OPTUM®

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® [1].

INSTRUCTIONS FOR USE

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

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member's benefits prior to using this guideline. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this guideline and the member's specific benefit, the member's specific benefit supersedes this guideline. Other clinical criteria may apply. Optum reserves the right, in its sole discretion, to modify its clinical criteria as necessary using the process described in *Clinical Criteria*.

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

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

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

BENEFIT CONSIDERATIONS

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

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[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* that are not excluded from coverage.

Indications for Coverage

The requested service or procedure must be reviewed against the language in the member's benefit document. When the requested service or procedure is limited or excluded from the member's benefit document, or is otherwise defined differently, it is the terms of the member's benefit document that prevails.

Per the specific requirements of the plan, health care services or supplies may not be covered when inconsistent with generally accepted standards and clinical guidelines.

A. Initial evaluation common criteria and best practices
- Optum recognizes the American Psychiatric Association's Practice Guidelines for the Psychiatric Evaluation of Adults (2016):
  - http://www.psychiatry.org > Psychiatrists > Practice > Clinical Practice Guidelines

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.
- Initial questions about the presence of intrusive thoughts, images, or urges, repetitive behaviors and mental rituals should be asked (Simpson, 2016).
  - 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 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).
- 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):
  - Yale-Brown Obsessive Compulsive Scale-Revised (Y- BOCS, CY-BOCS for children).
  - 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/).

- o Multidimensional Anxiety Scale (proprietary tool) (AMAS for adults, MASC for children).
        - o The Florida Obsessive-Compulsive Inventory symptom checklist and severity scale for adults.
        - o The Obsessive-Compulsive Inventory-Revised (OCI-R) for adults. The scale looks at each subtype (washing, checking, ordering, hoarding and neutralizing) (proprietary tool).
    - 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).
    - 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).
    - Compulsions without well-defined obsessions and rituals 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 intrusive thoughts and repetitive behaviors can usually distinguish these disorders from OCD (Simpson, 2016).
    - The differential diagnosis includes an examination of the following conditions with overlapping symptoms prior to confirming OCD:
        - o 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)
        - o 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):
            - ▪ 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).
            - ▪ 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).
            - ▪ 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).
        - o 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).

- o 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).
- o Tic Disorders or Tics are typically less complex than compulsions and are not aimed at neutralizing obsessions (Simpson, 2015).
- o 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).
- o 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).
- o Other disorders that include intrusive thoughts and repetitive behaviors can be distinguished from OCD by the nature of the thoughts and behaviors (Simpson, 2015).
  - ▪ In Body Dysmorphic Disorder, intrusive thoughts are limited to concerns about appearance.
  - ▪ 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.
- o Other behaviors that are sometimes considered "compulsive," include sexual behavior, gambling, and substance use (Simpson, 2015).

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 (American Psychiatric Association, Obsessive Compulsive Disorder, Guideline Watch (APA Watch), 2013):
  - o The Saving Inventory-Revised (SI-R) scale
  - o Hoarding Rating Scale (HRS-SR) Self-report measure
- • 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):
  - o 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).
  - o 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.
  - o Decision making about and categorization of possessions and whether there is distractibility and difficulty maintaining attention on tasks.
  - o Avoidance behaviors and whether completing daily routines and tasks to maintain order is possible (e.g., sorting mail, returning calls, washing dishes).
  - o Daily functioning and whether it is disrupted by ruminating about perfection or moving items from one pile to another without accomplishing a desired task.
  - o Compliance with medical care and whether the member is taking prescribed medications if applicable, and keeping up with medical appointments.
  - o Level of insight and whether there is awareness of one's own hoarding, clutter and how this impacts the member's life.
  - o 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.
  - o Baseline photographs of their cluttered areas.

- Differential Diagnosis:
    - In order to establish a Hoarding Disorder diagnosis, the following conditions should be ruled out:
        - 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

G. Psychosocial Interventions
- Cognitive Behavioral Therapy with Exposure and Response Prevention (CBT-ERP) is a first line intervention with or without medication (APA Watch, 2013).
    - CBT for OCD typically includes: patient and family education, cognitive restructuring, exposure therapy, and response prevention (Abramowitz, 2016).
- 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).
- 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).
- 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, avoidances, 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 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).
- 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).
- 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).

- 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).
- 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).
- The first line treatment for Hoarding Disorder is Cognitive Behavior Therapy that incorporates Exposure Response Prevention (ERP) and addresses the following (Saxena & Maidment, 2007):
  - Triggers associated with hoarding;
  - Information processing deficits;
  - Problems in forming emotional attachments;
  - Behavioral avoidance;
  - Erroneous beliefs about the nature of possessions;
  - Decision-making and coping skills;
  - Urges to save;
  - De-cluttering via ERP in the following steps:
    - Discarding
    - Organizing
    - Preventing incoming clutter
    - Introducing alternative behaviors
    - Ending treatment
  - CBT-ERP may include family, group and home sessions;
  - Periodic therapy "booster" sessions to maintain progress.
- Duration of treatment for Hoarding Disorder 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.

H. General Pharmacotherapy
- 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).
- Most members receiving outpatient treatment will require treatment for 6-12 weeks to experience improvement (APA 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 (Simpson, 2016).
- 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 (Guideline Watch, 2013).
  - If there is a moderate response to a SSRI, consider any of the following:

- Augment SSRI with aripiprazole or risperidone (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) (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).
- 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).

APPLICABE CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member-specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other clinical criteria may apply.

Diagnosis Codes	Description
300.3; F42.2	Obsessive Compulsive Disorder
300.3; F42.2	Hoarding Disorder

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

90840	Psychotherapy for crisis; each additional 30 minutes (list separately in addition to the code for primary service)
90846	Family psychotherapy (without the patient present), 50 minutes
90847	Family psychotherapy (conjoint psychotherapy) (with the patient present), 50 minutes
90849	Multiple-family group psychotherapy
90853	Group psychotherapy (other than of a multiple-family group)
90863	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure)
G0177	Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)
G0410	Group psychotherapy other than of a multiple-family group, in a partial hospitalization setting, approximately 45 to 50 minutes
G0411	Interactive group psychotherapy, in a partial hospitalization setting, approximately 45 to 50 minutes
H0004	Behavioral health counseling and therapy, per 15 minutes
H0015	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling, crisis intervention, and activity therapies or education
H0017	Behavioral health; residential (hospital residential treatment program), without room and board, per diem
H0018	Behavioral health; short-term residential (nonhospital residential treatment program), without room and board, per diem
H0019	Behavioral health; long-term residential (nonmedical, nonacute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem
H0025	Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)
H0035	Mental health partial hospitalization, treatment, less than 24 hours
H2001	Rehabilitation program, per 1/2 day
H2011	Crisis intervention service, per 15 minutes
H2012	Behavioral health day treatment, per hour
H2013	Psychiatric health facility service, per diem
H2017	Psychosocial rehabilitation services, per 15 minutes
H2018	Psychosocial rehabilitation services, per diem
H2019	Therapeutic behavioral services, per 15 minutes
H2020	Therapeutic behavioral services, per diem
H2033	Multisystemic therapy for juveniles, per 15 minutes
S0201	Partial hospitalization services, less than 24 hours, per diem
S9480	Intensive outpatient psychiatric services, per diem
S9482	Family stabilization services, per 15 minutes
S9484	Crisis intervention mental health services, per hour
S9485	Crisis intervention mental health services, per diem

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REVISION HISTORY

Date	Action/Description
02/14/2017	• Version 1
10/10/2017	• Version 2
02/12/2019	• Version 3