

Treatment of Posttraumatic Stress Disorder (PTSD)

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Product:

2001 Generic UnitedHealthcare COC/SPD

2007 Generic UnitedHealthcare COC/SPD

2009 Generic UnitedHealthcare COC/SPD

2011 Generic UnitedHealthcare COC/SPD

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**Related Coverage Determination
Guidelines:**

Related Medical Policies:

Optum Level of Care Guidelines

INSTRUCTIONS FOR USE

This Coverage Determination Guideline provides assistance in interpreting behavioral health benefit plans that are managed by Optum. This Coverage Determination Guideline is also applicable to behavioral health benefit plans managed by Pacificare Behavioral Health and U.S. Behavioral Health Plan, California (doing business as Optum California ("Optum-CA")). When deciding coverage, the enrollee specific document must be referenced. The terms of an enrollee's document (e.g., Certificates of Coverage (COCs), Schedules of Benefits (SOBs), or Summary Plan Descriptions (SPDs) may differ greatly from the standard benefit plans upon which this guideline is based. 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 document and the COC/SPD, the enrollee's specific benefit document supersedes these guidelines.

All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements that supersede the COC/SPD and the plan benefit coverage prior to use of this guideline. Other coverage determination guidelines and clinical guideline may apply.

Optum reserves the right, in its sole discretion, to modify its coverage determination guidelines and clinical guidelines as necessary.

While this Coverage Determination Guideline does reflect Optum's understanding of current best practices in care, it does not constitute medical advice.

Key Points

- According to the DSM, the essential feature of Posttraumatic Stress Disorder (PTSD) for adults, adolescents, and children older than 6 years is exposure to actual or threatened death, serious injury, or sexual violence; the presence of intrusive symptoms; persistent avoidance of stimuli; negative alterations in cognitions and mood; and marked alterations in arousal and reactivity associated with the traumatic event. The duration of the disturbance is more than 1 month and not attributable to the physiological effects of a substance or medical condition (*Diagnostic and Statistical Manual of Mental Disorders, 5th ed.*; American Psychiatric Association, 2013)
- The DSM-5 has separate diagnostic criteria for the diagnosis of PTSD in children younger than 6 years. Considerations in diagnosing this age group include the differentiation of distressing memories from play reenactment, re-experiencing of the trauma is the most frequent symptom, and knowledge that it may not be possible to ascertain whether frightening content of dreams is related to the traumatic event (DSM-5, 2013).
- Benefits are available for covered services that are not otherwise limited or excluded.
- Pre-notification is required for inpatient, residential treatment center, partial hospital/day treatment programs, intensive outpatient, and home-based outpatient treatment.
- Services should be consistent with evidence-based interventions and clinical best practices as described in Part II, and should be of sufficient intensity to address the member's needs (Certificate of Coverage, 2007, 2009 & 2011).

PART I: BENEFITS

Before using this guideline, please check enrollee's specific plan document and any federal or state mandates, if applicable.

Benefits

Benefits include the following services:

- Diagnostic evaluation and assessment
- Treatment planning
- Referral services
- Medication management
- Individual, family, therapeutic group and provider-based case management services
- Crisis intervention

Covered Services

Covered Health Service(s) – 2001

Those health services provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance abuse, or their symptoms.

A Covered Health Service is a health care service or supply described in Section 1: What's Covered--Benefits as a Covered Health Service, which is not excluded under Section 2: What's Not Covered--Exclusions.

Covered Health Service(s) – 2007, 2009 and 2011

Those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance abuse, or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Described in this Certificate of Coverage under Section 1: Covered Health Services and in the Schedule of Benefits.
- Not otherwise excluded in this Certificate of Coverage under Section 2: Exclusions and Limitations.

