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.
Key Points

- According to the DSM in Obsessive-Compulsive Disorder, there is a presence of obsessions, compulsions, or both (Diagnostic and Statistical Manual of Mental Disorders, 5th ed.; DSM-5; American Psychiatric Association, 2013):
  - Obsessions are defined by both of the following:
    - Recurrent and persistent thoughts, urges, or images that are experienced at some time during the disturbance as intrusive, unwanted, and cause marked anxiety or distress;
    - The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).
  - Compulsions are defined by both of the following:
    - Repetitive behaviors (e.g., hand washing, ordering, checking), or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly;
    - Behaviors or mental acts aimed at preventing or reducing distress and dreaded events or situations however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive. Young children may not be able to articulate the aims of these behaviors or mental acts.
- According to the DSM, the essential feature of Hoarding Disorder is persistent difficulty discarding or parting with possessions regardless of value due to a perceived need to save the items. There is significant distress associated with discarding, leading to an accumulation of possessions and cluttering of the member’s living areas to the point that the member’s social, occupational, or other areas of functioning are compromised. The hoarding is not attributable to a medical condition such as a brain injury, or better explained by another mental disorder such as Obsessive Compulsive Disorder, Major Depressive Disorder, Psychotic Disorders or Neurocognitive Disorders (Diagnostic and Statistical Manual of Mental Disorders, 5th ed.; DSM-5; American Psychiatric Association, 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, or a partial hospital/day treatment program require pre-service notification. Notification of a scheduled admission must occur at least five (5) business days before admission. Notification of an unscheduled admission (including Emergency admissions) should occur as soon as is reasonably possible. Benefits may be reduced if Optum is not notified of an admission to these levels of care. Check the member’s specific benefit plan document for the applicable penalty and provision for a grace period before applying a penalty for failure to notify Optum as required.

**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.

**Inconsistent or Inappropriate Services or Supplies – 2001, 2007, 2009 & 2011**

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 or intensive outpatient program without evidence-based treatment of acute symptoms.
• Admission to an inpatient, residential treatment, partial hospital/day treatment program or intensive outpatient program for the sole purpose of awaiting placement in a long-term facility.

• Admission to an inpatient, residential treatment, partial hospital/day treatment program or intensive outpatient program 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. Evaluating Obsessive-Compulsive Symptoms

2.1. If the standard evaluation suggests OCD symptoms, clinicians should complete a detailed OCD evaluation. Special attention should be given to rule out developmentally appropriate behaviors.

2.2. Initial questions about the presence of intrusive thoughts, images, or urges, repetitive behaviors and mental rituals should be asked (Simpson, 2016).

2.2.1. The frequency, amount of time consumed, and extent to which obsessions/compulsions cause distress or interfere with his or her life helps to distinguish OCD from occasional intrusive thoughts or repetitive behaviors that are common in the general population.
2.3. Identifying the main symptom patterns provides useful information to inform treatment and monitor changes in the severity of the disorder over time. Identifying a link between obsessions and compulsions, and confirming that the obsessions lead to anxiety or distress can help to differentiate OCD from other disorders of intrusive thoughts or repetitive behaviors (Simpson, 2016).

2.4. As a part of establishing a diagnosis, measuring the severity of symptoms, and measuring the patient’s progress over time, clinicians may use one or more of the following evidence-based tools (AACAP, 2012; APA Guideline Watch, 2013):

2.4.1. Yale-Brown Obsessive Compulsive Scale-Revised (Y-BOCS, CY-BOCS for children found at http://healthnet.umassmed.edu/mhealth/YBOCRatingScale.pdf,

2.4.2. Leyton Obsessional Inventory (proprietary tool), Anxiety Disorders Interview Schedule (ADIS, ADIS-C for children),

2.4.3. Pediatric Anxiety Rating Scale (PARS found at http://www.jaacap.com/) or the;

2.4.4. Multidimensional Anxiety Scale (proprietary tool) (AMAS for adults, MASC for children).

2.4.5. The Florida Obsessive-Compulsive Inventory symptom checklist and severity scale for adults (found at www.ocdscales.org).

