United Behavioral Health

Coverage Determination Guideline: Personality Disorders

**Document Number**: BH803PD032020  
**Effective Date**: March 16, 2020

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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.

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1 Optum is a brand used by United Behavioral Health and its affiliates.
**COVERAGE RATIONALE**

**Personality Disorder** as a principal diagnosis, as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, may be excluded from the member’s benefit plan. Please check the enrollee’s specific benefit plan requirements. When excluded from the benefit plan, indications for coverage are limited to circumstances where:

- Personality Disorder is a secondary diagnosis; and
- The principal diagnosis is a covered condition; and
- Treatment is primarily focused on the principal diagnosis; OR
- Personality Disorder is covered by the member’s benefit plan.

When **Personality Disorder** is a covered diagnosis according to the member’s specific benefit plan, available benefits include the following services:

- Diagnostic evaluation, assessment, and treatment planning
- Treatment and/or procedures
- Medication management and other associated treatments
- Individual, family, and group therapy
- Provider-based case management services
- Crisis intervention

A principal diagnosis is defined as the condition that, after a complete evaluation, is determined to be chiefly responsible for the member seeking treatment, and also becomes the focus of clinical attention during treatment. When a person has multiple diagnoses, the first disorder listed is assumed to be the principal diagnosis, unless the provider specified otherwise (American Psychiatric Association [APA], 2013).

**Indications for Coverage**

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

- Personality disorders (PD) have distinct and pervasive characteristics of maladaptive behaviors; the current most common approach for subcategories are: (*Diagnostic and Statistical Manual of Mental Disorders* 5th ed.; DSM-5; APA, 2013):
  - Cluster A: Paranoid PD; Schizoid PD; Schizotypal PD;
  - Cluster B: Borderline PD; Narcissistic PD; Histrionic PD; Antisocial PD;
  - Cluster C: Avoidant PD; Dependent PD; Obsessive-Compulsive PD.

- The DSM-5 (2013) presents an alternative model for the assessment of PD wherein impairments in personality functioning and traits are the essential elements:
  - Criterion A: level of personality functioning;
  - Criterion B: pathological personality traits;
  - Criteria C and D: pervasiveness and stability;

- Individuals with personality disorders can exhibit a continuum of psychopathology, ranging from mild up to severe levels of functioning (World Federation of Societies of Biological Psychiatry [WFSBP], 2007).

- Self-report scales have been widely used in population-based studies of borderline personality disorder and as screening measures in clinical settings. Widely used examples from the adult population, which have also been useful in adolescent samples, include (Sharp et al., 2018):
  - The borderline personality disorder (BPD) items of the SCID-II Personality Questionnaire (SCID-II-PQ);
  - The Borderline Personality Questionnaire (BPQ);
  - The McLean Screening Instrument for Borderline Personality Disorder (MSI-BPD);
  - The International Personality Disorder Examination Screening Questionnaire (IPDE-SQ);
The Revised Interpersonal Adjectives Scale—Big 5 (IASR-B5).

- Specifically for children and adolescents, the Borderline Personality Features Scale for Children (BPFS-C) is commonly used, including a parent report version of the measure (BPFS-P) (Sharp et al., 2018).
- Current evidence indicates that personality disorders emerge in early adolescence and may extend into adulthood (Sharp et al., 2018).
- Personality disorders, especially when more severe, are often associated with one or more other mental health disorders, such as depressive disorder and generalized anxiety disorder (Tyrer et al., 2015; WFSBP, 2007).
- Some individuals with personality disorders, particularly borderline personality disorder, may have high rates of co-occurring eating disorders, substance abuse, self-harm, suicidal thinking and behaviors, and suicide attempts (National Institute of Mental Health [NIMH], 2017; Too et al., 2019).
- The presentation of individual symptoms of borderline personality disorder may vary over time. Increased symptoms are observed in early adolescence, with a peak in mid-adolescence, and then begin to decrease in most, but not all, during young adulthood (Weiner et al., 2018).
  - Compared with adults, adolescents may be more likely to present with behaviors such as impulsivity, behavioral dysregulation, defiance, and attention deficits (Weiner et al., 2018).