In applying the above definition, "scientific evidence" and "prevailing medical standards" shall have the following meanings:

- "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
- "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

Pre-Service Notification

Admissions to an inpatient, residential treatment center, intensive outpatient home-based outpatient, or a partial hospital/day treatment program require pre-service notification. Notification of a scheduled admission must occur at least five (5) business days before admission. Notification of an unscheduled admission (including Emergency admissions) should occur as soon as is reasonably possible. Benefits may be reduced if Optum is not notified of an admission to these levels of care. Check the member's specific benefit plan document for the applicable penalty and provision for a grace period before applying a penalty for failure to notify Optum as required.

Limitations and Exclusions

The requested service or procedure for the treatment of a mental health condition must be reviewed against the language in the enrollee's benefit document. When the requested service or procedure is limited or excluded from the enrollee's benefit document, or is otherwise defined differently, it is the terms of the enrollee's benefit document that prevails.

Inconsistent or Inappropriate Services or Supplies – 2001, 2007, 2009 & 2011

Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and are therefore considered experimental.
- Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practice guidelines as modified from time to time.
- Not clinically appropriate for the member's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.

Additional Information

The lack of a specific exclusion that excludes coverage for a service does not imply that the service is covered. The following are examples of services that are inconsistent with the Level of Care Guidelines and Best Practice Guidelines (not an all inclusive list):

- Services that deviate from the indications for coverage summarized earlier in this document.
- Admission to an inpatient, residential treatment, partial hospital/day treatment program or intensive outpatient program without evidence-based treatment of acute symptoms.
- Admission to an inpatient, residential treatment, partial hospital/day treatment program or intensive outpatient program for the sole purpose of awaiting placement in a long-term facility.
- Admission to an inpatient, residential treatment, partial hospital/day treatment program or intensive outpatient program that does not provide adequate nursing care and monitoring, or physician coverage.
- The use of psychological or neuropsychological testing when a diagnostic or treatment planning question can be answered by means of a standard interview and behavior rating scale assessment.

- The use of Rebirthing Therapies or techniques in the treatment of children and adolescents with PTSD.
- Techniques that bind, restrict, withhold food or water or are otherwise coercive for the treatment of children with PTSD.
- The use of Recovered/Repressed Memory Therapy methods for the treatment of PTSD.

Please refer to the enrollee's benefit document for ASO plans with benefit language other than the generic benefit document language.

PART II: CLINICAL BEST PRACTICES

Evaluation and Treatment Planning

1. The initial evaluation:

- 1.1. Gathers information about the presenting issues from the member's perspective, and includes the member's understanding of the factors that lead to requesting services (i.e., the "why now" factors).
- 1.2. Focuses on the member's specific needs.
- 1.3. Identifies the member's goals and expectations.
- 1.4. Is completed in a timeframe commensurate with the member's needs, or otherwise in accordance with clinical best practices.
- 1.5. The provider collects information from the member and other sources, and completes an initial evaluation of the following:
 - 1.5.1.1. The member's chief complaint;
 - 1.5.1.2. The history of the presenting illness;
 - 1.5.1.3. The "why now" factors leading to the request for service;
 - 1.5.1.4. The member's mental status;
 - 1.5.1.5. The member's current level of functioning;
 - 1.5.1.6. Urgent needs including those related to the risk of harm to self, others, or property;
 - 1.5.1.7. The member's use of alcohol, tobacco, or drugs;
 - 1.5.1.8. Co-occurring behavioral health and physical conditions;
 - 1.5.1.9. The history of behavioral health services;
 - 1.5.1.10. The history of trauma;
 - 1.5.1.11. The member's medical history and current physical health status;
 - 1.5.1.12. The member's developmental history;

- 1.5.1.13. Pertinent current and historical life information including the member's :
 - 1.5.1.13.1. Age;
 - 1.5.1.13.2. Gender, sexual orientation;
 - 1.5.1.13.3. Culture;
 - 1.5.1.13.4. Spiritual beliefs;
 - 1.5.1.13.5. Educational history;
 - 1.5.1.13.6. Employment history;
 - 1.5.1.13.7. Living situation;
 - 1.5.1.13.8. Legal involvement;
 - 1.5.1.13.9. Family history;
 - 1.5.1.13.10. Relationships with family, and other natural resources;
- 1.5.1.14. The member's strengths;
- 1.5.1.15. Barriers to care;
- 1.5.1.16. The member's instructions for treatment, or appointment of a representative to make decisions about treatment;
- 1.5.1.17. The member's broader recovery, resiliency and wellbeing goals.
- 1.6. The provider uses the findings of the evaluation to assign a DSM/ICD diagnosis.