2.4.6. The Obsessive-Compulsive Inventory-Revised (OCI-R) for adults. The scale looks at each subtype (washing, checking, ordering, hoarding and neutralizing) (proprietary tool).

2.5. Medical history to include an inquiry of trauma, neurological history or history of Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcus (PANDAS) should be gathered (AACAP, 2012).

2.6. Developmental, academic and/or occupational history and functioning should include an assessment of OCD symptoms exhibited in the school setting for children and adolescents, and in occupational settings in adults (AACAP, 2012).

2.7. Family functioning should be assessed to include factors such as family accommodation, enmeshment or negative reinforcement of OCD behaviors (AACAP, 2012).
2.8. Education should be provided to parents regarding normal patterns of development and typical behaviors as compared to behavior patterns of children with OCD (AACAP, 2012).

2.9. A variety of informants should be used in evaluating children and adolescents, including parents and teachers (AACAP, 2012).

3. Evaluating OCD Symptoms in Children and Adolescents

3.1. Younger children may exhibit behavioral problems such as social withdrawal, aggressive behavior, apathy, sleep disruption, and weight loss (AACAP, 2012).

3.2. 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, 2012).

3.3. Limited insight and hidden symptoms of OCD are frequently poorly articulated in younger children (AACAP, 2012).

3.4. Compulsions without well-defined obsessions and rituals often center on the fear of a catastrophic family event (AACAP, 2012).

3.5. There may not be a clear precipitating trigger (AACAP, 2012).

4. Differential Diagnosis

4.1. The differential diagnosis of OCD routinely includes other Anxiety Disorders, Major Depressive Disorder, Tic Disorder, Psychotic Disorders, and Obsessive-Compulsive Personality disorder. The nature of intrusive thoughts and repetitive behaviors can usually distinguish these disorders from OCD (Simpson, 2016).

4.2. The differential diagnosis includes an examination of the following conditions with overlapping symptoms prior to confirming OCD:

4.2.1. Developmentally appropriate ritualistic behaviors that may mimic OCD symptoms. If these behaviors are present, it may indicate the need for further parental education and/or referral to address any concerns (AACAP, 2012)

4.2.2. Recurrent thoughts, avoidant behaviors, and repetitive requests for reassurance occur in Anxiety Disorders other than OCD. Distinguishing features of the following Anxiety Disorders can inform diagnosis (Simpson, 2015):
4.2.2.1. Recurrent thoughts that are present in GAD are usually about real-life concerns, while the obsessions in OCD usually are not. OCD-related concerns generally involve content that is odd, irrational, or of a seemingly magical nature. In OCD, compulsions are almost always present and usually linked to the obsessions (Simpson, 2015).

4.2.2.2. Like OCD, Specific Phobias include fear reactions to specific objects or situations. However, the feared objects in Specific Phobia are usually more circumscribed than those in OCD, and not characterized by rituals (Simpson, 2015).

4.2.2.3. With Social Anxiety Disorder, feared objects or situations are limited to social interactions or performance situations. Avoidance or reassurance-seeking is focused on reducing this social fear (Simpson, 2015).

4.2.3. Symptoms of Hoarding Disorder focus exclusively on the persistent difficulty of discarding or parting with possessions, marked distress associated with discarding items, and excessive accumulation of objects. Members who have obsessions that are typical of OCD (e.g., concerns about incompleteness or harm) that lead to compulsive hoarding behaviors (e.g., acquiring all objects in a set to attain a sense of completeness or not discarding old newspapers because they may contain information that could prevent harm) should be diagnosed with OCD (Simpson, 2015).

4.2.4. The ruminative thoughts present with MDD are typically mood-congruent and are not necessarily experienced as intrusive or distressing as in OCD. Ruminations in depression are not linked to compulsions as is typical in OCD (Simpson, 2015).

4.2.5. Tic Disorders or Tics are typically less complex than compulsions and are not aimed at neutralizing obsessions (Simpson, 2015).

