning, and assist members with integrating into community life.

The course of treatment in an Intensive Outpatient Program is focused on addressing the “why now” factors that precipitated admission (e.g., changes in the member’s signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the member’s condition can be safely, efficiently and effectively treated in a less intensive level of care.

An Intensive Outpatient Program can be used to treat mental health conditions or can specialize in the treatment of co-occurring mental health and substance-related disorders.

When supported by the benefit plan, coverage may be available for Intensive Outpatient Program services that are coupled with overnight housing.

1. Admission Criteria
   1.1. (See Common Criteria for All Levels of Care)
   
   AND

   1.2. The member is not in imminent or current risk of harm to self, others, and/or property.
   
   AND

   1.3. Assessment and diagnosis and/or treatment planning requires observation and interaction a minimum of 9 hours per week for adults and 6 hours per week for children/adolescents. Examples include:
   
   1.3.1. Assessment requires frequent interaction with the member and observation of the member with others.
   
   1.3.2. The treatment plan must be frequently changed which requires that the provider have face-to-face interactions with the member several times a week.

   OR

   1.4. The member requires engagement and support which requires extended interaction between the member and the program. Examples include:
1.4.1. The member requires a coordinated transition back into the community after treatment in Inpatient or a Residential Treatment Center.

1.4.2. The member has been unable to access or utilize family or other natural resources on their own.

OR

1.5. The member requires a structured environment to practice and enhance skills. This requires face-to-face interactions several times a week that cannot be provided in a less intensive setting. Examples of skills include those the help the member:

1.5.1.1. Maintain their current living situation;

1.5.1.2. Return to work or school.

OR

1.6. The member requires a structured environment to complete goals and develop a plan for post-discharge services in a less intensive setting. Examples of assistance include:

1.6.1.1. Assistance with developing the skills needed to self-manage medications.

1.6.1.2. Assistance with making progress toward goals in spite of an environment that does not support recovery and/or limited community support services.

Criteria for Overnight Housing Coupled with an Intensive Outpatient Program

1.7. Overnight housing is covered by the benefit plan.

AND

1.8. The treatment setting is separate from the housing.

AND

1.9. An unsupportive or high-risk living situation is undermining the member's recovery.

OR

1.10. Routine attendance at the Intensive Outpatient Program is hindered by the lack of transportation.

2. Continued Service Criteria

(See Common Criteria for All Levels of Care)

3. Discharge Criteria

3.1. (See Common Criteria for All Levels of Care)

4. Clinical Best Practices
4.1. Evaluation & Treatment Planning
   4.1.1. (See Common Clinical Best Practices for All Levels of Care)
   4.1.2. The responsible provider and the treatment team complete the initial evaluation commensurate with the member’s needs, no later than three (3) treatment days after admission.
   4.1.3. During admission, a psychiatrist is available to consult with the program during and after normal program hours.

4.2. Discharge Planning
   4.2.1. (See Common Clinical Best Practices for All Levels of Care)
Partial Hospitalization Program

A structured program that maintains hours of service for at least 20 hours per week during which assessment and diagnostic services, and active behavioral health treatment are provided to members who are experiencing serious signs and symptoms that result in significant personal distress and/or significant psychosocial and environmental issues. The purpose of services is to stabilize and reduce acute signs and symptoms, increase functioning, and assist a member with integrating into community life.

The course of treatment in a Partial Hospital Program is focused on addressing the “why now” factors that precipitated admission (e.g., changes in the member’s signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the member’s condition can be safely, efficiently and effectively treated in a less intensive level of care.

A Partial Hospital Program can be used to treat mental health conditions or can specialize in the treatment of co-occurring mental health and substance-related disorders.

When supported by the benefit plan, coverage may be available for Partial Hospital Program services that coupled with overnight housing.

