United Behavioral Health

Coverage Determination Guideline: Obsessive-Compulsive Disorder and Hoarding Disorder

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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®.

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.


1 Optum is a brand used by United Behavioral Health and its affiliates.
Available benefits for Obsessive-Compulsive Disorder and Hoarding Disorder 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* (APA) 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](http://www.psychiatry.org) > Psychiatrists > Practice > Clinical Practice Guidelines

B. Screening and Assessment
   - 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 (*Diagnostic and Statistical Manual of Mental Disorders* 5th ed.; DSM-5; APA, 2013).
   - Initial questions about the presence of recurrent intrusive thoughts, images, or urges, repetitive behaviors and mental rituals that cause distress should be asked (Fenski & Petersen, 2015):
     - 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.
   - Identifying the main symptom patterns provides useful information to inform treatment and monitor changes in the severity of the disorder over time. Identifying the association between obsessions and compulsions, and confirming that the obsessions lead to compulsions to counteract the anxiety can help to differentiate OCD from other disorders of intrusive thoughts or repetitive behaviors (Fenski & Petersen, 2015).
   - 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 (American Academy of Child & Adolescent Psychiatry [AACAP], 2012; APA Guideline Watch, 2013):
- Leyton Obsessional Inventory (proprietary tool), Anxiety Disorders Interview Schedule (ADIS, ADIS-C for children).
- Pediatric Anxiety Rating Scale (PARS found at http://www.jaacap.com/).
- Multidimensional Anxiety Scale (proprietary tool) (AMAS for adults, MASC for children).
- The Florida Obsessive-Compulsive Inventory symptom checklist and severity scale for adults.
- The Obsessive-Compulsive Inventory-Revised (OCI-R) for adults. The scale looks at each subtype (washing, checking, ordering, hoarding and neutralizing) (proprietary tool).

- Screening for OCD in children and adolescents is recommended even without being part of the presenting patient complaint (AACAP, 2012).
- 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).
- PANDAS is described as the abrupt onset of OCD symptoms in pediatric patients following a Group A streptococcus infection (Hallion et al., 2015).
- 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).
- Family functioning should be assessed to include factors such as family accommodation, enmeshment or negative reinforcement of OCD behaviors (AACAP, 2012).
- 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).
- A variety of informants should be used in evaluating children and adolescents, including parents and teachers (AACAP, 2012).

C. Evaluating OCD Symptoms in Children and Adolescents
- Younger children may exhibit behavioral problems such as social withdrawal, aggressive behavior, apathy, sleep disruption, and weight loss (AACAP, 2012).
- 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).
- Limited insight and hidden symptoms of OCD are frequently poorly articulated in younger children (AACAP, 2012).
- Most children display various obsessions and compulsions; these are commonly not well-defined and often center on the fear of a catastrophic family event (AACAP, 2012).
- There may not be a clear precipitating trigger (AACAP, 2012).

D. Differential diagnosis
- 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 obsessions are intrusive and unwanted thoughts which cause clear anxiety and distress. Most individuals with OCD have both obsessions and compulsions that differentiates from other disorders (DSM-5, 2013).
- The differential diagnosis includes an examination of the following conditions with overlapping symptoms prior to confirming OCD:
  - 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).
  - 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:
    - Recurrent thoughts that are present in generalized anxiety disorder (GAD) are usually about real-life concerns, while the obsessions in OCD usually are not. OCD-related concerns generally involve content that is odd or irrational. In OCD, compulsions are almost always present and usually linked to the obsessions, while in GAD there are no compulsions (Fenski & Petersen, 2015; Hallion et al., 2015).
Individuals with body dysmorphic disorder (BDD) also report intrusive thoughts and compulsions to decrease anxiety. The element of difference in BDD, is that obsessions and compulsions are regarding physical characteristics (Hallion et al., 2015).

- 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. Diverging with OCD, hoarding disorder is more likely to exhibit the absence of attempts to resist hoarding (Hallion et al., 2015).
- 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 (Fenski & Petersen, 2015).
- Tic disorders or tics are typically involuntary and less complex than compulsions and are not aimed at neutralizing obsessions (Fenski & Petersen, 2015).
- What distinguishes OCD from a delusional disorder or psychotic disorder is that those with OCD have obsessions and compulsions and recognize their thoughts as irrational and uncontrollable (Fenski & Petersen, 2015).
- Obsessive-Compulsive Personality Disorder (OCPD) is described as persistent rigidity, preoccupation with orderliness, perfectionism, and control. Individuals with OCPD do not have complaints of intrusive thoughts, images or compulsions performed as a result of these intrusions (DSM-5, 2013).
- Other disorders that include intrusive thoughts and repetitive behaviors can be distinguished from OCD by the nature of the thoughts and behaviors (DSM-5, 2013; Fenski & Petersen, 2015):
  - In Trichotillomania, the repetitive behavior is limited to hair-pulling.
  - In Anorexia Nervosa, intrusive thoughts and repetitive behaviors are limited to concerns about weight and food.
- Other behaviors that are sometimes considered “compulsive,” include sexual behavior, gambling, and substance use (DSM-5, 2013).