4.2.6. What distinguishes OCD from a delusional disorder or psychotic disorder is that those with OCD have obsessions and compulsions, not other features such as hallucinations or disorganized thinking/formal thought disorder (Simpson, 2015).
4.2.7. Obsessive-Compulsive Personality Disorder involves an enduring and pervasive maladaptive pattern of excessive perfectionism and rigid control that often leads to ritualized behavior. OCPD is not a version of OCD, and is not characterized by obsessions. The repetitive behaviors in OCPD are not performed in response to obsessions (Simpson, 2015).

4.2.8. Other disorders that include intrusive thoughts and repetitive behaviors can be distinguished from OCD by the nature of the thoughts and behaviors (Simpson, 2015).

4.2.8.1. In Body Dysmorphic Disorder, intrusive thoughts are limited to concerns about appearance.

4.2.8.2. In Trichotillomania, the repetitive behavior is limited to hair-pulling.

4.2.8.3. In Anorexia Nervosa, intrusive thoughts and repetitive behaviors are limited to concerns about weight and food.

4.2.9. Other behaviors that are sometimes considered “compulsive,” include sexual behavior, gambling, and substance use (Simpson, 2015).

5. Evaluation of Hoarding Symptoms

5.1. As a part of establishing the diagnosis, measuring the severity of symptoms may include the use one or more of the following evidence-based tools (American Psychiatric Association, Obsessive Compulsive Disorder, Guideline Watch (APA Watch), 2013):

5.1.1. The Saving Inventory-Revised (SI-R) scale

5.1.2. Hoarding Rating Scale (HRS-SR) Self-report measure

5.2. Hoarding Rating Scale Interview: In order to establish a Hoarding Disorder diagnosis, the clinician should gather information about the following (Saxena & Maidment, Treatment of Compulsive Hoarding, Focus, 2007, retrieved from psychiatryonline.org):

5.2.1. Amount of clutter and whether it extends beyond the member’s home (e.g., cars, garage, storage areas); and if the clutter impacts normal activities (e.g., sleeping in a bed, sitting on couches or using the kitchen counter).
5.2.2. Beliefs about possessions and whether the member feels responsible for possessions, feels that each item has a special significance, or goes to great lengths to avoid wastefulness.

5.2.3. Decision making about and categorization of possessions and whether there is distractibility and difficulty maintaining attention on tasks.

5.2.4. Avoidance behaviors and whether completing daily routines and tasks to maintain order is possible (e.g., sorting mail, returning calls, washing dishes).

5.2.5. Daily functioning and whether it is disrupted by ruminating about perfection or moving items from one pile to another without accomplishing a desired task.

5.2.6. Compliance with medical care and whether the member is taking prescribed medications if applicable, and keeping up with medical appointments.

5.2.7. Level of insight and whether there is awareness of one’s own hoarding, clutter and how this impacts the member’s life.

5.2.8. Social and occupational functioning and whether the member has family or social support or if their hoarding has them socially isolated. Work performance may also be impaired.

5.2.9. Baseline photographs of their cluttered areas.

5.3. Differential Diagnosis:

5.3.1. In order to establish a Hoarding Disorder diagnosis, the following conditions should be ruled out:

5.3.1.1. OCD should be assigned when the symptoms are judged to be a direct consequence of typical obsessions or compulsions (e.g., fears of contamination,

5.3.1.2. Psychotic Disorders and symptoms (e.g., Schizophrenia, intrusive thoughts, ruminations).

6. Treatment Planning

6.1. 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:

6.1.1. The short- and long-term goals of treatment;
6.1.2. The type, amount, frequency and duration of treatment;

6.1.3. 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;

6.1.4. How the member’s family and other natural resources will participate in treatment when clinically indicated;

6.1.5. How treatment will be coordinated with other providers as well as with agencies or programs with which the member is involved.

6.2. 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.

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

6.3. 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.

6.4. 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.

6.5. The treatment plan and level of care are reassessed when the member’s condition improves, worsens or does not respond to treatment.

6.5.1. When the member’s condition has improved, the provider determines if the treatment plan should be altered, or if treatment is no longer required.

