United Behavioral Health

# Coverage Determination Guideline: Depressive 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®[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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## COVERAGE RATIONALE

**Available benefits for Depressive Disorders include the following levels of care, procedures, and conditions:**

- Levels of Care
  - Inpatient
  - Intensive Outpatient Program
  - Outpatient
  - Partial Hospital Program
  - Residential Treatment Facility
- Procedures
  - Diagnosis, evaluation, assessment, and treatment planning
  - Treatment and/or procedures
  - Medication management and other associated treatments
  - Individual, family, and group therapy
  - Provider-based case management
  - Crisis intervention
- Conditions
  - Depressive Disorders classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association* that are not excluded from coverage.

**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 common criteria and best practices
- 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
- Patients should receive a thorough diagnostic assessment to establish the diagnosis of major depressive disorder, identify other psychiatric or general medical conditions requiring attention, and develop a comprehensive treatment plan (American Psychiatric Association [APA], 2010).
- A careful and ongoing evaluation of suicide risk is necessary for all patients with major depressive disorder (APA, 2016).

B. Baseline Measurement
- Many clinician- and/or member-administered rating scales have demonstrated their validity and reliability in research studies and may be useful in the initial evaluation and ongoing clinical monitoring of depression (APA, 2016).
- Commonly used quantitative instruments that measure the presence and severity of depressive symptoms include:
  - Patient Health Questionnaire-9 (PHQ-9); (VA/DOD, 2016);
  - Beck Depression Inventory (BDI) (APA, 2010);
  - Hamilton Depression Rating Scale (HDRS; HAM-D) (APA, 2010);
  - Montgomery-Asberg Depression Rating Scale (MADRS) (APA, 2010);
  - Inventory of Depressive Symptomatology (IDS; QIDS) (APA, 2010);
  - Mood Disorders Questionnaire (MDQ) (McIntyre et al., 2019).

C. Differential Diagnoses:
- Differential diagnosis for major depressive disorder (MDD) includes (*Diagnostic and Statistical Manual of Mental Disorders* 5th ed.; DSM-5; APA, 2013):
  - Manic episodes with irritable mood or mixed episodes;
  - Mood disorder due to another medical condition;

    - Substance/medication-induced depressive or bipolar disorder;
    - Attention-deficit/hyperactivity disorder;
    - Adjustment disorder with depressed mood;
    - Sadness.
- Clinical evaluation recommended to differentiate depression versus bipolar disorder include number of episodes and the age of onset, illness severity, sleep history with current sleep habits, and grandiose behaviors. Additional evaluation information is an accurate family history with supporting knowledge from the family. Secondary causes such as medical co-morbidities or medications must be ruled out (McIntyre et al., 2019).
- Differential diagnosis for premenstrual dysphoric disorder includes (APA, 2013):
    - Premenstrual syndrome;
    - Dysmenorrhea;
    - Bipolar disorder;
    - Major depressive disorder;
    - Persistent depressive disorder;
    - Use of hormonal treatments.
- Differential diagnosis for disruptive mood dysregulation disorder (DMDD) includes (APA, 2013):
    - Bipolar disorder;
    - Oppositional defiant disorder;
    - Attention-deficit/hyperactivity disorder;
    - Major depressive disorder;
    - Anxiety disorder;
    - Autism spectrum disorder;
    - Intermittent explosive disorder.

D. Treatment planning best practices
- 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

E. Initial treatment of depression involves medications, psychotherapy, or a combination of the two:
- Antidepressants
    - Selective serotonin reuptake inhibitors (SSRIs, including fluoxetine, citalopram, sertraline, paroxetine, and escitalopram), serotonin-norepinephrine reuptake inhibitors (SNRIs, including venlafaxine and duloxetine), bupropion, and mirtazapine are common antidepressant choices because they have a better side effect profile than older classes of antidepressants, such as tricyclics, monoamine oxidase inhibitors (MAOIs), and tetracyclics (Qaseem et al. for the American College of Physicians [ACP], 2016; APA, 2010).
    - The use of MAOIs should be restricted to individuals with resistance to other treatments due to the side effects and dietary restrictions (APA, 2010; VA/DOD, 2016).
    - Numerous forms of medication exist across these classes and each has different side effects (APA, 2010).
    - For individuals with MDD that is moderate or severe, most second-generation antidepressants are the initial treatment. For individuals with mild depressive symptoms, the initial treatments include psychoeducation and psychotherapies (Canadian Network for Mood and Anxiety Treatments [CANMET], 2016).
    - For individuals who have limited or no response to initial medication monotherapy with a maximum medication dose, after at least four to six weeks of treatment; the recommendation is switching to another monotherapy (medication or psychotherapy) or adding a second medication or psychotherapy (VA/DOD, 2016).
- Psychotherapies
    - Commonly used initial psychotherapy strategies for depression include interpersonal therapy (IPT), cognitive behavioral therapy (CBT), acceptance and comittment therapy for depression (ACT-D), mindfulness-based cognitive therapy (MBCT), and problem-solving therapy (PST) (VA/DOD, 2016).

