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®1.

INSTRUCTIONS FOR USE

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

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

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

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

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

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

BENEFIT CONSIDERATIONS

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

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Available benefits for Neurocognitive 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**

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 > Practice Guidelines](http://www.psychiatry.org)

B. Screening and Assessment
   - The assessment of major and mild neurocognitive disorders should include:
     - Historical information regarding cognitive, behavioral, and psychological symptoms that interfere with daily activities (National Institute for Health and Clinical Excellence [NICE], 2018).
       - Assessment information is provided by the individual with suspected dementia, and if plausible, from someone who knows the person well (NICE, 2018).
     - Assessment of the cognitive domains that consist of complex attention, executive function, learning and memory, language, perceptual-motor abilities, and social cognition (Diagnostic and Statistical Manual of Mental Disorders 5th ed.; DSM-5; APA, 2013).
     - Consider assessment tools such as the Mini Mental State Examination (MMSE), the 6-Item Cognitive Impairment Test (6-CIT), the General Practitioner of Cognition (GPCOG), or the Montreal Cognitive Assessment (MOCA) (Ngo & Holroyd-Leduc, 2015; NICE, 2018).
     - According to the American Academy of Neurology (AAN, 2018), assessment of mild cognitive impairment (MCI) is a significant consideration in early detection of dementia. MCI is common with aging and poses an increased risk of progressing to dementia.
       - When assessing for early dementia, a distinction between MCI and dementia is the presence of functional impairment in dementia (AAN, 2018).
   - An essential distinction between major and mild neurocognitive disorders is the significant decline in independent functioning regarding major neurocognitive disorders (Stokin et al., 2015).
   - Evaluation of risk factors include age, gender, education, occupation, vascular conditions, and family history (Stokin et al., 2015).
   - Level of impairment/progression of symptoms and dependency on others for daily activities (APA, 2007).
   - Co-occurring conditions, especially those that may mimic or exacerbate symptoms of major and mild neurocognitive disorders such as schizophrenia, depression and delirium (APA, 2007).
   - Laboratory testing to include a full blood count, electrolytes, fasting blood glucose, folate, vitamin B12, and thyroid tests (Friedman, 2021; Ngo & Holroyd-Leduc, 2015). Some individuals may require HIV and/or syphilis testing as indicated (Ngo & Holroyd-Leduc, 2015; Tung et al., 2020).
   - When a dementia diagnosis is determined, refer to a dementia specialist such as a geriatric specialist, a geriatric psychiatrist or a neurologist, for the diagnosis of a dementia subtype (Ngo & Holroyd-Leduc, 2015; NICE, 2018).
     - Further testing is necessary for dementia subtypes of Alzheimer’s disease, Lewy bodies, frontotemporal, and vascular (NICE, 2018).
   - A complete evaluation of major and mild neurocognitive disorders symptoms should
provide:

- A clear medical picture prior to introducing any interventions, especially psychotropic medications (APA, 2007).
- A well-defined history of the onset and progression of behavioral symptoms from family members, caregivers, the primary care physician and other medical and/or behavioral health providers (APA, 2007).
- Assessment of safety such as suicidal ideation, aggression, falls, wandering, and driving ability (APA, 2007; Ngo & Holroyd-Leduc, 2015).
- Evaluation of common dementia symptoms such as cognitive, psychosis and agitation, depression, and sleep disturbances (APA, 2007).
- Establishment of a robust therapeutic alliance with family and caregivers (APA, 2007).
- A plan for decision-making as individuals diagnosed with dementia often lose decision-making abilities with disease progression. Medical, legal, and financial decisions must be handled by family members or an authorized representative (APA, 2007).

C. Differential diagnosis for neurocognitive disorders includes (DSM-5, 2013):

- Assessment of suspected major and mild neurocognitive disorders should include a thorough differential diagnosis to rule out the following:
  - Depressive Disorders
  - Delirium due to medications, general medical conditions and surgeries (APA, 2007).
  - Delirium is characterized by a reduced ability to maintain attention, with fluctuating cognitive deficits, whereas deficits related to dementia are stable and progressive over time.
  - A close evaluation of medications for comorbid disorders may reveal and clarify a diagnosis of delirium vs. major and mild neurocognitive disorders.
  - In the event that delirium is diagnosed, referral for the appropriate medical attention should be initiated.
- Agitation as a result of infection (urinary tract infection), dehydration, untreated or undertreated pain, recent surgery, constipation, myocardial infarction, or physical or emotional discomfort; acute medical problems should be treated by appropriate medical services (APA, 2007).
  - Careful consideration is required in order to rule out underlying medical causes for major or mild NCD (Friedman, 2021).
  - Typical physical signs and symptoms (fever as a result of infection or pain due to myocardial infarction) may not be manifested in elderly individuals when medical conditions are present (APA, 2007); and
- Sensory deficits may worsen psychiatric and/or cognitive symptoms (APA, 2007).

