Optum
Coverage Determination Guideline

ANXIETY DISORDERS

Policy Number: BH727AD_032018 **Effective Date**: March 14, 2018

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Relevant Diagnoses:

- Separation anxiety disorder
- Specific phobia
- Social anxiety disorder (social phobia)
- Panic disorder
- Agoraphobia
- Generalized anxiety disorder

Related Clinical Policies and Guidelines:

- Obsessive-Compulsive Disorder
- Other Specified and Unspecified Disorders

BENEFIT CONSIDERATIONS

Before using this policy, 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 anxiety disorders 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

EVIDENCE-BASED CLINICAL GUIDELINES

A. Initial evaluation common criteria and best practices
   - 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

B. Screening and Assessment
- Anxiety disorders are the most common class of mental disorders, and often co-exist with other related conditions, such as mood or substance use disorder (National Institute of Mental Health, 2016; Combs & Markman 2014).
- Self-injury, suicidal ideation, and suicide attempts may be elevated in individuals with anxiety disorders (Combs & Markman 2014).
- Onset of anxiety disorders may occur in childhood or adolescence and predict later psychopathology; identification of people at risk and interventions at young ages are important considerations (Craske & Stein 2016).
    - Psychiatric assessment of children and adolescents should routinely include screening questions about anxiety symptoms (AACAP 2007).
- Screening tools desgned to address the full spectrum of co-occurring affective and anxiety disorders are especially useful (Combs & Markman 2014).
    - The Hospital Anxiety and Depression Scale and the Beck Anxiety Inventory distinguish between depression and anxiety if both are present (Metzler et al 2016; Combs & Markman 2014).
    - Other broad-based instruments, such as the PRIME-MD-PHQ, can identify anxiety and mood disorders (Combs & Markman 2014).
    - The GAD-7 and the GAD-2 are commonly used screening tools for generalized anxiety disorder, and the PHQ Panic Disorder Scale is commonly used to screen for panic disorder (Combs & Markman 2014)

C. Differential diagnosis for an anxiety disorder includes (American Psychiatric Association, 2013):
- Conduct disorder;
- Trauma- and stressor-related disorders;
- Depressive and bipolar disorders;
- Oppositional defiant disorder;
- Psychotic disorders;
- Personality disorders;
- Neurodevelopmental disorders;
- Obsessive-Compulsive disorder;
- Schizophrenia spectrum and other psychotic disorders.

D. Treatment planning common criteria and best practices
- 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
- Anxiety disorders are generally treated with psychotherapy, medication, or both. Some research studies have shown that patients treated with a combination of psychotherapy and medication have better outcomes (National Institute of Mental Health, 2016; Bandelow et al 2012).
- The choice of treatment depends on factors such as patient preference and motivation, ability to engage in treatment, severity of illness, prior response to treatment, and presence of comorbid medical or psychiatric disorders (Katzman et al 2014); Bandelow et al 2012.
    - Choosing the right medication, medication dose, and treatment plan should be based on a person's needs and medical situation (National Institute of Mental Health, 2016).
- For children and adolescents, psychological therapies are generally preferred over pharmacotherapy as an initial treatment strategy; if warranted, combination therapy may be appropriate (Stein & Sareen 2015; Katzman et al 2014).
    - Treatment planning for children and adolescents should consider a multimodal treatment approach, including education of the parents and child about the anxiety disorder, and consultation with school personnel and primary care physicians (AACAP 2007).

E. Psychosocial Interventions
- Cognitive behavioral therapy (CBT) is considered a first-line treatment for anxiety disorders, and can teach the individual different ways of thinking, behaving, and reacting to anxiety-producing and fearful situations. It may be conducted individually or in a group setting (National Institute of Mental Health, 2016; Metzler et al 2016; Combs & Markman 2014).
    - Exposure therapy focuses on confronting the fears underlying an anxiety disorder in order to help people engage in activities they have been avoiding (National Institue of Mental Health, 2016). Exposure-based CBT has received the most empirical support for the treatment of anxiety disorders in youths (AACAP 2007).

- To be effective, psychotherapy must be directed at the person's specific anxieties and tailored to his or her needs (National Institute of Mental Health, 2016).