2. Evaluation of Posttraumatic Stress Disorder

If the standard evaluation suggests PTSD, clinicians should complete a detailed PTSD evaluation that includes:

- 2.1. The identification of the member's symptom pattern (i.e., persistent re-experiencing, increased arousal, avoidance) and whether the symptoms are associated with direct or witnessed exposure to a traumatic event. Examples of traumatic events include:
 - 2.1.1. Combat trauma
 - 2.1.2. Rape
 - 2.1.3. Physical or sexual abuse
 - 2.1.4. School violence
 - 2.1.5. Refugee trauma
 - 2.1.6. Assault
 - 2.1.7. Transportation accidents

- 2.1.8. Torture
- 2.1.9. Acts of terrorism
- 2.1.10. Natural disasters
- 2.2. Determine the most recent and prior traumatic events with the following details about the event(s):
 - 2.2.1.1.1. History of exposure to traumatic event(s)
 - 2.2.1.1.2. Nature of the trauma
 - 2.2.1.1.3. Severity of the trauma
 - 2.2.1.1.4. Duration and frequency of the trauma
 - 2.2.1.1.5. Age at time of trauma
 - 2.2.1.1.6. Member's reaction at the time of the trauma
 - 2.2.1.1.7. Presence of multiple traumas
 - 2.2.1.1.8. Ability to recount or tolerate recounting the trauma
- 2.3. The use of self-rating scales such as the Trauma Symptom Inventory for adults and the Children's PTSD Inventory and Trauma Symptom Checklist for Young Children (VA/DoD, 2010).
- 2.4. The use of structured diagnostic interviews such as the Detailed Assessment of PTSD and the Clinician-Administered PTSD Scale (CAPS) for adults and (CAPS-CA) for children and adolescents; and the Endler Multidimensional Anxiety Scale for adults and adolescents (VA/DoD, 2010) (APA, 2009).
- 2.5. The risk of violence may be assessed using the Classification of Violence Risk (4) or the Historical Clinical Risk Management 20 (HCR-20). The Dimensions of Anger Scale (DAR-6) may also assess aggressive urges when angry (VA/DoD, Assessing Risk, 2015).
- 2.6. The participation of family or social supports in the evaluation of the member (VA/DoD, 2010).
- 2.7. Education provided to the member and the family about PTSD including the trauma, its effects, ways of coping and the treatment process (VA/DoD, 2010).

3. Differential Diagnosis

- 3.1. Consider and exclude other disorders that could account for the above symptoms (e.g., Substance Use Disorders, other Anxiety Disorder, Psychotic Disorder, Mood Disorder with Psychotic features, Delirium) (VA/DoD, 2010).

- 3.2. Consider comorbidities and symptom overlap with other psychiatric conditions such as ADHD, Bipolar Disorder, Substance Use Disorders, Anxiety Disorders, Mood Disorders, Psychosis and medical conditions such as bone and joint, neurologic, cardiovascular, respiratory, and metabolic disease that may mimic symptoms of PTSD (VA/DoD, 2010; Sareen, 2016).

