Covered Determination Guideline: Anxiety Disorders

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### INTRODUCTION

*Coverage Determination Guidelines* are a set of objective and evidence-based behavioral health criteria used by Commercial plans that don’t have a provision for medical necessity to standardize coverage determinations, promote evidence-based practices, and support members’ recovery, resiliency, and wellbeing for behavioral health benefit plans that are managed by Optum®.

This guideline provides assistance in interpreting UnitedHealthcare Commercial benefit plans, and is used to make coverage determinations as well as to inform discussions about evidence-based practices and discharge planning for behavioral health benefit plans managed by Optum. When deciding coverage, the member’s specific benefits must be referenced.

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member’s benefits prior to using this guideline. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this guideline and the member’s specific benefit, the member’s specific benefit supersedes this guideline. Other clinical criteria may apply.

Optum reserves the right, in its sole discretion, to modify its clinical criteria as necessary using the process described in *Clinical Criteria*.

This guideline is provided for informational purposes. It does not constitute medical advice.

Optum may also use tools developed by third parties that are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Optum may develop clinical criteria or adopt externally-developed clinical criteria that supersede this guideline when required to do so by contract or regulation.

### BENEFIT CONSIDERATIONS

Before using this policy, please check the member-specific benefit plan document and any federal or state mandates, if applicable.

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1 Optum is a brand used by United Behavioral Health and its affiliates.
**Pre-Service Notification**

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

**Available benefits for 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

**Indications for Coverage**

The requested service or procedure must be reviewed against the language in the member's benefit document. When the requested service or procedure is limited or excluded from the member's benefit document, or is otherwise defined differently, it is the terms of the member's benefit document that prevails.

Per the specific requirements of the plan, health care services or supplies may not be covered when inconsistent with generally accepted standards and clinical guidelines.

**A. Initial Evaluation**
- Optum recognizes the American Psychiatric Association’s Practice Guidelines for the Psychiatric Evaluation of Adults (2016):
  - [http://www.psychiatry.org > Psychiatrists > Practice > Clinical Practice Guidelines](http://www.psychiatry.org)

**B. Screening and Assessment**
- Anxiety disorders are the most common class of mental disorders, with a lifetime prevalence rate of 29%, and often co-exist with other related conditions, such as mood or substance use disorder (National Institute of Mental Health [NIMH], 2016; Metzler et al., 2016).
- Self-injury, suicidal ideation, and suicide attempts may be elevated in individuals with anxiety disorders (Combs & Markman, 2014; Too et al., 2019).
- Onset of anxiety disorders may occur in childhood or adolescence and predict later psychopathology. The onset usually occurs before 25 years old with increased prevalence among ages 13-17. Identification of people at risk and interventions at young ages is a noteworthy consideration (Hughes & Kahl, 2018).
  - Psychiatric assessment of children and adolescents should routinely include screening questions about anxiety symptoms (AACAP, 2007).
- Screening tools designed to address the full spectrum of co-occurring affective and anxiety disorders are especially useful (Metzler et al., 2016).
  - The Hospital Anxiety and Depression Scale and the Beck Anxiety Inventory (BAI) distinguish between depression and anxiety if both disorders are present (Metzler et al., 2016).
  - Other broad-based instruments, such as the PRIME-MD-PHQ, can identify anxiety and mood disorders (Narayana & Wong, 2015).
  - The Symptom Driven Diagnostic System-Primary Care (SDDS-PC) screens for a manifold of psychiatric conditions (Metzler et al., 2016).
  - The GAD-7 and the GAD-2 are commonly used screening tools for generalized anxiety disorder, panic disorder, and post-traumatic stress disorder.
  - The Panic Disorder Severity Scale (PDDS) is commonly used to screen for panic disorder (Keefe et al., 2019).
Clinician-administered screening tools effective for measuring anxiety and depression in children and adolescents are (Oar et al., 2017):
  - Children’s Depression Rating Scale-Revised
  - Pediatric Anxiety Rating Scale