D. Treatment Planning

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

- In addition to focusing on specific symptoms and general medical conditions, a treatment plan includes consideration of appropriate environment and care settings (APA, 2007):
  - Home care
  - Day Care
  - Long-Term Care
  - Inpatient General Medical or Surgery Services
  - Psychiatric Inpatient Services

E. Psychosocial Interventions

- The evidence does not recommend one psychosocial intervention over another and also suggests interventions be focused on improving/maintaining cognition, functioning, adaptive behavior, and quality of life (APA Watch, 2014).
- Typically, psychosocial interventions are used as an adjunct to pharmacotherapy to include:
  - Behavioral interventions should be aimed at reducing the presenting behavioral disturbances with the active participation of caregivers (APA, 2007).
Cognitive interventions are focused on cognitive stimulation to activate cognitive functions such as attention, memory, and language (Manera et al., 2020).

Emotional oriented treatment such as supportive psychotherapy can be implemented to address issues of loss in the early stages of major and mild neurocognitive disorders and helping individuals adjust to their illness (APA, 2007).

Reminiscence therapy interventions may incorporate the use of items from the past to include photographs, voice recordings, music or letters aimed at stimulating the senses, reducing anxiety and challenging behaviors, and boosting cognition and mood (APA, 2007; Manera et al., 2020).

All interventions and chosen treatments should take into account the level of cognitive impairment (i.e., attention, concentration, orientation, short and long-term memory, executive functioning and language) and should be modified as appropriate (APA, 2007).

Because the behavioral symptoms of major and mild neurocognitive disorders tend to change over time, intervention choices may also change to target current symptoms, with the ultimate goal of maximizing function in the context of existing deficits (APA, 2007).

Monitor for behavioral and psychological symptoms approximately every 3 months (Ngo & Holroyd-Leduc, 2015).

Interventions should also target new symptoms after the introduction of a new medication or change in dosage of an existing medication (APA, 2007).

Be alert regarding the risk of abuse and report as required to applicable officials (Ngo & Holroyd-Leduc, 2015).

Monitor for signs of caregiver distress such as anger, social withdrawal, anxiety, depression, sleep deprivation, irritability, poor concentration, increased physical health problems, and denial of the disease process (APA, 2007).

Support programs for caregivers and individuals with dementia reduce the possibility for institutionalization and also serve to improve caregiver well-being (APA Watch, 2014).

F. General Pharmacotherapy

Medications must be used with caution in older individuals who may have altered levels of absorption, distribution, metabolism, the elimination of many medications, and are more likely to experience adverse side effects (APA, 2007).

Antipsychotic medications are associated with adverse side effects; other medication categories have shown small to moderate risk, these include cognitive enhancers such as cholinesterase inhibitors and memantine, and antidepressants such as selective serotonin reuptake inhibitors (SSRIs) (Mathys, 2018).

If antipsychotics are required, use of the lowest effective dose for the shortest amount of time with re-assessments regarding continuation every 6 weeks (APA, 2016; NICE, 2018).

- Antipsychotic medications prescribed for individuals diagnosed with dementia and displaying agitation or psychosis should be monitored for improvement with a 4-week trial of adequate dosing. If there is no significant and improved response, the medication should be tapered and withdrawn (APA, 2016).

A retrospective case-control study published in the Journal of the American Medical Association (JAMA) Psychiatry (2015), reviewed mortality risk associated with antipsychotics, valproic acid, and antidepressants. The study revealed mortality risk differences between individuals with dementia using medications compared to medication nonusers. Haloperidol was found to have the highest mortality risk among the study medications, while risperidone was the highest in the atypical antipsychotic category (Maust et al., 2015).

Benzodiazepines and mood stabilizers administered for major neurocognitive disorders have shown a high risk of adverse effects and minimal effectiveness (Mathys, 2018).

Falls are common and potentially serious for elderly individuals with Major and Mild Neurocognitive Disorders. Falls can lead to hip fracture, head trauma, and a variety of other injuries, including subdural hematomas, which may further worsen cognitive function (APA, 2007).

One of the most effective ways to prevent falls includes withdrawing medications that are associated with falls, central nervous system sedation, or cardiovascular side effects (especially orthostatic hypotension), when appropriate (APA, 2007).
A reassessment should occur at least every 3-6 months after the initiation of treatment and adjustments should be made accordingly (APA, 2007).

REFERENCES


REVISION HISTORY

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<tr>
<td>08/08/2017</td>
<td>Version 1 – Annual Review</td>
</tr>
<tr>
<td>07/11/2018</td>
<td>Annual update: Updates to template and formatting, references.</td>
</tr>
<tr>
<td>07/15/2019</td>
<td>Annual Update: updates to template, formatting, references.</td>
</tr>
<tr>
<td>11/16/2020</td>
<td>Annual Update: update to sourcing, references, removal of coding grids</td>
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