6.5.2. 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.
6.5.3. 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 for Adults with OCD

1. Psychotherapy for Adults with Obsessive-Compulsive Disorder

1.1. Cognitive Behavioral Therapy with Exposure and Response Prevention (CBT-ERP) is a first line intervention with or without medication (APA Watch, 2013).

1.1.1. CBT for OCD typically includes: patient and family education, cognitive restructuring, exposure therapy, and response prevention (Abramowitz, 2016).

1.2. The use of CBT-ERP rather than medication as a first-line treatment is typically recommended for members with non-comorbid OCD. An SSRI can be used for members who prefer medication to psychotherapy, or when CBT is not available (Simpson, 2016).

1.3. Prior to beginning psychotherapy, the member should be provided with education regarding OCD and given a clear explanation as to how CBT-ERP is expected to be helpful in reducing OCD. Such education is an important first step in therapy to motivate the patient to tolerate the distress that typically accompanies exposure practice (Simpson, 2016).

1.4. CBT-ERP treatment seeks to strategically increase symptoms of anxiety through exposure while preventing avoidance, distraction, and rituals as ways of coping with the anxiety. This approach creates the opportunity for habituation to anxiety-inducing situations that impact the patient's OCD symptoms (APA, 2007).

1.5. CBT-ERP treatment components include (APA, 2007):

1.5.1. A detailed assessment of the individual’s fears, avoidances, and rituals which demonstrates the OCD symptom pattern;

1.5.2. Development of an exposure hierarchy rating scale of feared or avoided items or thoughts (0-100 based on level of discomfort);

1.5.3. Development of a response prevention plan detailing how to prevent engaging in rituals (behavioral or cognitive) and a form of self-monitoring of rituals by the patient to be provided to the clinician to help assess progress and to further identify triggers;
1.5.4. In vivo exposure or direct exposure of the patient to the feared item, situation, or thoughts from the hierarchy, steadily progressing from lower to higher rated items.

1.5.5. A 13-20 week trial of weekly outpatient sessions is recommended, and an evaluation of the member’s response with the use of measurement tools should be completed.

1.6. The Y-BOCS should be used to measure and re-measure OCD symptoms after an initial trial of psychotherapy has been completed (Siebell and Hollander, 2014).

1.7. If there has been an adequate response, the clinician should provide monthly outpatient booster sessions for 3-6 months or more frequently if there is a partial response (APA, 2007).

1.8. If response to CBT-ERP is clinically significant but inadequate (i.e., moderate response) or clinically insignificant and inadequate (i.e., little or no response), second trial treatments should be initiated (APA, 2007).

1.9. For OCD Prolonged Exposure Therapy is often indicated when the member requires therapist-guided repeated and prolonged exposure to situations that provoke obsessional fear along with abstinence from compulsive behaviors (response prevention). This might occur in the form of repeated actual confrontation with feared low-risk situations, or in the form of imaginal confrontation with the feared disastrous consequences of confronting the low-risk situations (Abramowitz, 2015).

1.9.1. PE may be indicated for OCD for up to 16 twice-weekly treatment sessions, lasting about 90 to 120 minutes each, over about eight weeks (Abramowitz, 2016).

1.10. Adjunctive interventions may be initiated that do not address the core symptoms of OCD but may be useful in addressing acceptance, resistance or the interpersonal consequences of OCD. Examples include (APA, 2007):

1.10.1. Motivational Interviewing; and

1.10.2. Family therapy to reduce intra-familial tensions that may be exacerbating symptoms.

2. Pharmacotherapy for Adults with OCD

2.1. SSRIs (with the exception of citalopram & escitalopram) or clomipramine alone or with CBT-ERP are first line treatments for adults with comorbid OCD (APA Watch, 2013).
2.2. Most members receiving outpatient treatment will require treatment for 6-12 weeks to experience improvement (APA Watch, 2013).

2.3. Higher doses of antidepressants have generally been found to be more effective for OCD. For example, fluoxetine can be gradually titrated to 40 to 80 mg/day. The medication should be continued within the therapeutic range for at least six weeks before concluding that the drug is ineffective (Simpson, 2016).