F. General Pharmacotherapy
- Medications are sometimes used as the initial treatment of an anxiety disorder, or if there is an insufficient response to a course of psychotherapy (National Institute of Mental Health, 2016).
    - SSRI and SNRI antidepressants are considered the first-line pharmacological treatment for most anxiety disorders, on the basis of evidence of efficacy from randomized controlled trials, overall safety, and absence of misuse potential. No evidence exists that any antidepressant is better than any other for the treatment of anxiety disorders (Craske & Stein 2016; Metzler et al 2016; Combs & Markman 2014; Bandelow et al 2012).
    - Most expert guidelines continue to recommend use of benzodiazepines as second-line or third-line agents, either as monotherapy or in conjunction with antidepressants, for patients without history of substance use disorders. (Craske & Stein 2016; Combs & Markman 2014).
        - Due to concerns about possible dependency, sedation, cognitive impairment, and other side effects, benzodiazepines should usually be restructed to short-term use (Metzler et al 2016; Katzman et al 2014).
    - Evidence-based pharmacological maintenance strategies for anxiety disorders are lacking (Craske & Stein 2016).

G. Specific Phobia
- Identified by intense fear, anxiety, or avoidance of defined objects or situations (Craske & Stein 2016).
- Specific phobias are frequently comorbid with other psychiatric disorders, including substance use disorders, mood disorders, and other anxiety or related disorders (Katzman et al 2014).
- Psychosocial interventions, particularly exposure-based treatments, are generally the initial treatment of choice and are associated with a high degree of success in providing remission of specific phobias (Katzman et al 2014).
- Pharmacotherapy in the treatment of specific phobia is not a recommended treatment for most cases, largely due to the success of exposure-based therapies, and a lack of research on medications in this condition (Katzman et al 2014; Bandelow et al 2012).

H. Panic Disorder
- Identified by recurrent, unexpected panic attacks followed by at least one month of persistent concern or worry about further attacks (Craske & Stein 2016; Katzman et al 2014).
- Patients with panic disorder have significantly increased odds of being diagnosed with a comorbid disorder, including another anxiety disorder or major depressive disorder (Katzman et al 2014).
- Treatment of panic disorder involves prevention of panic attacks and reducing anxiety about future attacks (Combs & Markman 2014).
- Pharmacotherapy, cognitive behavioral therapy (CBT) alone, and CBT combined with pharmacotherapy are supported as initial treatments for panic disorder (Katzman et al 2014).
    - CBT has been extensively studied, and is an efficacious psychological treatment for panic disorder (Combs & Markman 2014; Katzman et al 2014). CBT protocols for panic disorder typically comprise 12-14 weekly sessions, with briefer strategies of 6-7 sessions also showing effectiveness (Katzman, et al 2014).
    - Evidence from meta-analyses and RCTs supports the use of SSRIs and SNRIs as first-line pharmacological agents for treating panic disorder (Katzman et al 2014).

I. Generalized Anxiety Disorder (GAD)
- Identified by anxiety or worry about various areas of life, such as work or school performance, on a majority of days for at least 6 months (Craske & Stein 2016).
- GAD is associated with high rates of comorbid psychiatric conditions, including other anxiety or related disorders and major depressive disorder (Katzman et al 2014).
- Brief questionnaires, such as the Generalized Anxiety Disorder 7-Item (GAD-7) Questionnaire can be used to screeen for the disorder and to longitudinally monitor outcomes (Stein & Sareen 2015).
- Randomized controlled trials provide strong evidence of the benefits of certain types of pharmacotherapy, psychotherapy, or both for GAD. Initial choice of treatment should depend largely on patient preference (Stein & Sareen 2015).
    - Cognitive behavioral therapy (CBT) is an effective first-line option for the treatment of GAD (Stein & Sareen 2015; Katzman et al 2014).
    - Benefit of pharmacotherapy is generally comparable to that of CBT for treating GAD; first-line agents include SSRIs and SNRIs (Stein & Sareen 2015; Katzman et al 2014; Combs & Markman 2014).

J. Discharge planning common criteria and best practices
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
H0015	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling, crisis intervention, and activity therapy
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

HCPCS Code	Description
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)
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
F93.0	Separation anxiety disorder of childhood
F40.218	Other animal type phobia
F40.228	Other natural environment type phobia
F40.230	Fear of blood
F40.231	Fear of injections and transfusions
F40.232	Fear of other medical care
F40.233	Fear of injury
F40.10	Social phobia, unspecified
F41.0	Panic disorder [episodic paroxysmal anxiety]
F40.00	Agoraphobia, unspecified
F41.1	Generalized anxiety disorder

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.

REFERENCES*

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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 Review: Updates to formatting, references