- CBT shows equal efficacy as second-generation antidepressants (SGAs) as initial treatment in alleviating mild to severe MDD symptoms for adult outpatients (Agency for Healthcare Research & Quality [AHRQ], 2016).
- A meta-analysis of 575 participants revealed that psychotherapy provided in addition to medication yielded a decrease in self-reported symptoms of depression (Ijaz et al., 2018).

F. Measurement of Progress
- Many clinician- and/or member-administered rating scales have demonstrated their validity and reliability in research studies, and may be useful in the initial evaluation and ongoing clinical monitoring of depression (APA, 2016).
- Commonly used quantitative instruments that measure the presence and severity of depressive symptoms include (VA/DOD, 2016):
  - Patient Health Questionnaire-9 (PHQ-9);
  - Beck Depression Inventory (BDI);
  - Hamilton Depression Rating Scale (HDRS; HAM-D);
  - Montgomery-Asberg Depression Rating Scale (MADRS);
  - Inventory of Depressive Symptomatology (IDS; QIDS).

G. Switching/Augmenting the Course of Treatment
- Clinicians should carefully reevaluate patients with depression that have not responded to initial treatment including:
  - Adherence to the treatment plan (Caffrey, 2017);
  - That an adequate dose of medication has been given for an adequate duration with a minimum of 4-8 weeks and/or (VA/DOD Guidelines; AHRQ, 2016);
  - That psychotherapy has been or is being conducted over an appropriate period of time with an adequate frequency of visits such as at least 8 visits of 30 minutes each (AHRQ, 2016);
  - Consider if the patient is a rapid metabolizer of antidepressants (Caffrey, 2017).
- If a patient has not responded to initial treatment, it may suggest a need to reconsider the accuracy of that diagnosis (APA, 2016).
- Treatment switching or augmentation may be reasonable options for those patients with depression who do not respond to initial therapy (AHRQ, 2016; ACP, 2016).
- On March 5, 2019, the Food and Drug Administration (FDA) approved esketamine nasal spray for treatment resistant depression. The FDA approval includes a risk valuation and mitigation strategy (REMS) intended to help safeguard proper clinician training in administration and careful candidate selection (Emergency Care Research Institute [ECRI], 2019).

H. Other treatments
- Brain stimulation such as electroconvulsive therapy (ECT) may be a treatment option in individuals with severe depression when there is a history of poor response to medications and when there is a need for a rapid, definitive response due to the severity of the condition (e.g., imminent risk of suicide, signs or symptoms of psychosis, substantial cognitive impairment as a result of the depression) (APA, 2010; National Institute of Mental Health [NIMH], 2018; Weiss et al., 2019).
- Brain stimulation such as transcranial magnetic stimulation (TMS) may also be considered in individuals who have not responded to prior antidepressant therapy (APA, 2010; NIMH, 2018) .

I. Treatment considerations for premenstrual dysphoric disorder (PMDD):
- Individual and group therapy may help to relieve symptoms (Hantsoo & Epperson, 2015);
- Cognitive-behavioral therapy (CBT) has shown to improve coping strategies (Hantsoo & Epperson, 2015).
- The American College of Obstetricians and Gynecologists (2015), describes PMDD as a severe form of premenstrual syndrome; selective serotonin reuptake inhibitors (SSRIs) are recommended for the treatment of PMDD.
- SSRIs, including sertraline, fluoxetine, citalopram, and paroxetine have also been shown to reduce symptoms of PMDD (Hantsoo & Epperson, 2015).

- For women who do not respond to or cannot tolerate SSRIs, consultation or referral to a medical care provider for other medication therapies may be necessary (Hantsoo & Epperson, 2015).

