United Behavioral Health

Coverage Determination Guideline: Other and Unspecified Disorders

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INTRODUCTION

Coverage Determination Guidelines are a set of objective and evidence-based behavioral health criteria used by Commercial plans that don't have a provision for medical necessity to standardize coverage determinations, promote evidence-based practices, and support members' recovery, resiliency, and wellbeing for behavioral health benefit plans that are managed by Optum®[1].

INSTRUCTIONS FOR USE

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

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

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

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

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

BENEFIT CONSIDERATIONS

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

[1] Optum is a brand used by United Behavioral Health and its affiliates.

COVERAGE RATIONALE

Available benefits for Other and Unspecified Disorders include the following levels of care, procedures, and conditions:

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

Effective and efficient treatment is facilitated by the clarity and accuracy of the diagnosis. An "Other Specified" or "Unspecified" diagnosis is used when a comprehensive evaluation and further diagnostic specificity is not possible. Clinicians assign these diagnoses when there are diagnostic features of a disorder within a diagnostic class but the presenting signs, symptoms and features do not meet the full criteria for a specific disorder.

The "Other Specified Disorder" category allows the clinician to communicate the specific reason that the presentation does not meet the criteria for any specific category within a diagnostic class. This is done by recording the name of the category, followed by the specific reason (*Diagnostic and Statistical Manual of Mental Disorders,* 5th ed.; DSM-5; American Psychiatric Association, p.15, 2013).

The following is an example of Other and Unspecified Disorders:

- A member has clinically significant depressive symptoms lasting 4 weeks but symptomatology falls short of the diagnostic threshold for a major depressive episode, then the clinician would record "Other Specified Depressive Disorder, depressive episode with insufficient symptoms" (DSM-5, p. 15, 2013).

The use of the "Unspecified Disorder" as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association is excluded.

It is given when the clinician does not specify the reason that the criteria are not met within a diagnostic class. (DSM-5, p. 16, 2013).

The following is an example of a circumstance under which mental health treatment for Other and Unspecified Disorders are excluded:

- In an emergency department setting, only the most prominent symptom expressions associated with a particular category are identified (e.g., delusions, hallucinations, mania, depression, anxiety, or substance intoxication) rather than assigning the "Other Specified Disorder" (DSM-5, p. 20, 2013).

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

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
- 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
- When establishing a diagnosis, consider the following:
  - An "Other Specified" or "Unspecified" diagnosis is not the same as a "provisional diagnosis." A "provisional diagnosis "(a.k.a. "working diagnosis") is given when there is limited information that prevents a clinician from establishing a firm principal DSM diagnosis. A "provisional diagnosis" is applied when:
    - There is a strong presumption that the full criteria of a DSM classified disorder will ultimately be met, but not enough information is available to determine a diagnosis (i.e., a full history is needed to establish if full criteria are met) (DSM-5, p. 23, 2013).
    - Differential diagnosis is dependent exclusively on the duration of the illness (i.e., remission cannot be confirmed until 6 months has lapsed) (DSM-5, p. 23, 2013).
  - Carefully differentiate symptoms that support an "Other Specified" or "Unspecified" diagnosis from those that:
    - Support a "provisional diagnosis"; or
    - Meet the full criteria for a specific disorder.
- Further assessment should confirm whether the member's symptoms continue to warrant an "Other Specified" or "Unspecified" diagnosis (e.g., there, is uncertainty about whether the symptoms are substance induced or due to a general medical condition, there is insufficient opportunity to complete data collection, or there is inconsistent or contradictory information). Coverage for an "Other Specified" may be indicated when:
  - The member's diagnosis meets the DSM definition of a "Other Specified Disorder" or "Unspecified Disorder";
  - The member's diagnosis does not meet the full criteria for a specific disorder;
  - There will be further assessment to confirm whether the member's symptoms continue to warrant an "Other Specified" diagnosis due to:
    - Uncertainty about whether the symptoms are substance induced or due to a general medical condition,
    - Insufficient opportunity to complete data collection, or
    - Inconsistent or contradictory information.
  - Coverage for "Other Specified" may be reviewed against the Coverage Determination Guideline of the specific condition that coincides with the "Other Specified" (e.g., Major Depressive Disorder will be used to review a diagnosis of "Other Specified Depressive Disorder").
  - When treating an "Other Specified" or "Unspecified" disorder, consider using evidence-based practices which are recommended for the specific condition which is most like the "Other Specified" or "Unspecified" disorder.

