United Behavioral Health

Coverage Determination Guideline: Personality 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

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, 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 > Psychiatrists > Practice > Clinical Practice Guidelines

B. Screening and Assessment
   - 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, 2007)
   - Self-report scales have been widely used in population-based sudies 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 (Fonagy, et al 2015):
     - 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)
   - 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) (Fonagy, et al 2015)
   - 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; World Federation of Societies of Biological Psychiatry, 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, 2016)
   - The presentation of individual symptoms of borderline personality disorder may vary over time (Fonagy, et al 2015).
     - Compared with adults, adolescents may be more likely to present with more "acute" symptoms of borderline personality disorder, such as self-harm and suicidal behavior. (Kaess, et al 2014)

C. Differential Diagnoses
- A thorough interview and comprehensive medical exam can help rule out other possible causes of symptoms (National Institute of Mental Health, 2016)
- Clinical differentiation of borderline personality disorder from bipolar disorder (namely nonpsychotic bipolar II disorder) is often reported as a common diagnostic dilemma (Bayes, et al 2014)

D. 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
- A treatment plan should be developed based on the individual's psychopathology, severity of illness and malfunctioning, and history of previous treatments (World Federation of Societies of Biological Psychiatry, 2007)
- Most of the existing evidence on treatment of personality disorders is for the specific treatment of borderline personality disorder (Bateman, et al 2015).

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 (National Institute of Mental Health, 2016; Combs & Oshman, 2016)
  - 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 (National Institue of Mental Health, 2016);
  - Schema-Focused Therapy combines elements of CBT with forms of psychotherapy that focus on the ways people view themselves (National Institute of Mental Health, 2016)
  - 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, 2018).
  - Dialectical Behavioral Therapy (DBT) is considered an evidence-based and empirically supported treatment for borderline personality disorder (Rizvi, et al 2013); focuses on 4 skills modules: mindfulness, distress toleratnce, emotional regulation, and interpersonal effectiveness (Levy, 2018); randomized controlled trials indicate DBT is associated with improvements in problem behaviors, including suicidal ideation/behavior, non-suicidal self-injury, and hospitalization (MacPherson, et al 2013)
    - 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 (MacPherson, et al 2013; Levy, 2018)
    - Standard DBT consists of weekly individual therapy (approximately 1 hour/week) and group skills training sessions (2-2.5 hours/week) (MacPherson, et al 2013; Linehan, et al 2006; Chapman, 2006; Levy, 2018)
    - 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 (National Institute of Mental Health, 2016; Kaess, et al 2014; World Federation of Societies of Biological Psychiatry, 2007)

- When indicated, pharmacotherapy should be integrated into psychosocial treatment(s), time-limited to manage specific symptoms, and withdrawn when these are resolved (Bateman, et al 2015; 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)

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
F60.0	Paranoid personality disorder
F60.1	Schizoid personality disorder
F21	Schizotypal personality disorder
F60.2	Antisocial personality disorder
F60.3	Borderline personality disorder
F60.4	Histrionic personality disorder
F60.81	Narcissistic personality disorder
F60.6	Avoidant personality disorder
F60.7	Dependent personality disorder
F60.5	Obsessive-compulsive personality disorder

Procedure Codes	Description
90785	Interactive complexity (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 and/or family member
90833	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)
90834	Psychotherapy, 45 minutes with patient and/or family member
90836	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)
90837	Psychotherapy, 60 minutes with patient and/or family member
90838	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)
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)
90847	Family psychotherapy (conjoint psychotherapy) (with the patient present)
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 therapy
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

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REVISION HISTORY

Date	Action/Description
11/2016	• Version 1 – Draft
11/16/2017	• Version 2 Annual Update
1/10/2018	• Version 3 Annual Update: Updates to formatting, references, coding.
03/18/2019	• Version 4 Annual Update