1. Admission Criteria

1.1. (See Common Criteria for All Levels of Care)

AND

1.2. The member is not in imminent or current risk or harm to self, others, and/or property.

AND

1.3. Assessment and diagnosis and/or treatment planning requires observation and interaction for at least 20 hours per week. Examples include:

1.3.1. Assessment requires frequent interaction with the member, and observation of the member with others.

1.3.2. The treatment plan must be changed frequently which requires that the provider have face-to-face interactions with the member several times a week.

OR

1.4. The member requires engagement and support which requires extended interaction between the member and the program. Examples include:

1.4.1. The member requires a coordinated transition back into the community after treatment in Inpatient or a Residential Treatment Center, such as engagement with wraparound services or natural resources.
1.4.2. The member has been unable to access or utilize family or other natural resources on their own.

**OR**

1.5. The member requires a structured environment to practice and enhance skills. This requires face-to-face interactions several times a week that cannot be provided in a less intensive setting. Examples of skills include those that help the member:

1.5.1. Maintain their current living situation;
1.5.2. Return to work or school.

**OR**

1.6. The member requires a structured environment to complete goals and develop a plan for post-discharge services in a less intensive setting. Examples of assistance include:

1.6.1.1. Assistance with developing the skills needed to self-manage medications.
1.6.1.2. Assistance with making progress toward goals in spite of an environment that does not support recovery and/or limited community support services.

**Criteria for Overnight Housing Coupled with a Partial Hospital Program**

1.7. Overnight housing is covered by the benefit plan.

**AND**

1.8. The treatment setting is separate from the housing.

**AND**

1.9. An unsupportive or high-risk living situation is undermining the member's recovery.

**OR**

1.10. Routine attendance at the Partial Hospital is hindered by the lack of transportation.

1. **Continued Service Criteria**

   1.1. (See Common Criteria for All Levels of Care)

2. **Discharge Criteria**

   2.1. (See Common Criteria for All Levels of Care)

3. **Clinical Best Practices**

   3.1. Evaluation & Treatment Planning

   3.1.1. (See Common Clinical Best Practices for All Levels of Care)
3.1.2. The psychiatrists and the treatment team complete the initial evaluation commensurate with the member’s needs, no later than 24 hours following admission.

3.1.3. During admission, a psychiatrist is available to consult with the program during and after normal business hours.

3.1.4. A psychiatrist sees the member commensurate with the member’s needs, with no less than weekly visits.

3.2. Discharge Planning

3.2.1. (See Common Clinical Best Practices for All Levels of Care)
Residential Treatment Center

A sub-acute facility-based program which delivers 24-hour/7-day assessment and diagnostic services, and active behavioral health treatment to members who do not require the intensity of nursing care, medical monitoring and physician availability offered in Inpatient.

The course of treatment in a Residential Treatment Center is focused on addressing the “why now” factors that precipitated admission (e.g., changes in the member’s signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the member’s condition can be safely, efficiently and effectively treated in a less intensive level of care.

1. Admission Criteria

1.1. (See Common Criteria for All Levels of Care)

AND

1.2. The member is not in imminent or current risk of harm to self, others, and/or property.

AND

1.3. The “why now” factors leading to admission cannot be safely, efficiently or effectively assessed and/or treated in a less intensive setting due to acute changes in the member’s signs and symptoms and/or psychosocial and environmental factors. Examples include:

1.3.1. Acute impairment of behavior or cognition that interferes with activities of daily living to the extent that the welfare of the member or others is endangered.

1.3.2. Psychosocial and environmental problems that are likely to threaten the member’s safety or undermine engagement in a less intensive level of care without the intensity of services offered in this level of care.

1.4. Treatment is not primarily for the purpose of providing custodial care. Services are custodial when they are any of the following:

1.4.1. Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
1.4.2. Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.

1.4.3. Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

2. Continued Service Criteria

2.1. (See Common Criteria for All Levels of Care)

AND

2.2. Treatment is not primarily for the purpose of providing custodial care.

Services are custodial when they are any of the following:

2.2.1. Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).

2.2.2. Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.