### E. Evaluation of Hoarding Symptoms

- 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 (Tolin et al., 2018):
  - The Saving Inventory-Revised (SI-R) scale
  - Hoarding Rating Scale (HRS-SR) Self-report measure
  - Difficulties in Emotional Regulation Scale (DERS)
- In order to establish a hoarding disorder diagnosis, the clinician should gather information about the following (DSM-5, 2013; Fenski & Petersen, 2015; Tolin et al., 2018):
  - Obtain an accurate history of hoarding behaviors as symptom onset is often between 11 and 15 years old.
  - 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).
  - 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.
  - Lack of emotional clarity regarding possessions.
  - Avoidance behaviors due to lack of emotional regulation that results from discarding possessions.
  - Daily functioning and whether it is disrupted by ruminating about perfection or moving items from one pile to another without accomplishing a desired task.
  - Level of insight and whether there is awareness of one’s own hoarding, clutter and how this impacts the member’s life.
  - 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.
- Differential Diagnosis:
In order to establish a Hoarding Disorder diagnosis, the following conditions should be ruled out (DSM-5, 2013):

- OCD should be assigned when the symptoms are judged to be a direct consequence of typical obsessions or compulsions (e.g., fears of contamination);
- Psychotic disorders and symptoms (e.g., Schizophrenia, intrusive thoughts, ruminations).

F. Treatment planning 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](http://www.psychiatry.org>

G. Psychosocial Interventions

- Cognitive Behavioral Therapy with Exposure and Response Prevention (CBT-ERP) is a first line intervention with or without medication (APA Guideline Watch, 2013).
- Psychotherapy interventions and pharmacotherapy have approximately equivalent efficacy for the treatment of most anxiety and related disorders. If individuals do not experience reduced symptoms from CBT or have a limited response, a trial of pharmacotherapy is recommended. Likewise, individuals that exhibit minimal improvement from pharmacotherapy may benefit from CBT (Katzman et al., 2014).
- Prior to beginning psychotherapy, the individual should be provided with education regarding OCD and given a clear explanation regarding treatment choices, preferences, symptom exacerbation, and signs of relapse (Katzman et al., 2014).
- 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).
- CBT-ERP treatment components include (APA, 2007):
  - A detailed assessment of the individual’s fears, avoidance, and rituals which demonstrates the OCD symptom pattern;
  - Development of an exposure hierarchy rating scale of feared or avoided items or thoughts (0-100 based on level of discomfort);
  - 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;
  - 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.
  - 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.

- The individual’s progress should be measured by objective scales for OCD (Katzman et al., 2014).
- 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).
- 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).
- Exposure-based treatments have shown success for anxiety disorders if sessions are grouped closely together, when the exposure is prolonged, when the exposure is real versus imagined, and when performed in various settings (Katzman et al., 2014).
  - Exposure-based therapy is usually conducted over 12 to 16 sessions, and is provided once a week. If necessary, therapy can be delivered more frequently, such as twice weekly (Tartakovsky, 2019).
* 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):
  - Motivational Interviewing; and
  - Family therapy to reduce intra-familial tensions that may be exacerbating symptoms.
* Combination psychotherapy and pharmacotherapy is recommended for children and adolescents (AACAP, 2012; Skapinakis et al., 2016).
* The first line treatment for hoarding disorder (HD) is Cognitive Behavior Therapy, although due to the chronic nature of HD, the goal is improvement of symptoms rather than remission. The interventions incorporate the following (Mathews et al., 2016):
  - Motivational interviewing
  - Cognitive restructuring
  - Exercises focused on sorting and discarding
  - Reducing cluttering and acquiring behaviors.

H. General Pharmacotherapy
* SSRIs (with the exception of citalopram & escitalopram) or clomipramine alone or with CBT-ERP are first line treatments for adults with OCD (APA Guideline Watch, 2013).
  - Current evidence shows that SSRIs are recommended before a clomipramine trial due to its side effect profile, and SSRIs are most often better tolerated (Skapinakis et al., 2016).
* Most members receiving outpatient treatment will require treatment for 6-12 weeks to experience improvement (APA Guideline Watch, 2013).
* 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 (APA, 2007).
* If there is adequate response to outpatient treatment, pharmacotherapy should be continued for 1-2 years then gradually tapered (APA, 2007).
* If there is no response to a moderate response, second trial treatments should be initiated (APA, 2007).
* Considerations when choosing the most appropriate agent include (APA, 2007):
  - Age of the patient
  - Previous treatment response
  - Risk of overdose or misuse
  - Tolerability
  - Interactions and side effects
* Second Trial
  - If there is little or no response to CBT-ERP treatment only, or a moderate response, add a SSRI (APA, 2007).
  - If there is little or no response to a SSRI, consider any of the following (APA, 2007):
    - Switch to a different SSRI, clomipramine, or venlafaxine.
    - Augment SSRI with aripiprazole or risperidone (APA Guideline Watch, 2013).
  - If there is a moderate response to a SSRI, consider any of the following:
    - Augment SSRI with aripiprazole or risperidone (APA Guideline Watch, 2013).
  - If response to Second Trial is moderate, third trial treatments are indicated.
* Third Trial
  - If response to second trial is moderate, consider either of the following:
    - Switch to a different augmenting antipsychotic (aripiprazole or risperidone) (APA Guideline Watch, 2013).
    - Switch to a different SSRI (APA, 2007).
* Pharmacotherapy recommendations are the same for adults and children with the following specific recommendations for children/adolescents with OCD:
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):