4. Treatment Planning

- 4.1. The provider and, whenever possible, the member use the findings of the initial evaluation and the diagnosis to develop a treatment plan. The treatment plan addresses:
 - 4.1.1. The short- and long-term goals of treatment;
 - 4.1.2. The type, amount, frequency and duration of treatment;
 - 4.1.3. The expected outcome for each problem to be addressed expressed in terms that are measurable, functional, time-framed and directly related to the “why now” factors;
 - 4.1.4. How the member’s family and other natural resources will participate in treatment when clinically indicated;
 - 4.1.5. How treatment will be coordinated with other providers as well as with agencies or programs with which the member is involved.
- 4.2. As needed, the treatment plan also includes interventions that enhance the member’s motivation, promote informed decisions, and support the member’s recovery, resiliency, and wellbeing.
 - 4.2.1. Examples include psychoeducation, motivational interviewing, recovery and resiliency planning, advance directive planning, and facilitating involvement with self-help and wraparound services.
- 4.3. The provider informs the member of safe and effective treatment alternatives, as well as the potential risks and benefits of the proposed treatment. The member gives informed consent acknowledging willingness and ability to participate in treatment and abide by safety precautions.
- 4.4. Treatment focuses on addressing the “why now” factors to the point that the member’s condition can be safely, efficiently, and effectively treated in a less intensive level of care, or the member no longer requires care.
- 4.5. The treatment plan and level of care are reassessed when the member’s condition improves, worsens or does not respond to treatment.

- 4.5.1. When the member's condition has improved, the provider determines if the treatment plan should be altered, or if treatment is no longer required.
- 4.5.2. When the member's condition has worsened or not responded to treatment, the provider verifies the diagnosis, alters the treatment plan, or determines if the member's condition should be treated in another level of care.
- 4.6. In the event that all information is unavailable at the time of the evaluation, there must be enough information to provide a basis for the diagnosis, guide the development of the treatment plan, and support the need for treatment in the proposed level of care.

Treatment Interventions

The preferred treatment of PTSD is trauma-focused cognitive-behavioral therapy (CBT), medication (a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI)), or a combination of both modalities (Stein, 2016).

1. Pharmacotherapy – Choice of medications and dosages are to be aligned with the current national standards of practice and care, the patient's specific medical needs and manufacturer recommendations.

1.1. First Line Treatments include: Antidepressants have shown effective in treating the core symptomatology and functioning in adult and child/adolescent members with PTSD (International Society for Traumatic Stress Studies, 2009) (AACAP, 2009).

1.1.1. SSRIs should be chosen as the first-line treatment for PTSD in adults and children/adolescents. They not only reduce PTSD symptoms and produce global improvement but are also effective with comorbid disorders and associated symptoms. Treatment with the use of Paroxetine, Sertraline, Fluoxetine, Fluvoxamine or Citalopram is most common for PTSD (American Psychiatric Association, Guideline Watch (APA), 2009). Common dosages include (VA/DoD, Clinician's Guide to Medication, 2015):

1.1.1.1. Sertraline – 50mg to 200mg daily

1.1.1.2. Paroxetine – 20mg to 60mg daily

1.1.1.3. Fluoxetine – 20mg to 60mg daily

1.1.2. SSRI efficacy is well established in women with PTSD resulting from civilian trauma, including childhood and adult sexual assault, other interpersonal traumas, and motor vehicle accidents (APA, 2009).

- 1.1.3. SNRIs may also be considered a first line treatment as an alternative to an SSRI for the treatment of PTSD (APA, 2009).
- 1.1.4. SNRIs may also be chosen as a first-line treatment for PTSD in adults, especially with Venlafaxine (ISTSS, 2009). It is as effective as an SSRI and useful in treating comorbid depression. Venlafaxine may exacerbate hypertension. Common dosages include (VA/DoD, Clinician's Guide to Medications, 2015):
 - 1.1.4.1. Mirtazapine 7.5mg to 45mg daily
 - 1.1.4.2. Venlafaxine 75mg to 300mg daily
 - 1.1.4.3. Nefazodone 200mg to 600mg daily
- 1.1.5. Antiadrenergic or beta-blocking agents appear to reduce arousal, re-experiencing and dissociative symptoms. Special precautions must be taken when treating members with low blood pressure (VA/DoD, 2010).
 - 1.1.5.1. Prazosin and cyproheptadine may be used for the treatment of trauma-related nightmares and sleep disruption and has also shown efficacy in treating total PTSD symptoms in members with chronic PTSD (VA/DoD, 2010).
 - 1.1.5.2. Propranolol is effective specifically in treating high stress levels and frequency of re-experiencing of a traumatic event and in the prevention of further development of PTSD (APA, 2009).
 - 1.1.5.3. Clonidine and Guanfacine are both effective in treating chronic forms of PTSD and Guanfacine has shown to be effective in treating dissociative symptoms (ISTSS, 2009).
 - 1.1.5.4. Antiadrenergic agents alone or in combination with an SSRI may be used with children and adolescents to target severe symptoms and/or comorbid conditions (ISTSS, 2009).