2.2.3. Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

3. Discharge Criteria

3.1. (See Common Criteria for All Levels of Care)

4. Clinical Best Practices

4.1. Evaluation & Treatment Planning

4.1.1. (See Common Clinical Best Practices for All Levels of Care)

4.1.2. The psychiatrist in conjunction with the treatment team completes the initial evaluation commensurate with the member’s needs, no later than 24 following admission.

4.1.3. During admission, a psychiatrist is available to consult with the program during and after normal program hours. A psychiatric consultation occurs at least weekly commensurate with the member’s needs.

4.2. Discharge Planning

4.2.1. (See Common Clinical Best Practices for All Levels of Care)
4.2.2. The first treatment appointment and medication management visit are scheduled to occur within a timeframe that is commensurate with the risk that the “why now” factors which led to admission will reoccur, but no later than 7 days from discharge.
Inpatient
A structured hospital-based program which provides 24-hour/7-day nursing care, medical monitoring, and physician availability; assessment and diagnostic services, active behavioral health treatment, and specialty medical consultation with an immediacy needed to avoid serious jeopardy to the health of the member or others.

The course of treatment in an inpatient setting is focused on addressing the “why now” factors that precipitated admission (e.g., changes in the member’s signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the member’s condition can be safely, efficiently and effectively treated in a less intensive level of care.

1. Admission Criteria
1.1. (See Common Criteria for All Levels of Care)

    AND

1.2. The “why now” factors leading to admission, and/or the member’s history of response to treatment suggest that there is imminent or current risk of harm to self, others, and/or property which cannot be safely, efficiently, and effectively managed in a less intensive level of care. Examples include:

   1.2.1. A life-threatening suicide attempt;
   1.2.2. Self-mutilation, injury or violence toward others or property;
   1.2.3. Threat of serious harm to self or others;
   1.2.4. Command hallucinations directing harm to self or others.

    OR

1.3. The “why now” factors leading to admission suggest that the member’s condition cannot be safely, efficiently, and effectively treated in a less intensive setting due to a physical complication. Example include:

   1.3.1. A physical cause for the member’s signs and symptoms cannot be ruled out in a less intensive setting.
   1.3.2. A severe medication side effect requires the level of monitoring and intervention available in an inpatient setting.

    OR
1.4. The “why now” factors leading to admission cannot be safely, efficiently, and effectively assessed and/or treated in a less intensive setting due to acute changes in the member’s signs and symptoms, and/or psychosocial and environmental factors. Examples include:

1.4.1. Acute impairment of behavior or cognition that interferes with activities of daily living to the extent that the welfare of the member or others is endangered.

1.4.2. Psychosocial and environmental problems that threaten the member’s safety or undermines engagement in a less intensive level of care.

OR

1.5. The “why now” factors which led to admission to Crisis Stabilization & Assessment or 23-Hour Observation cannot be addressed, and the member must be admitted to inpatient.

2. **Continued Service Criteria**

2.1. (See Common Criteria for All Levels of Care)

AND

2.2. Treatment is not primarily for the purpose of providing custodial care. Services are custodial when they are any of the following:

2.2.1. Non-health-related services, such as assistance with Activities of Daily Living (examples include feeding, dressing, bathing, transferring and ambulating).

2.2.2. Health-related services that are provided for the primary purpose of meeting the personal needs of the member or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.

2.2.3. Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

3. **Discharge Criteria**

3.1. (See Common Criteria for All Levels of Care)

4. **Clinical Best Practices**

4.1. Evaluation & Treatment Planning

4.1.1. (See Common Clinical Best Practices for All Levels of Care)
4.1.2. The psychiatrist in conjunction with the treatment team completes the initial evaluation commensurate within 24 hours of admission.

4.1.3. During admission, the psychiatrist sees the member at least 5 times per week, and supervises and evaluates the treatment program to determine the extent to which treatment goals are being realized and whether changes in the treatment plan are needed.