C. Differential diagnosis for an anxiety disorder includes (Diagnostic and Statistical Manual of Mental Disorders 5th ed.; DSM-5; APA, 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
- 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. Research consistently reveals that individuals treated with a combination of psychotherapy and medications have better outcomes (Bandelow et al., 2012; Combs & Markman, 2014; NIMH, 2016).
- 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).
  - Choosing the right medication, medication dose, and treatment plan should be based on the individual's needs and medical situation (NIMH, 2016).
- For children and adolescents, psychological therapies are generally preferred over pharmacotherapy as an initial treatment strategy; if warranted, combination therapy may be appropriate (Katzman et al., 2014; Stein & Sareen, 2015).
  - Treatment planning for children and adolescents should consider a collaborative 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, including children and adolescents. CBT methods 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 (Combs & Markman, 2014; NIMH, 2016; Metzler et al., 2016; Oar et al., 2017).
  - Exposure therapy focuses on confronting the fears underlying an anxiety disorder in order to help people engage in activities they have been avoiding (NIMH, 2016).
  - Current empirical evidence supports CBT for children and youth that integrates psychoeducation, cognitive restructuring, exposure, and behavioral activation (Oar et al., 2017).
- To be effective, psychotherapy must be directed at the person’s specific anxieties and tailored to his or her needs (NIMH, 2016; Oar et al., 2017).

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 (NIMH, 2016).
  - Selective serotonin reuptake inhibitors (SSRI) and serotonin-norepinephrine reuptake inhibitors (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 (Bandelow et al., 2012; Chen et al., 2019; Combs & Markman,
2014; Metzler et al., 2016).
- 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 individuals
without history of substance use disorders (Combs & Markman, 2014).
  o Due to concerns about possible dependency, sedation, cognitive impairment, and
other side effects, benzodiazepines should usually be restricted to acute anxiety
(Katzman et al., 2014; Metzler et al., 2016).
- Pharmacotherapy continued for at least 12-24 months is associated with reduced symptoms
and reduced relapse (Katzman et al., 2014).

G. Specific Phobia
- Identified by persistent, intense, unreasonable fear, anxiety, or avoidance of defined objects
or situations. There is significant distress or impairment related to the fear (Eaton et al., 2018;
Katzman et al., 2014).
- Age of onset can vary by type of phobia with most events beginning during ages 5-12
(Katzman et al., 2014).
- Specific phobias are frequently comorbid with other psychiatric disorders, including substance
use disorders, mood disorders, and other anxiety or related disorders (Eaton et al., 2018;
Katzman et al., 2014).
  o Specific phobia versus agoraphobia is diagnosed when fear, anxiety, or avoidance is
limited to only one agoraphobic fear such as using public transportation, being in open
or enclosed spaces, being in a crowd or in line, and being outside of the home (DSM-5,
2013).
- 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).
  o The standard approach of exposure therapy is in-vivo or images of phobic stimuli or
circumstances (Eaton et al., 2018).
- 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 (Eaton et al., 2018; Katzman et al., 2014).

H. Panic Disorder
- Identified by recurrent, unexpected panic attacks followed by at least one month of persistent
concern or worry about further attacks (DSM-5, 2013).
- Individuals diagnosed with panic disorder, particularly those with agoraphobia, commonly
present with a comorbid disorder, another anxiety disorder or major depressive disorder
(Keefe et al., 2019).
- 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).
  o CBT has been extensively studied, and is an efficacious psychological treatment for
panic disorder (Combs & Markman, 2014; Katzman et al., 2014).
  o 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).
  o 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 excessive anxiety or worry about various areas of life, such as work or school
performance, on a majority of days for at least 6 months; these symptoms cause significant
impairment in important areas of daily functioning (DSM-5, 2013).
- Physical symptoms associated with GAD such as migraine headaches and gastrointestinal
disease can lead to misdiagnoses (Slee et al., 2019).
• GAD is associated with high rates of comorbid psychiatric conditions, including other anxiety or related disorders and major depressive disorder (Katzman et al., 2014; Slee et al., 2019).
• Clinical research shows a significant risk of suicide in individuals diagnosed with GAD (Chen et al., 2019).
• Brief questionnaires, such as the Generalized Anxiety Disorder 7-Item (GAD-7) Questionnaire can be used to screen for the disorder and to longitudinally monitor outcomes (Stein & Sareen, 2015).
• Many interventions are proven clinically effective for GAD in comparison with placebo, such as pharmacological treatment including SSRIs, SNRIs, benzodiazepines, tricyclic antidepressants, second-generation antipsychotics, buspirone, and pregabalin; psychotherapy including CBT, psychodynamic therapy, and self-help interventions (Chen et al., 2019).
  o SSRIs and SNRIs are currently considered first-line pharmacology treatments for GAD (Chen et al., 2019).
  o Cognitive behavioral therapy (CBT) is an effective first-line psychotherapy option for the treatment of GAD (Katzman et al., 2014; Stein & Sareen, 2015).
  o Benefit of pharmacotherapy is generally comparable to that of CBT for treating GAD; first-line agents include SSRIs and SNRIs (Combs & Markman, 2014; Katzman et al., 2014; Stein & Sareen, 2015).