2.4. If there is adequate response to outpatient treatment, pharmacotherapy should be continued for 1-2 years then gradually tapered (APA, 2007).

2.5. If there is no response to a moderate response, second trial treatments should be initiated (APA, 2007).

2.6. Considerations when choosing the most appropriate agent include (APA, 2007):
   2.6.1. Age of the patient
   2.6.2. Previous treatment response
   2.6.3. Risk of overdose or misuse
   2.6.4. Tolerability
   2.6.5. Interactions and side effects

2.7. Second Trial
   2.7.1. If there is little or no response to CBT-ERP treatment only, or a moderate response, add a SSRI (APA, 2007).
   2.7.2. If there is little or no response to a SSRI, consider any of the following (APA, 2007):
      2.7.2.1. Switch to a different SSRI, clomipramine, or venlafaxine.
      2.7.2.2. Augment SSRI with aripiprazole or risperidone (Guideline Watch, 2013).
   2.7.3. If there is a moderate response to a SSRI, consider any of the following:
      2.7.3.1. Augment SSRI with aripiprazole or risperidone (Guideline Watch, 2013).
   2.7.4. If response to Second Trial is moderate, third trial treatments are indicated.

2.8. Third Trial
2.8.1. If response to second trial is moderate, consider either of the following:

2.8.1.1. Switch to a different augmenting antipsychotic (aripiprazole or risperidone) (Guideline Watch, 2013).

2.8.1.2. Switch to a different SSRI (APA, 2007).

Treatments for Children/Adolescents with OCD

1. Combination psychotherapy and pharmacotherapy is recommended for children and adolescents (AACAP, 2012).

2. Pharmacotherapy recommendations are the same for adults and children with the following specific recommendations:

   2.1. 14 outpatient visits over 12 weeks that spread across 5 phases. With the exception of weeks 1 and 2, all outpatient visits are weekly. The phases include (AACAP, 2012):

   2.1.1. Psychoeducation;
   2.1.2. Cognitive Training;
   2.1.3. Mapping OCD;
   2.1.4. Exposure and Response Prevention (E/RP); and
   2.1.5. Relapse Prevention and Generalization Training.

2.2. If there has been no response to CBT interventions after 8-10 sessions or 6-8 E/RP sessions, implement second trial recommendations (AACAP, 2012).

2.3. Titration schedules should be conservative; with modest increases from initial dose each three weeks to allow for improvement to manifest before increasing doses (AACAP, 2012).

2.4. Treatment is generally continued for 6-12 months following initial stabilization and then very gradually withdrawn over several months (AACAP, 2012).

Treatments for Hoarding Disorder

1. Psychotherapy

   1.1. The first line treatment for Hoarding Disorder is Cognitive Behavior Therapy that incorporates Exposure Response Prevention (ERP) and addresses the following (Saxena & Maidment, 2007):

       1.1.1. Triggers associated with hoarding;
       1.1.2. Information processing deficits;
       1.1.3. Problems in forming emotional attachments;
1.1.4. Behavioral avoidance;
1.1.5. Erroneous beliefs about the nature of possessions;
1.1.6. Decision-making and coping skills;
1.1.7. Urges to save;
1.1.8. De-cluttering via ERP in the following steps:
   1.1.8.1. Discarding
   1.1.8.2. Organizing
   1.1.8.3. Preventing incoming clutter
   1.1.8.4. Introducing alternative behaviors
   1.1.8.5. Ending treatment
1.1.9. CBT-ERP may include family, group and home sessions;
1.1.10. Periodic therapy “booster” sessions to maintain progress.

1.2. Duration of treatment may be up to one year with the involvement of family members and motivational enhancement techniques to promote progress and reduce the risk of relapse.

2. Pharmacotherapy

2.1. As a second-line or combination treatment with CBT, SSRI medications may be prescribed although patients with hoarding behaviors typically have a poor response rate to SSRI medications (Saxena & Maidment, 2007).