1.2. Second Line Treatments

- 1.2.1. Monoamine Oxidase Inhibitors (MAOIs) such as Phenelzine and Tranylcypromine are also considered second-line antidepressant agents for PTSD in adults. (VA/DoD, 2010) (APA, 2009).
 - 1.2.1.1. Caution is advised for the use of MAOIs as outlined below:

- 1.2.1.2. Compliance with MAOI dietary restrictions is an important limitation of MAOI Treatment (VA/DoD, 2010) (APA, 2009).
- 1.2.1.3. Contraindications exist for members who use alcohol, illicit drugs or prescription drugs for the treatment of other conditions (VA/DoD, 2010) (APA, 2009).
- 1.2.1.4. Cardiovascular and hepatotoxic side effects must be monitored with MAOIs (APA, 2009).
- 1.2.2. Tricyclic antidepressants such as Imipramine, Amitriptyline, Desipramine, Nortriptyline, Protriptyline, and Clomipramine may be used as second-line antidepressant treatments for adults with PTSD (VA/DoD, 2010).
 - 1.2.2.1. TCAs are not recommended for the treatment of childhood PTSD due to cardiac effects to include sudden death in children (AACAP, 2009).
 - 1.2.2.2. TCAs appear to be less effective in global improvement than MAOIs but have fewer serious side effects (APA, 2009).
 - 1.2.2.3. Side effects include hypotension, cardiac arrhythmias, sedation and behavioral activation (APA, 2009).
- 1.2.3. Atypical Antipsychotics such as risperidone, quetiapine and olanzapine are recommended as adjunctive/augmenting treatments for members who have partially responded to an SSRI or an SNRI (ISTSS, 2009).
 - 1.2.3.1. These agents are useful with members who exhibit extreme hyper vigilance, paranoia, physical aggression, social isolation and trauma-related psychotic symptoms (ISTSS, 2009).
 - 1.2.3.2. Members receiving treatment with antipsychotics should be monitored for side effects including weight gain and metabolic changes due to the risk of metabolic syndromes including type-2 diabetes (ISTSS, 2009).
 - 1.2.3.3. Atypical agents alone or in combination with an SSRI may be used with children and adolescents to target severe symptoms and/or comorbid conditions (ISTSS, 2009).

2. Psychotherapeutic Treatments

2.1. Psychotherapy during inpatient/residential stays for PTSD target rapid stabilization and safety. Some of the below therapeutic approaches may be initiated during an inpatient or residential stay, but full engagement in the methods recommended for PTSD will not likely occur until the patient is stabilized and discharged to a lower level of care.

2.2. Providers should explain to all members with PTSD the range of therapeutic options that are available and should include general advantages and disadvantages associated with each therapeutic option (APA, 2009).

2.3. **First-Line Psychotherapeutic Treatments for Adults**

2.3.1. **Cognitive Approaches**

2.3.1.1. Cognitive Behavioral Therapy (CBT) combination treatments that include elements of exposure, stress inoculation, cognitive therapeutic techniques or a combination of one or more of the following therapies are recommended as first-line psychotherapeutic treatment for PTSD (ISTSS, 2009).

