Treatment of Depressive Disorders (Major Depressive Disorder, Persistent Depressive Disorder & Premenstrual Dysphoric Disorder)

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Product:
- 2001 Generic UnitedHealthcare COC/SPD
- 2007 Generic UnitedHealthcare COC/SPD
- 2009 Generic UnitedHealthcare COC/SPD
- 2011 Generic UnitedHealthcare COC/SPD

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Related Coverage Determination Guidelines:
- Custodial Care and Inpatient Services
- Electroconvulsive Therapy (ECT)
- Transcranial Magnetic Stimulation

Related Medical Policies:
- Level of Care Guidelines

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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

- Major Depressive Disorder (MDD) is a form of Depressive Disorder whose essential feature is the presence of a Major Depressive episode of at least two weeks in duration during which there is either depressed mood or the loss of interest or pleasure in nearly all activities (Diagnostic and Statistical Manual of Mental Disorders, 5th ed.; DSM-5; American Psychiatric Association, 2013).

- Persistent Depressive Disorder is a form of Depressive Disorder whose essential feature is a chronically depressed mood that occurs for most of the day more days than not for at least 2 years, or 1 year for children and adolescents (DSM-5, 2013).

- Premenstrual Dysphoric Disorder (PMDD) is a form of Depressive Disorder whose essential feature is the presence of at least five of the following symptoms (marked affective lability, irritability, anger, depressed mood, decreased interest in activities, difficulty in concentration, lethargy, changes in appetite, hypersomnia, insomnia, being overwhelmed, physical symptoms) during the final week before the onset of menses in the majority of menstrual cycles. The symptoms start to improve within a few days after the onset of menses, and become minimal or absent in the week of post menses (DSM-5, 2013).

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

- Pre-notification is required for inpatient, residential treatment, partial hospital/day treatment programs, intensive outpatient programs, and home-based outpatient treatment.

- Services should be consistent with evidence-based interventions and clinical best practices as described in Part III, and should be of sufficient intensity to address the member's needs (UnitedHealth Care, Certificate of Coverage (COC), 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, partial hospital/day treatment program, intensive outpatient, and home-based outpatient treatment 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, intensive outpatient program, or home-based outpatient treatment without evidence-based treatment of acute symptoms.

• Admission to an inpatient, residential treatment, partial hospital/day treatment program, intensive outpatient program, or home-based outpatient treatment for the sole purpose of awaiting placement in a long-term facility.

• Admission to an inpatient, residential treatment, partial hospital/day treatment program, intensive outpatient program, or home-based outpatient treatment 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 Depressive Symptoms

2.1. All of the following is evaluated for Major Depressive Disorder, Persistent Depressive Disorder and Premenstrual Dysphoric Disorder (American Psychiatric Association, Clinical Practice Guideline, Major Depressive Disorder (APA Guideline), 2010):
2.1.1. The events leading up to the current episode of care;

2.1.2. Determine if the following symptoms are present (Lyness, 2016):
   2.1.2.1. Depressed mood most the day
   2.1.2.2. Loss of interest or pleasure in most or all activities
   2.1.2.3. Insomnia or hypersomnia
   2.1.2.4. Significant weight loss or weight gain (e.g., 5 percent within a month) or decrease or increase in appetite nearly every day
   2.1.2.5. Psychomotor retardation or agitation nearly every day that is observable by others
   2.1.2.6. Fatigue or low energy
   2.1.2.7. Decreased ability to concentrate, think, or make decisions
   2.1.2.8. Thoughts of worthlessness or excessive or inappropriate guilt
   2.1.2.9. Recurrent thoughts of death or suicidal ideation, or a suicide attempt

2.1.3. The use of baseline measurement scales such as (O’Reardon, 2007):
   2.1.3.1. Patient Health Questionnaire (PHQ-9)
   2.1.3.2. Beck Depression Scale (BDI),
   2.1.3.3. Hamilton Depression Rating Scale (HDRS),
   2.1.3.4. Montgomery-Asberg Depression Rating Scale (MADRS) or
   2.1.3.5. MMSE to measure cognitive functioning