C. Differential Diagnoses
- A thorough interview and comprehensive medical exam can help rule out other possible causes of symptoms (NIMH, 2017).
- According to the DSM-5 (2013), differential diagnoses can be:
  - Other mental disorders and personality traits
  - Psychotic disorders
  - Anxiety and depressive disorders
  - Post-traumatic stress disorder
  - Substance use disorders
  - Personality changes due to a medical condition.
- Clinical differentiation of borderline personality disorder from bipolar II disorder is often reported as a common diagnostic dilemma (Paris, 2018).
  - The primary differentiation regarding bipolar II disorder concerns the hypomanic episodes. These episodes have defined requirements of severity, time scale, and persistence. A bipolar II diagnosis would not meet those hypomanic requirements with mood swings that last less than 4 days or in those individuals where mood does not remain abnormal over the entire episode (DSM-5, 2013; Paris, 2018).

D. 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
- Borderline personality disorder and the treatment has been the most empirically studied of the personality disorders. The treatment plan requires long-term efforts over the course of multiple years with a high level of intensity (Levy et al., 2018).
- A treatment plan should be developed based on the individual’s psychopathology, severity of illness and malfunctioning, and history of previous treatments (WFSBP, 2007).

E. Psychosocial Interventions
- Psychotherapy is the primary treatment for individuals with personality disorders, specifically borderline personality disorder, and can be provided in one-on-one and/or group settings (Bateman et al., 2015; Combs & Oshman, 2016; NIMH, 2017).
  - Cognitive Behavioral Therapy (CBT) can help identify and change core beliefs and/or behaviors underlying inaccurate perceptions; CBT can also help reduce a range of mood and anxiety symptoms, and reduce suicidal or self-harming behaviors (NIMH, 2017).
o Schema-Focused Therapy combines elements of CBT with forms of psychotherapy that focus on the ways people view themselves (NIMH, 2017).

o Mentalization-Based Therapy is a collaborative and structured psychotherapy that can be utilized in both individual and group settings. Focus is on distortion of the ability to understand the actions of oneself and others, especially in interpersonal situations (Levy et al., 2018).

o Dialectical Behavioral Therapy (DBT) was initially developed for chronically suicidal individuals diagnosed with borderline personality disorder. DBT is considered an evidence-based and empirically supported treatment for borderline personality disorder (Dimidjian et al., 2016; Levy et al., 2018).

o Individual therapy, skills training, phone coaching, and a consultation group for the therapist are the current methods for comprehensive DBT (Dimidjian et al., 2016).

  - Currently, DBT technique consists of the following:
    - The delivery of DBT is structured in an overall dialectical framework; the dialectic between acceptance and change is the primary guiding feature;
    - The treatment goals are clear and are organized in the hierarchy of life-threatening behaviors, therapy-interfering behaviors, quality-of-life behaviors, and skills acquisition;
    - The core behavioral skills of mindfulness, distress tolerance, interpersonal effectiveness, and emotion regulation are taught as components in a repeated cycle (Dimidjian et al., 2016).

  - DBT has five functions: enhancing behavioral capabilities; improving motivation; assuring generalization of gains to the natural environment; structuring the environment so that it reinforces functional behaviors; and enhancing therapist capabilities and motivation (Levy et al., 2018).

  - Standard DBT consists of weekly individual therapy (approximately 1 hour/week) and group skills training sessions (2-2.5 hours/week) (Levy et al., 2018; Rizvi et al., 2013).

  - The majority of research on DBT consists of delivery over a 12 month period; some studies have also found evidence of efficacy for a shorter, 6-month course of DBT (Rizvi et al., 2013).