2.3.1.2. Cognitive Therapy (CT) for PTSD (Ehlers & Clark model) typically involves the goals of modifying excessively negative appraisals, correcting autobiographical memory disturbances, and removing problematic behavioral and cognitive strategies (VA/DoD, Overview of Psychotherapy, 2015). cognitive

2.3.1.2.1. CT is based on the understanding that an interpretation of an event rather than the event itself determines one's emotional reactions. The identification of erroneous or harmful cognitions, evaluating the evidence for and against such cognitions and the development of more realistic or useful cognitions are the goals of CT (VA/DoD, 2010).

2.3.1.3. Cognitive Processing Therapy has the primary focus on challenging and modifying maladaptive beliefs related to the trauma, often with a written component (VA/DoD, Overview of Psychotherapy, 2015).

2.3.1.4. Stress Inoculation Training (SIT) is a type of CBT that can be thought of as a set of skills for managing anxiety and stress. This treatment was developed for the management of anxiety symptoms and adapted for treating women rape trauma survivors (VA/DoD, 2010).

2.3.1.4.1. SIT typically consists of education and training of coping skills, including deep muscle relaxation training, breathing control, assertiveness, role playing, covert modeling, thought stopping, positive thinking and self-talk (VA/DoD, 2010).

2.3.1.5. Imagery Rehearsal Therapy (IRT) is aimed at changing the content of the patient's nightmare to promote mastery over the threat, thereby altering the meaning, importance, and orientation to the nightmare (VA/DoD, 2010).

Imagery Rehearsal Therapy:

2.3.1.5.1. Deemphasizes exposure by avoiding discussion of trauma or traumatic content of nightmares

2.3.1.5.2. Focuses on habitual components of disturbing dreams and sleeplessness

2.3.1.5.3. Provides no group psychotherapy

2.3.1.5.4. Offers minimal instruction for dealing with unpleasant imagery

2.3.1.5.5. Emphasizes relaxation

2.3.1.5.6. Conveys no specific non-sleep-related instructions for managing post-traumatic stress, anxiety, or depressive symptoms.

2.4. Exposure Based Treatments (e.g., Exposure Response Therapy (ERP) or Prolonged Exposure (PE) helps members with PTSD reduce the fear associated with their experience through repetitive, therapist-guided confrontation of feared places, situations, memories, thoughts, and feelings (ISTSS, 2009).

2.4.1. Members are repeatedly exposed to their own individualized fear stimuli, until their arousal and fear responses are consistently diminished (APA, 2009).

2.4.2. Exposure can be accomplished via "imaginal" exposure or "in vivo" exposure. Both methods involve encouraging the patient to revisit the experience, recalling the experience through verbally describing the emotional details of the trauma (VA/DoD, 2010).

2.4.3. Exposure Therapy is typically delivered as part of a more comprehensive "package" of treatment, combined with PTSD education, coping skills training, and cognitive restructuring (VA/DoD, 2010).

- 2.4.4. Because ET may temporarily increase members' level of distress, providers must take concrete steps to prepare members for the treatment and ensure members are suitable and stable enough to handle this type of treatment (VA/DoD, 2010).
- 2.4.5. For PTSD, Prolonged Exposure Therapy is indicated when there is a need to reexpose the member to a past traumatic experience via imaginal, in vivo, directed therapeutic, written, verbal or recorded recounting in order to help the member reduce the fear associated with their experience through repetitive, therapist-guided confrontation of feared places, situations, memories, thoughts, and feelings (American Psychiatric Association, Clinical Practice Guideline, Acute Stress and Posttraumatic Stress Disorder, 2010).
 - 2.4.5.1. Prolonged exposure is usually delivered in 9 to 12 weekly or twice weekly, 90 minute sessions, but can be shorter or longer based on the member's needs and response (Rothbaum, 2015).

2.5. **Eye Movement Desensitization and Reprocessing (EMDR)** is a type of psychotherapy that was originally designed to alleviate the distress associated with traumatic memories and facilitates the accessing and processing of traumatic memories to bring these to an adaptive resolution (VA/DoD, 2010).