2.1.4. Current level of functioning;

2.1.5. History of medication treatment trials for depression and response;

2.1.6. The history of interventions targeting depression or co-occurring conditions including psychosocial interventions, use of community resources, and response to previous interventions;

2.1.7. Side effects experienced from prescribed and over-the-counter medications;

2.1.8. Results of laboratory tests when indicated;

2.1.9. The history of the onset and progression of symptoms;
2.1.10. The member’s ability to make informed treatment decisions;

2.1.11. The ability of the member’s family/caregiver to participate in the member’s treatment;

2.1.12. The optimal treatment setting and the member’s ability to benefit from a different level of care; and

2.1.13. Determination if the member meets criteria for a Depressive Disorder according to the DSM.

3. Evaluation of Suicidality

3.1. Assessment of suicide risk includes the following (American Psychiatric Association, Assessment of Patients with Suicidal Behaviors (APA Guideline), 2003):

3.1.1. The member’s most current diagnoses;

3.1.2. Current suicidal ideation, intent, plan, and available means and actions;

3.1.3. History of suicidal behavior including previous attempts;

3.1.4. Comorbid psychiatric and general illnesses;

3.1.5. The nature of the current crisis or other unique issues that may have precipitated suicidal behavior; and

3.1.6. Relevant familial factors such as family history of attempts, completion of suicide, and mental illness

3.2. A plan for further evaluation and treatment should be developed according to the level of risk present (Lyness, 2016).

3.3. There is insufficient evidence that a suicide contract reduces risk, especially when the member is in crisis, agitated, psychotic, impulsive, or intoxicated (APA Guideline, 2010).

4. Special Considerations for Evaluating Children and Adolescents

4.1. Younger children may exhibit behavioral problems such as social withdrawal, aggressive behavior, apathy, sleep disruption, and weight loss (American Academy of Children and Adolescent Psychiatry, Parameter for Depressive Disorders (AACAP Guideline), 2007).

4.2. Adolescents may present with somatic complaints, self-esteem problems, rebelliousness, poor performance in school, or a pattern of engaging in risky or aggressive behavior (AACAP Guideline, 2007).
4.3. A variety of informants should be used in evaluating children and adolescents, including parents and teachers (AACAP Guideline, 2007).

5. Differential Diagnosis

5.1. Differential diagnosis is conducted as part of the evaluation to identify medical and/or psychiatric disorders that may mimic or overlap with the symptoms of a Depressive Disorder (APA Guideline, 2010).

5.2. The differential diagnosis of depressive disorders includes another (general) medical disorder, complicated grief, Attention-Deficit/Hyperactivity Disorder, Bipolar Disorder, Schizoaffective Disorder, Schizophrenia, and Adjustment Disorder with depressed mood (Lyness, 2016).

5.3. Due to the risks of misdiagnosis and differing treatment recommendations for Depressive Disorders and Bipolar Disorder, careful differential diagnosis will ensure the most appropriate care is delivered (i.e., the correct diagnosis is made and appropriate treatment goals are set) and should be a routine part of the evaluation with the following considerations (APA Guideline, 2010):

5.3.1. Major depressive episodes or recurrent depressive episodes are common in the course of both Bipolar I and II.

5.3.2. Acute psychosis, a history of mania or hypomania, and/or a family history of Bipolar Disorder may be indicators of the need for additional evaluation and screening for Bipolar Disorder.

6. Evaluation Considerations for PMDD

6.1. Premenstrual dysphoric disorder is marked by emotional and behavioral symptoms that occur repeatedly during the week before onset of menses and remit with onset of menses or a few days thereafter, and which interfere with some aspect of the patient's life (Lyness, 2016).

6.2. If PMDD is suspected, a clear diagnosis is established before treatment is considered. As part of confirming a PMDD diagnosis, the following information should be gathered as part of the evaluation (Yonkers & Casper, 2014):

6.2.1. A detailed menstrual history to confirm that the member has been symptom-free during the follicular phase. This can be best discerned by having a member chart her mood and physical symptoms daily over the course of at least one menstrual cycle.
6.2.2. If the member’s cycles are regular (25 to 35 day interval), detailed information about her symptoms should then be obtained (type, pattern of onset and offset, severity, presence of functional impairment, and confirmation that symptoms are recurrent).