J. Discharge planning
• Optum recognizes the American Psychiatric Association’s Practice Guidelines for the Psychiatric Evaluation of Adults (2016):
  o [http://www.psychiatry.org > Psychiatrists > Practice > Clinical Practice Guidelines](http://www.psychiatry.org)

### APPLICABLE CODES

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

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

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<th>Procedure Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>G0177</td>
<td>Training and educational services related to the care and treatment of patient’s disabling mental health problems per session (45 minutes or more)</td>
</tr>
<tr>
<td>G0410</td>
<td>Group psychotherapy other than of a multiple-family group, in a partial hospitalization setting, approximately 45 to 50 minutes</td>
</tr>
<tr>
<td>G0411</td>
<td>Interactive group psychotherapy, in a partial hospitalization setting, approximately 45 to 50 minutes</td>
</tr>
<tr>
<td>H0004</td>
<td>Behavioral health counseling and therapy, per 15 minutes</td>
</tr>
<tr>
<td>H0015</td>
<td>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</td>
</tr>
<tr>
<td>H0017</td>
<td>Behavioral health; residential (hospital residential treatment program), without room and board, per diem</td>
</tr>
<tr>
<td>H0018</td>
<td>Behavioral health; short-term residential (nonhospital residential treatment program), without room and board, per diem</td>
</tr>
<tr>
<td>H0019</td>
<td>Behavioral health; long-term residential (nonmedical, nonacute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem</td>
</tr>
<tr>
<td>H0025</td>
<td>Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)</td>
</tr>
<tr>
<td>H0035</td>
<td>Mental health partial hospitalization, treatment, less than 24 hours</td>
</tr>
<tr>
<td>H2001</td>
<td>Rehabilitation program, per ½ day</td>
</tr>
<tr>
<td>H2011</td>
<td>Crisis intervention service, per 15 minutes</td>
</tr>
<tr>
<td>H2012</td>
<td>Behavioral health day treatment, per hour</td>
</tr>
<tr>
<td>H2013</td>
<td>Psychiatric health facility service, per diem</td>
</tr>
<tr>
<td>H2017</td>
<td>Psychosocial rehabilitation services, per 15 minutes</td>
</tr>
<tr>
<td>H2018</td>
<td>Psychosocial rehabilitation services, per diem</td>
</tr>
<tr>
<td>H2019</td>
<td>Therapeutic behavioral services, per 15 minutes</td>
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<tr>
<td>H2020</td>
<td>Therapeutic behavioral services, per diem</td>
</tr>
<tr>
<td>H2033</td>
<td>Multisystemic therapy for juveniles, per 15 minutes</td>
</tr>
<tr>
<td>S0201</td>
<td>Partial hospitalization services, less than 24 hours, per diem</td>
</tr>
<tr>
<td>S9480</td>
<td>Intensive outpatient psychiatric services, per diem</td>
</tr>
<tr>
<td>S9482</td>
<td>Family stabilization services, per 15 minutes</td>
</tr>
<tr>
<td>S9484</td>
<td>Crisis intervention mental health services, per hour</td>
</tr>
<tr>
<td>S9485</td>
<td>Crisis intervention mental health services, per diem</td>
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</tbody>
</table>

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REFERENCES


### REVISION HISTORY

<table>
<thead>
<tr>
<th>Date</th>
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<tr>
<td>02/14/2017</td>
<td>• Version 1</td>
</tr>
<tr>
<td>3/14/2018</td>
<td>• Annual Review: Updates to formatting, references</td>
</tr>
<tr>
<td>5/20/2019</td>
<td>• Annual Review: Updates to formatting, references</td>
</tr>
<tr>
<td>03/16/2020</td>
<td>• Annual Review: Updates to references</td>
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