B. Treatment planning
- 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
- The following are examples of services that are inconsistent with best practices:
  - Services that deviate from the indications for coverage summarized in this document.
  - The use of "Other Specified" when the presenting signs, symptoms and functional impairments demonstrate evidence to support the full criteria of a DSM classified condition.
  - The use of an "Other Specified" diagnosis when a "provisional" diagnosis is more appropriate.
  - Use of an "Other Specified" diagnosis when all general medical conditions and substance induced conditions have not been ruled out.

- Use of an "Other Specified" diagnosis when there has been sufficient opportunity to gather data or clarify inconsistent or contradictory information.

- Carpenter and Regier (2016) emphasize that utilizing provisional and not otherwise classified diagnoses introduces a significant barrier in the scientific advancement of psychopathology. Individuals with these diagnoses are excluded from clinical trials; quality research that promotes generalizable knowledge is dependent upon a firm DSM-5 diagnosis.

APPLICABLE CODES

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

Diagnosis Codes	Description
F20.9	Schizophrenia, unspecified
F20.89	Other schizophrenia
F25.9	Schizoaffective disorder, unspecified
F25.8	Other schizoaffective disorders
F30.8	Other manic episodes
F30.9	Manic episode, unspecified
F31.89	Other bipolar disorder
F31.9	Bipolar disorder, unspecified
F32.89	Other specified depressive episodes
F32.9	Major depressive disorder, single episode, unspecified
F33.9	Major depressive disorder, recurrent, unspecified
F39	Unspecified mood (affective) disorder
F40.8	Other phobic anxiety disorders
F40.9	Phobic anxiety disorder, unspecified
F41.8	Other specified anxiety disorder
F41.9	Anxiety disorder, unspecified
F42.8	Other obsessive-compulsive disorder
F42.9	Obsessive-compulsive disorder, unspecified
F43.10	Post-traumatic disorder, unspecified
F43.20	Adjustment disorder, unspecified
F43.8	Other reactions to severe stress
F43.9	Reaction to severe stress, unspecified
F44.89	Other dissociative and conversion disorders
F44.9	Dissociative and conversion disorder, unspecified
F45.20	Hypochondriacal disorder, unspecified
F45.29	Other hypochondriacal disorders
F45.8	Other somatoform disorders
F45.9	Somatoform disorder, unspecified
F48.8	Other specified nonpsychotic mental disorders

F48.9	Nonpsychotic mental disorder, unspecified
F50.89	Other specified eating disorder
F80.9	Developmental disorder of speech and language, unspecified
F50.89	Other specified eating disorder
F50.9	Eating disorder, unspecified
F90.8	Attention-deficit hyperactivity disorder, other type
F90.9	Attention-deficit hyperactivity disorder, unspecified type

Procedure Codes	Description
90785	Interactive complexity (list separately in addition to the code for psychiatric 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

REFERENCES

1. American Psychiatric Association. (2016). *Practice guidelines for the psychiatric evaluation of adults* (3rd ed.). American Psychiatric Publishing.
2. American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Publishing.
3. Carpenter, W.T. & Regier, D. (2016). Diagnostic categories: Provisional, not otherwise classified, or place-holder? *Schizophrenia Bulletin,* 42(6), 1305-1306.

REVISION HISTORY

Date	Action/Description
10/01/2016	• Version 1
10/10/2017	• Version 2
02/12/2019	• Version 3
03/16/2020	• Version 4: annual review