6.2.3. If the member reports irregular cycles, consider consultation or referral to a medical specialist who may choose to address the following:

6.2.3.1. Measuring serum human chorionic gonadotropin (hCG), thyrotropin (TSH), prolactin, and follicle-stimulating hormone (FSH) is recommended for members who experience irregular menstrual cycles (<25 or >35 days) particularly during the menopausal transition.

6.2.3.2. A list of medications, including hormone treatment. Members taking oral contraceptives (OCs) should be asked if their premenstrual symptoms were present before the OC was started, or if the symptoms first began after initiation of the OC (i.e., if the PMDD is OC induced).

6.2.3.3. Determination of endocrine disorders that can cause similar symptoms, such as hyper- or hypothyroidism and cortisol excess.

6.2.3.4. Laboratory testing should be limited to serum TSH to rule out hyper- and hypothyroidism, both of which can cause mood symptoms.

6.2.4. Standardized scales may be used to measure symptoms over time to include (DSM-5, 2013):

6.2.4.1. Daily Rating of Severity of Problems;
6.2.4.2. Visual Analogue Scales for Premenstrual Mood Symptoms; or
6.2.4.3. Premenstrual Tension Syndrome Rating Scale

6.2.5. If the patient’s symptom history is consistent with PMDD, and there is no evidence of other medical disorders, the patient should be asked to record symptoms prospectively for two months to confirm the diagnosis (Yonkers & Casper, 2014).

7. Treatment Planning

7.1. 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:
7.1.1. The short- and long-term goals of treatment;
7.1.2. The type, amount, frequency and duration of treatment;
7.1.3. 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;
7.1.4. How the member’s family and other natural resources will participate in treatment when clinically indicated;
7.1.5. How treatment will be coordinated with other providers as well as with agencies or programs with which the member is involved.

7.2. 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.
7.2.1. Examples include psychoeducation, motivational interviewing, recovery and resiliency planning, advance directive planning, and facilitating involvement with self-help and wraparound services.

7.3. 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.

7.4. 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.

7.5. The treatment plan and level of care are reassessed when the member’s condition improves, worsens or does not respond to treatment.
7.5.1. When the member’s condition has improved, the provider determines if the treatment plan should be altered, or if treatment is no longer required.
7.5.2. 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.
7.6. 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.

Treatments and Interventions

For initial treatment, the combination of pharmacotherapy and psychotherapy, is preferred over either of these treatments alone. However, clinical trials have not established the superiority of any specific medication/psychotherapy combination (Lyness, 2016).

1. **Psychotherapy**

   1.1. Cognitive Behavioral Therapy (CBT) and Interpersonal Therapy (IPT) are recommended first line forms of psychotherapy for the treatment of MDD.

   1.2. CBT combines cognitive therapy and behavioral therapy. Cognitive therapy attempts to modify the dysfunctional thoughts, beliefs, and attitudes (e.g., “I'm no good,” “there's nothing I can do,” or “my situation is hopeless”) that maintain behaviors associated with depression. Behavioral therapy focuses upon modifying the patient’s problematic behavioral responses (e.g., social isolation and inactivity) to environmental stimuli or dysfunctional thoughts (Katon, W., Roy-Byre, P., Sullivan, D., as cited in uptodate.com).

   1.3. Interpersonal therapy addresses problematic interpersonal relationships or circumstances that are directly related to the current depressive episode. The therapy focuses upon four types of problems: grief over loss (e.g., death of a spouse), role disputes (e.g., conflicts at work or home about expectations from the relationship), role transitions (e.g., childbirth, divorce, or retirement), and interpersonal skill deficits (e.g., pervasive problems starting and maintaining relationships, and chronically contentious and unfulfilling relationships) (Katon, et al., as cited in uptodate.com).

2. **Pharmacotherapy**

   2.1. Medication treatment options include:

      2.1.1. Buproprion, Venlafaxine, or Mirtazapine and SSRI and SNRI class medications are first line agents for the treatment of MDD and Persistent Depressive Disorder in addition to other current FDA approved medications for the treatment of MDD or Persistent Depressive Disorder.
2.1.2. For Persistent Depressive Disorder, there are no specific agents that have been shown more effective than others (APA Guideline, 2010).