4.2. Discharge Planning

4.2.1. (See Common Clinical Best Practices for All Levels of Care)

4.2.2. The first treatment appointment and medication management visit are scheduled to occur within a timeframe that is commensurate with the risk that the “why now” factors which led to admission will reoccur, but no later than 7 days from discharge.

PART IV: ADDITIONAL RESOURCES

Clinical Protocols
Optum maintains clinical protocols that include the Level of Care Guidelines and Best Practice Guidelines which describe the scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding treatment. These clinical protocols are available to Covered Persons upon request, and to Physicians and other behavioral health care professionals on ubhonline.

Peer Review
Optum will offer a peer review to the provider when services do not appear to conform to this guideline. The purpose of a peer review is to allow the provider the opportunity to share additional or new information about the case to assist the Peer Reviewer in making a determination including, when necessary, to clarify a diagnosis.

Second Opinion Evaluations
Optum facilitates obtaining a second opinion evaluation when requested by an enrollee, provider, or when Optum otherwise determines that a second opinion is necessary to make a determination, clarify a diagnosis or improve treatment planning and care for the member.

Referral Assistance
Optum provides assistance with accessing care when the provider and/or enrollee determine that there is not an appropriate match with the enrollee’s clinical needs and goals, or if additional providers should be involved in delivering treatment.

PART V: DEFINITIONS
**Adjustment Disorders** According to the DSM, the essential feature of Adjustment Disorders is development of clinically significant emotional or behavioral symptoms in response to an identifiable psychosocial stressor or stressors occurring within 3 months of the onset of the stressor. These symptoms may be characterized by marked distress, in excess of what would be expected from exposure to the stressor, and significant impairment in social or occupational functioning. Subtypes include Adjustment Disorder with Depressed Mood, Anxiety, Mixed Anxiety and Depressed Mood, Disturbance of Conduct, Mixed Disturbance of Emotions and Conduct, and Unspecified.

**Diagnostic and Statistical Manual of the American Psychiatric Association (DSM)** A manual produced by the American Psychiatric Association which provides the diagnostic criteria for mental health and substance use disorders, and other problems that may be the focus of clinical attention. Unless otherwise noted, the current edition of the DSM applies.

**Inpatient** A secured and structured hospital-based service that provides 24-hour nursing care and monitoring, assessment and diagnostic services, treatment, and specialty medical consultation services with an urgency that is commensurate with the member’s current clinical need.

**Intensive Outpatient Program** A freestanding or hospital-based program that maintains hours of service for at least 3 hours per day, 2 or more days per week. It may be used as an initial point of entry into care, as a step up from routine outpatient services, or as a step down.

**Mental Illness** Those mental health or psychiatric diagnostic categories that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded under the Policy.

**Outpatient** Visits provided in an ambulatory setting.

**Partial Hospital/Day Treatment Program** A freestanding or hospital-based program that maintains hours of service for at least 20 hours per week, and may also include half-day programs that provide services for less than 4 hours per day. A partial hospital/day treatment program may be used as a step up from a less intensive level of care, or as a step down from a more intensive level of care.

**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.

**Residential Treatment Center** A facility-based or freestanding program that provides overnight services to members who do not require 24-hour nursing care and monitoring offered in an acute inpatient setting but who do require 24-hour structure.

**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.
PART VI: REFERENCES

17. The Psychopharmacology Treatment Planner: Adjustment Disorders with Depression or Anxiety, 2007.

PART VII: CODING

The Current Procedural Terminology (CPT) codes and HCPCS codes listed in this guideline are for reference purposes only. Listing of a service code in this guideline does not imply that the service described by this code is a covered or non-covered health service. Coverage is determined by the benefit document.

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<td>Interactive group psychotherapy, in a partial hospitalization setting, approximately 45 to 50 minutes</td>
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**DSM-5 Codes**

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<td>(Range describes various unbundled behavioral health treatments/services)</td>
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<td>(Range describes various sites that provider 24-hour services)</td>
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### PART VIII: HISTORY

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