- Psychoeducation;
- Cognitive Training;
- Mapping OCD;
- Exposure and Response Prevention (E/RP); and
- Relapse Prevention and Generalization Training.

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

### 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.

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<thead>
<tr>
<th>Diagnosis Codes</th>
<th>Description</th>
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<tr>
<td>F42.9</td>
<td>Obsessive Compulsive Disorder</td>
</tr>
<tr>
<td>F42.3</td>
<td>Hoarding Disorder</td>
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<tr>
<th>Procedure Codes</th>
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<tr>
<td>90785</td>
<td>Interactive complexity (list separately in addition to the code for primary psychiatry procedure)</td>
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<tr>
<td>90791</td>
<td>Psychiatric diagnostic evaluation</td>
</tr>
<tr>
<td>90792</td>
<td>Psychiatric diagnostic evaluation with medical services</td>
</tr>
<tr>
<td>90832</td>
<td>Psychotherapy, 30 minutes with patient</td>
</tr>
<tr>
<td>90833</td>
<td>Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)</td>
</tr>
<tr>
<td>90834</td>
<td>Psychotherapy, 45 minutes with patient</td>
</tr>
<tr>
<td>90836</td>
<td>Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)</td>
</tr>
<tr>
<td>90837</td>
<td>Psychotherapy, 60 minutes with patient</td>
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<tr>
<td>90838</td>
<td>Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)</td>
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<td>90839</td>
<td>Psychotherapy for crisis; first 60 minutes</td>
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<td>90840</td>
<td>Psychotherapy for crisis; each additional 30 minutes (list separately in addition to the code for primary service)</td>
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<tr>
<td>90846</td>
<td>Family psychotherapy (without the patient present), 50 minutes</td>
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<tr>
<td>90847</td>
<td>Family psychotherapy (conjoint psychotherapy) (with the patient present), 50 minutes</td>
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<tr>
<td>90849</td>
<td>Multiple-family group psychotherapy</td>
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<tr>
<td>90853</td>
<td>Group psychotherapy (other than of a multiple-family group)</td>
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<tr>
<td>90863</td>
<td>Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure)</td>
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<tr>
<td>G0177</td>
<td>Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)</td>
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<td>G0410</td>
<td>Group psychotherapy other than of a multiple-family group, in a partial hospitalization setting, approximately 45 to 50 minutes</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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<tr>
<td>H0004</td>
<td>Behavioral health counseling and therapy, per 15 minutes</td>
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<td>H0015</td>
<td>Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling, crisis intervention, and activity therapies or education</td>
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<td>H0017</td>
<td>Behavioral health; residential (hospital residential treatment program), without room and board, per diem</td>
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<td>H0018</td>
<td>Behavioral health; short-term residential (nonhospital residential treatment program), without room and board, per diem</td>
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<tr>
<td>H0019</td>
<td>Behavioral health; long-term residential (nonmedical, nonacute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem</td>
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<td>H0025</td>
<td>Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)</td>
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<td>H0035</td>
<td>Mental health partial hospitalization, treatment, less than 24 hours</td>
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<td>H2011</td>
<td>Crisis intervention service, per 15 minutes</td>
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<td>Psychiatric health facility service, per diem</td>
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<td>Psychosocial rehabilitation services, per 15 minutes</td>
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<td>H2018</td>
<td>Psychosocial rehabilitation services, per diem</td>
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<td>Therapeutic behavioral services, per 15 minutes</td>
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<td>Therapeutic behavioral services, per diem</td>
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<td>H2033</td>
<td>Multisystemic therapy for juveniles, per 15 minutes</td>
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<td>S0201</td>
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<td>S9482</td>
<td>Family stabilization services, per 15 minutes</td>
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<tr>
<td>S9484</td>
<td>Crisis intervention mental health services, per hour</td>
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<td>S9485</td>
<td>Crisis intervention mental health services, per diem</td>
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**REFERENCES**


**REVISION HISTORY**

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