2.1.3. Consider combining a SSRI with an aripiprazole for depressive symptoms with psychotic features (APA Guideline, 2010).

2.1.4. Consider tricyclic antidepressants for members who have a history of poor response to standard first line agents, and who have been successfully treated with tricyclic antidepressants agents (APA Guideline, 2010).

2.1.5. Except for lower initial doses to avoid unwanted effects, the doses of the antidepressants in children and adolescents are similar to those used for adult members (AACAP Guideline, 2007).

3. Treatment algorithms include:

3.1. Sequenced Treatment Alternatives to Relieve Depression (STAR*D) or Texas Medication Algorithm Project (TMAP).

3.1.1. STAR*D consists of the following algorithm (Maroney, M. (2012). Retrieved from www.pharmacytimes.org:

3.1.1.1. Level 1: Initial treatment with citalopram

3.1.1.2. Level 2: Switch to bupropion SR, cognitive therapy, sertraline, venlafaxine XR; or

3.1.1.3. Augment with bupropion SR, buspirone, cognitive therapy

3.1.1.3.1. Level 2 (a): Only for those receiving cognitive therapy in Level 2 – May switch to bupropion SR or venlafaxine

3.1.1.4. Level 3: Switch to mirtazapine or nortriptyline; or

3.1.1.5. Augment with lithium, T3 (only with bupropion SR, sertraline, venlafaxine XR)

3.1.1.6. Level 4: Switch to tranylcypromine or mirtazapine plus venlafaxine XR

3.1.2. TMAP consists of the following algorithm: (Maroney, M., 2012):

3.1.2.1. Stage 1: SSRI, bupropion mirtazapine or SNRI

3.1.2.1.1. Stage 1A: If partial response, augment with SSRI, SNRI, bupropion, mirtazapine, buspirone or T3.
3.1.2.2. Stage 2: Alternate stage 1 treatment

3.1.2.2.1. Stage 2A: If partial response, augment with option from 1A.

3.1.2.3. Stage 3: SSRI/SNRI plus bupropion; SSRI/SNRI plus mirtazapine; SSRI plus TCA; TCA plus or minus lithium; or MAOI.

3.1.2.3.1. Stage 3A: If partial response, augment with lamitrogine, bupropion, mirtazapine or D2 agonist.

3.1.2.4. Stage 4: If on a combination at stage 3, use TCA plus or minus lithium or MAOI. If TCA or MAOI at stage 3 use combo SSRI/SNRI plus olanzapine or risperidone; SSRI plus lamitrogine or ECT.

3.1.2.5. Stage 5: ECT or VNS

3.1.2.6. Stage 6: Triple antidepressant therapy

3.1.2.7. Stage 7: Alternate stages 2 or 3 combination or consider ECT or VNS if not used previously.

3.1.2.8. Stage 8: Alternate stages 2 or 3 drug combination.

3.2. Treatment Considerations for PMDD

3.2.1. For women with mild symptoms that do not cause distress or dysfunction, lifestyle measures such as regular exercise and stress reduction techniques should be implemented (Yonkers & Casper, 2014).

3.2.2. Selective serotonin reuptake inhibitors (SSRIs) are first-line therapies for women with PMDD. Fluoxetine or sertraline are preferred (Yonkers & Casper, 2014).

3.2.3. SSRIs can be administered as a daily therapy or luteal phase-only treatment (starting on cycle day 14), but that the patient must be asymptomatic during the follicular phase to avoid being undertreated (Yonkers & Casper, 2014).

3.2.4. For women who have not responded to or cannot tolerate SSRIs, oral contraceptives administered continuously or a shortened pill-free regimen is recommended. An oral contraceptive containing drospirenone is preferred (Yonkers & Casper, 2014).
3.2.5. For women who have not responded to or cannot tolerate SSRIs or oral contraceptives and continue to experience severe symptoms, gonadotropin-releasing hormone (GnRH) agonist therapy with estrogen-progestin is recommended (Yonkers & Casper, 2014).

3.2.6. Medication therapy of PMDD is usually successful. As a result, surgery is considered only in the cases with severe, disabling symptoms that have not responded to GnRH agonist and hormone (HT) therapy for at least six months (Yonkers & Casper, 2014).