J. Treatment considerations for disruptive mood dysregulation disorder (DMDD):
- DMDD is a fairly new diagnosis, and treatment is often based on what has been helpful for other disorders that share symptoms of irritability and temper tantrums, including attention-deficit/hyperactivity disorder, anxiety disorders, oppositional defiant disorder, and major depressive disorder (NIMH, 2017).
- The initial diagnosis should not be before 6 years old or after 18 years old (APA, 2013).
- The frequent symptoms of DMDD interfere with function capabilities at school, at home, or with friends. Previously, some of these children were diagnosed with bipolar disorder, although they did not display all of the bipolar signs and symptoms (American Academy of Child & Adolescent Psychiatry, 2019).
- Medications (e.g., stimulants, antidepressants) and/or psychological treatments (e.g., cognitive-behavioral therapy, parent training) may be useful in treating DMDD (NIMH, 2017).
- SSRIs and central nervous system (CNS) stimulants are viable medication options; CNS stimulants have shown minimal side effects and minimal risk of manic activation (Baweja et al., 2016).
- Given the complexity of DMDD, a combination of therapies, including psychosocial techniques will likely be required for meaningful improvement (Baweja et al., 2016).

## 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.

| Diagnosis Codes | Description |
|---|---|
| F32.0-F32.9; F33.0-F33.9 | Major Depressive Disorder |
| F34.1 | Persistent Depressive Disorder (Previously Dysthymia) |
| F32.81 | Premenstrual Dysphoric Disorder |
| F34.81 | Disruptive Mood Dysregulation Disorder |

| Procedure Codes | Description |
|---|---|
| 90785 | Interactive complexity (list separately in addition to the code for primary psychiatric service/procedure) |
| 90791 | Psychiatric diagnostic evaluation |
| 90792 | Psychiatric diagnostic evaluation with medical services |
| 90832 | Psychotherapy, 30 minutes with patient |
| 90833 | Psychotherapy, 30 minutes with patient when performed with an evaluation and management service(list separately in addition to the code for primary procedure) |
| 90834 | Psychotherapy, 45 minutes with patient |
| 90836 | Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure) |
| 90837 | Psychotherapy, 60 minutes with patient |
| 90838 | Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure) |
| 90839 | Psychotherapy for crisis; first 60 minutes |
| 90840 | Psychotherapy for crisis; each additional 30 minutes (list separately in addition to |

| | |
|---|---|
| | the code for primary service) |
| 90846 | Family psychotherapy (without the patient present), 50 minutes |
| 90847 | Family psychotherapy (conjoint psychotherapy) (with the patient present), 50 minutes |
| 90849 | Multiple-family group psychotherapy |
| 90853 | Group psychotherapy (other than of a multiple-family group) |
| 90863 | Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure) |
| G0177 | Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more) |
| G0410 | Group psychotherapy other than of a multiple-family group, in a partial hospitalization setting, approximately 45 to 50 minutes |
| G0411 | Interactive group psychotherapy, in a partial hospitalization setting, approximately 45 to 50 minutes |
| H0004 | Behavioral health counseling and therapy, per 15 minutes |
| H0015 | Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling, crisis intervention, and activity therapies or education |
| H0017 | Behavioral health; residential (hospital residential treatment program), without room and board, per diem |
| H0018 | Behavioral health; short-term residential (nonhospital residential treatment program), without room and board, per diem |
| H0019 | Behavioral health; long-term residential (nonmedical, nonacute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem |
| H0025 | Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior) |
| H0035 | Mental health partial hospitalization, treatment, less than 24 hours |
| H2001 | Rehabilitation program, per 1/2 day |
| H2011 | Crisis intervention service, per 15 minutes |
| H2012 | Behavioral health day treatment, per hour |
| H2013 | Psychiatric health facility service, per diem |
| H2017 | Psychosocial rehabilitation services, per 15 minutes |
| H2018 | Psychosocial rehabilitation services, per diem |
| H2019 | Therapeutic behavioral services, per 15 minutes |
| H2020 | Therapeutic behavioral services, per diem |
| H2033 | Multisystemic therapy for juveniles, per 15 minutes |
| S0201 | Partial hospitalization services, less than 24 hours, per diem |
| S9480 | Intensive outpatient psychiatric services, per diem |
| S9482 | Family stabilization services, per 15 minutes |
| S9484 | Crisis intervention mental health services, per hour |
| S9485 | Crisis intervention mental health services, per diem |

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## REVISION HISTORY

| Date | Action/Description |
|---|---|
| 02/12/2019 | • Annual update |
| 01/27/2020 | • Annual update |