Discharge Planning

1. The provider and, whenever possible, the member develops an initial discharge plan at the time of admission, and estimates the length of treatment.
   1.1. The provider and, whenever possible, the member updates the initial discharge plan during the admission ensuring that:
      1.1.1. An appropriate discharge plan is in place prior to discharge;
      1.1.2. The discharge plan is designed to mitigate the risk that the “why now” factors which precipitated admission will reoccur;
      1.1.3. The member agrees with the discharge plan.
   1.2. For members continuing treatment, the discharge plan includes:
      1.2.1. The discharge date;
1.2.2. The post-discharge level of care, and the recommended forms and frequency of treatment;

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

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

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

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

1.2.7. An appointment for necessary lab tests is provided;

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

1.2.9. Recommended self-help and community support services;

1.2.10. Information about what the member should do in the event of a crisis prior to the first appointment.

1.2.11. 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.

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

1.2.13. 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.

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

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

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

1.3.1. The discharge date;

1.3.2. Recommended self-help and community support services;
1.3.3. Information about what the member should do in the event of a crisis or to resume services.

1.3.4. 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.
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.
Outpatient

Assessment, diagnosis and active behavioral health treatments are provided in an ambulatory setting. The course of treatment in Outpatient 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 “why now” factors that precipitated admission no longer require treatment.

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 the 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

(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)

1.2. The member is not in imminent or current risk or harm to self, others, and/or property.

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.

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.

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 3 hours per day, 2 or more days 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.

**Mental Illness** 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.

**Obsessive Compulsive Disorder** According to the DSM, the essential feature of Obsessive Compulsive Disorder (OCD) is a pervasive pattern of either obsessions or compulsions that the person recognizes as excessive or unreasonable.

**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** The results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.

**PART VI: REFERENCES**


6. 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>
<th>X Yes □ No</th>
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<tr>
<td>90791</td>
<td>Psychiatric diagnostic evaluation</td>
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<tr>
<td>90791 plus interactive add-on code (90785)</td>
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<td>90832</td>
<td>Psychotherapy, 30 minutes with patient and/or family</td>
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<td>90834 plus pharmacological add-on code</td>
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(90863) family member (pharmacological management)

90837 Psychotherapy, 60 minutes with patient and/or family member

90837 plus interactive add-on code (90785) Psychotherapy, 60 minutes with patient and/or family member (interactive)

90837 plus pharmacological add-on code (90863) Psychotherapy, 60 minutes with patient and/or family member (pharmacological management)

90839 Psychotherapy for crisis, first 60 minutes

90839 plus interactive add-on code (90785) Psychotherapy for crisis, first 60 minutes (interactive)

90846 Family psychotherapy without the patient present

90847 Family psychotherapy, conjoint psychotherapy with the patient present

90849 Multiple-family group psychotherapy

90853 Group psychotherapy (other than of a multiple-family group)

90853 plus interactive add-on code (90785) Group psychotherapy (other than of a multiple-family group) (interactive)

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

H0015 Intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapy

H0035 Mental health partial hospitalization, treatment, less than 24 hours

S0201 Partial hospitalization services, less than 24

S9480 Intensive outpatient psychiatric services, per die

<table>
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<tr>
<th>DSM-5 Codes</th>
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<td>300.3</td>
<td>F42* F42.2</td>
<td>Obsessive Compulsive Disorder</td>
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<td>300.3</td>
<td>F42* F42.3</td>
<td>Hoarding Disorder</td>
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<td></td>
<td>F42.4</td>
<td>Excoriation (Skin Picking) Disorder</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.

**Limited to place of service (POS)?** ☐ Yes ☒ No

**Limited to specific provider type?** ☐ Yes ☒ No

**Limited to specific revenue codes?** ☒ Yes ☐ No
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<td>(Range describes various all-inclusive inpatient services)</td>
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<tr>
<td>900-919</td>
<td>(Range describes various unbundled behavioral health treatments/services)</td>
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<tr>
<td>1000-1005</td>
<td>(Range describes various sites that provide 24-hour services)</td>
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**PART VIII: HISTORY**

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