F. General Pharmacotherapy

- Medications should not be a primary treatment for borderline personality disorder, but may be recommended for treatment of specific symptoms, such as mood swings, depression, or other disorders (Combs & Oshman, 2016; NIMH, 2017; WFSBP, 2007).

- When indicated, pharmacotherapy should be integrated into psychosocial treatment(s), time-limited to manage specific symptoms, and withdrawn when these are resolved (Combs & Oshman, 2016).

- Providers should carefully consider individual risks and benefits, including side effects and drug-drug interactions, when prescribing medications for individuals with personality disorders (Combs & Oshman, 2016).

- No drug is specifically approved as a direct treatment of any personality disorder (Combs & Oshman, 2016).

### APPLICABLE CODES

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

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F21</td>
<td>Schizotypal personality disorder</td>
</tr>
<tr>
<td>Procedure Codes</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>F60.0</td>
<td>Paranoid personality disorder</td>
</tr>
<tr>
<td>F60.1</td>
<td>Schizoid personality disorder</td>
</tr>
<tr>
<td>F60.2</td>
<td>Antisocial personality disorder</td>
</tr>
<tr>
<td>F60.3</td>
<td>Borderline personality disorder</td>
</tr>
<tr>
<td>F60.4</td>
<td>Histrionic personality disorder</td>
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<tr>
<td>F60.5</td>
<td>Obsessive-compulsive personality disorder</td>
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<td>F60.6</td>
<td>Avoidant personality disorder</td>
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<tr>
<td>F60.7</td>
<td>Dependent personality disorder</td>
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<tr>
<td>F60.81</td>
<td>Narcissistic personality disorder</td>
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<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>90785</td>
<td>Interactive complexity (list separately in addition to the code for primary psychiatric procedure)</td>
</tr>
<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 and/or family member</td>
</tr>
<tr>
<td>90833</td>
<td>Psychotherapy, 30 minutes with patient and/or family member 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 and/or family member</td>
</tr>
<tr>
<td>90836</td>
<td>Psychotherapy, 45 minutes with patient and/or family member 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 and/or family member</td>
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<tr>
<td>90838</td>
<td>Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the code for primary procedure)</td>
</tr>
<tr>
<td>90839</td>
<td>Psychotherapy for crisis; first 60 minutes</td>
</tr>
<tr>
<td>90840</td>
<td>Psychotherapy for crisis; each additional 30 minutes (list separately in addition to the code for primary service)</td>
</tr>
<tr>
<td>90846</td>
<td>Family psychotherapy (without the patient present)</td>
</tr>
<tr>
<td>90847</td>
<td>Family psychotherapy (conjoint psychotherapy) (with the patient present)</td>
</tr>
<tr>
<td>90849</td>
<td>Multiple-family group psychotherapy</td>
</tr>
<tr>
<td>90853</td>
<td>Group psychotherapy (other than of a multiple-family group)</td>
</tr>
<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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<tr>
<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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<tr>
<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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<tr>
<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 therapy</td>
</tr>
<tr>
<td>H0017</td>
<td>Behavioral health; residential (hospital residential treatment program), without room and board, per diem</td>
</tr>
<tr>
<td>H0018</td>
<td>Behavioral health; short-term residential (nonhospital residential treatment program), without room and board, per diem</td>
</tr>
<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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</tbody>
</table>
REFERENCES


REVISION HISTORY

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<tr>
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<th>Action/Description</th>
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<td>Version 1 – Draft</td>
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<td>11/16/2017</td>
<td>Version 2 Annual Update</td>
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<td>Date</td>
<td>Action/Description</td>
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<td>1/10/2018</td>
<td>• Version 3 Annual Update: Updates to formatting, references, coding.</td>
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<tr>
<td>03/18/2019</td>
<td>• Version 4 Annual Update</td>
</tr>
<tr>
<td>03/16/2020</td>
<td>• Version 5 Annual Update: Updates to references</td>
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