4. Measuring Progress

4.1. Tailoring the treatment plan requires ongoing and systematic assessment of the member’s needs. This can be facilitated by integrating clinician and/or member administered rating scale measurements into initial and ongoing evaluation (APA Guideline, 2010).

4.2. Clinician rated and/or self-rated scales help determine the course and effects of treatment (APA Guideline, 2010).

4.3. Self-rated scales require review, interpretation, and discussion with the member (APA Guideline, 2010). Commonly used tools include (APA Guideline, 2010):

4.3.1. Inventory of Depressive Symptoms (IDS), which is available in clinician-rated and self-rated versions

4.3.2. Clinician-rated Hamilton Rating Scale for Depression (HAM-D)

4.3.3. Clinician-rated Montgomery Asberg Depression Rating Scale (MADRS)

4.3.4. Self-rated Patient Health Questionnaire (PHQ-9)

4.3.5. The Beck Depression Inventory (BDI, BDI-II), copyrighted, 21-question multiple-choice self-rated instrument.

5. Changing or Augmenting the Course of Treatment

5.1. If the member’s depressive symptoms have not improved or have worsened prior to the current episode of care, a reassessment is indicated to stabilize the member’s current symptoms and modify the overall course of treatment. As part of the reassessment, the treating provider should verify:

5.1.1. If the member is following the treatment plan;
5.1.2. That an adequate dose of medication has been given for an adequate duration (generally 4-6 weeks) (STAR*D, 2010); and

5.1.3. That psychotherapy has been or is being skillfully executed and conducted over an appropriate period of time with an adequate frequency of visits (to be reassessed every 3-4 months) (STAR*D, 2010).

5.2. If it is determined through the process of reassessment that the member has not adequately responded to prior or current treatment efforts leading to an exacerbation of symptoms, the following should be considered:

5.2.1. The member has been misdiagnosed;

5.2.2. The frequency or intensity of treatment or the current level of care is inadequate;

5.2.3. Consider augmenting initial treatments by increasing the intensity or frequency of psychotherapy, combining psychotherapy with medications, or increasing medication to the upper limit in consideration of efficacy, side effects and adherence (APA Guideline, 2010).

5.2.4. Changing to a different antidepressant medication (either from one in the same class or to one of a different class) using (STAR*D) second-step treatment recommendations.

5.2.5. Consider implementation of motivational enhancement interventions in order to assist the member in engaging into the treatment process (APA Guideline, 2010).

5.2.6. Consider supplementing the treatment plan with community-based and peer support resources (LOCGs, 2016).

5.2.7. Consider Electroconvulsive Therapy (APA Guideline, 2010).

5.2.8. If covered, consider Transcranial Magnetic Stimulation (APA Guideline, 2010).

6. Other Treatments

6.1. Consider Electroconvulsive Therapy when there is significant risk to managing the member’s MDD including the following (APA Guideline, 2010):

6.1.1. Members who are imminent risk for suicide
6.1.2. Members who evidence signs/symptoms of psychosis

6.1.3. Members who evidence substantial cognitive impairment as a result of the member’s Depression.

6.1.4. Members who are otherwise severely incapacitated

6.2. When covered by the benefit plan, consider Transcranial Magnetic Stimulation (TMS) as indicated by the Coverage Determination Guideline for TMS.

**Discharge Planning**

1. **Discharge Planning Process**

1.1. The provider and, whenever possible, the member develops an initial discharge plan at the time of admission, and estimates the length of treatment.

1.2. The provider and, whenever possible, the member updates the initial discharge plan during the admission ensuring that:

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

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

   1.2.3. The member agrees with the discharge plan.

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

   1.3.1. The discharge date;

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

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

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

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

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

   1.3.7. An appointment for necessary lab tests is provided;

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

   1.3.9. Recommended self-help and community support services;
1.3.10. Information about what the member should do in the event of a crisis prior to the first appointment.

1.4. 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.

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

1.6. 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.

1.7. Notification of the Care Advocate that the member is discontinuing treatment may trigger outreach and assistance to the member.

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

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

   1.9.1. The discharge date;

   1.9.2. Recommended self-help and community support services;

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

   1.9.4. 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.
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 that 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

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 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**
**Cognitive Behavioral Therapy (CBT)**: A classification of therapies that are predicated on the idea that behavior and feelings are caused by thoughts.

**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.

**Electroconvulsive Therapy (ECT)**: A treatment technique which provokes a therapeutic response by applying an electrical current to the brain.

**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 6 hours 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.

**Interpersonal Therapy**: A brief and highly structured manual-based form of psychotherapy which focuses on understanding and improving the handling of interpersonal events such as disputes, role transitions and impoverished relationships that, if not addressed, may impact the development of mental illness.

**Major Depressive Disorder**: According to the DSM, Major Depressive Disorder is a form of Mood Disorder whose essential feature is the presence of a Major Depressive episode of at least two weeks duration during which there is either depressed mood or the loss of interest or pleasure in nearly all activities.

**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.

Suicide Contract (a.k.a. No Harm Contract)  A non-legal agreement in which the patient agrees not to attempt suicide.

PART VI: REFERENCES


5. Association for Ambulatory Behavioral Healthcare, Standards and Guidelines for Partial Hospital Programs, 2008.


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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<thead>
<tr>
<th>Limited to specific CPT and HCPCS codes?</th>
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<tbody>
<tr>
<td>90791</td>
<td>Psychiatric diagnostic evaluation</td>
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<tr>
<td>90791 plus interactive add-on code (90785)</td>
<td>Psychiatric diagnostic evaluation (interactive)</td>
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<td>Psychotherapy, 30 minutes with patient and/or family</td>
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<td>Psychotherapy, 30 minutes with patient and/or family (interactive)</td>
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<td>Therapeutic Repetitive Transcranial Magnetic Stimulation Treatment; Subsequent delivery and management, per session</td>
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<td>90869</td>
<td>Therapeutic Repetitive Transcranial Magnetic Stimulation Treatment; Subsequent motor threshold redetermination with delivery and management</td>
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<td>G0411</td>
<td>Interactive group psychotherapy, in a partial hospitalization setting, approximately 45 to 50 minutes</td>
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<td>H0035</td>
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<td>Partial hospitalization services, less than 24 hours</td>
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<td>S9480</td>
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<td>N94.3*</td>
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<td></td>
<td>F32.81</td>
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*Original codes and new codes will both be listed in document for a 90-day period. After this period has passed, the original codes will be removed.

<table>
<thead>
<tr>
<th>Limited to place of service (POS)?</th>
<th>☐ Yes X No</th>
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<tbody>
<tr>
<td>Limited to specific provider type?</td>
<td>☐ Yes X No</td>
</tr>
<tr>
<td>Limited to specific revenue codes?</td>
<td>X Yes ☐ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Limited to specific revenue codes?</th>
<th>X Yes ☐ No</th>
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</thead>
<tbody>
<tr>
<td>100-160</td>
<td>(Range describes various all-inclusive inpatient services)</td>
</tr>
<tr>
<td>900-919</td>
<td>(Range describes various unbundled behavioral health treatments/services)</td>
</tr>
<tr>
<td>1000-1005</td>
<td>(Range describes various sites that provider 24-hour services)</td>
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### PART VIII: HISTORY

<table>
<thead>
<tr>
<th>Revision Date</th>
<th>Name</th>
<th>Revision Notes</th>
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<tbody>
<tr>
<td>8/2010</td>
<td>L. Urban</td>
<td>Version 1-Final</td>
</tr>
<tr>
<td>4/2012</td>
<td>L. Urban</td>
<td>Version 2-Final</td>
</tr>
<tr>
<td>5/2013</td>
<td>L. Urban</td>
<td>Version 3-Final</td>
</tr>
<tr>
<td>4/2014</td>
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<td>Version 4-Final</td>
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<td>10/2014</td>
<td>L. Urban</td>
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<td>10/2015</td>
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<tr>
<td>5/2016</td>
<td>L. Urban</td>
<td>Version 7-Final</td>
</tr>
<tr>
<td>10/2016</td>
<td>L. Urban</td>
<td>Version 7-Final Revised</td>
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