- 2.5.1. During EMDR members are asked to identify: (1) a disturbing image that encapsulates the worst part of the traumatic event; (2) associated body sensations; (3) a negative thought that expresses what the patient "learned" from the trauma; (4) a positive thought that the patient wishes could replace the negative thought (ISTSS, 2009).
- 2.5.2. The patient is then asked to hold the disturbing image, sensations, and the negative cognition in mind while various procedures and protocols are used. One of the procedural elements is "dual stimulation" using bilateral eye movements, tones, tactile stimulation or taps. The choice of procedure or combination of elements is customized to each client (ISTSS, 2009).
 - 2.5.2.1. Between sessions, the patient is directed to keep a journal of any situations that provoke PTSD symptoms and of any insights or dreams about the trauma (ISTSS, 2009).
 - 2.5.2.2. Standard CBT rating scales are used throughout the sessions to document changes in the intensity of the symptoms (ISTSS, 2009).

- 2.5.2.3. Members being treated with Eye Movement Desensitization and Reprocessing (EMDR) for PTSD may require up to 90-minute sessions with a minimum of 12 sessions, up to a maximum of 25 sessions. The number and frequency of sessions within this range should be dictated by the number and severity of traumas present as well as the member's treatment goals (Optum Behavioral Health Sciences, 2012).

2.6. Traumatic Incident Reduction (TIR) is a brief, memory-based, therapeutic intervention for members who have experienced crime-related and/or interpersonal violence, war, disasters, torture, childhood abuse, neglect, emotional abuse, traumatic bereavement, or other severe or shocking events (National Registry of Evidence-Based Programs, 2011).

- 2.6.1. Depending on the trauma, the member is typically able to resolve his/her symptoms in 1-2 sessions that last anywhere from 90-120 minutes.
- 2.6.2. Each TIR session begins with an assessment step, in which the client identifies the most significant item to be addressed during the session.
- 2.6.3. The assessment step is followed by a viewing step, in which the client examines the incident, including aspects such as the time and duration of an incident, awareness of and connectedness to each incident, and a verbal report of the incident.
- 2.6.4. At the completion of the session, it is expected that the client will be able to talk calmly about the traumatic incident with a sense of autonomy and without a return of the symptoms caused by the incident.

2.7. Psychoeducation

- 2.7.1. Psychoeducation is a useful adjunct to therapy and functions to educate members and their families about the symptoms of PTSD and the various treatments that are available (VA/DoD, 2010).
- 2.7.2. Psychoeducation provides reassurance that trauma related symptoms are normal and expected shortly after a trauma and can often be overcome with time and treatment (VA/DoD, 2010).
- 2.7.3. Education about the symptoms and treatment of comorbid disorders may also be included as part of psychoeducation (VA/DoD, 2010).

- 2.7.4. Psychoeducational group treatment models for PTSD treatment may be an option for women with multiple traumas as well as combat veterans if available (VA/DoD, 2010).

2.8. First-Line Psychotherapeutic Treatments for Children and Adolescents

- 2.8.1. Trauma-Focused Therapy is the first-line recommended treatment for PTSD in children and adolescents (AACAP, 2010).
- 2.8.2. Trauma-focused therapy (1) directly addresses children's traumatic experiences, (2) includes parents in treatment in some manner as important agents of change, and (3) focus not only on symptom improvement but also on enhancing functioning, resiliency, and/or development (AACAP, 2010).
- 2.8.3. Traumatic Incident Reduction (TIR) is a brief, memory-based, therapeutic intervention for members who have experienced crime-related and/or interpersonal violence, war, disasters, torture, childhood abuse, neglect, emotional abuse, traumatic bereavement, or other severe or shocking events (National Registry of Evidence-Based Programs, 2011).
 - 2.8.3.1. Depending on the trauma, the member is typically able to resolve his/her symptoms in 1-2 sessions that last anywhere from 90-120 minutes.
 - 2.8.3.2. Each TIR session begins with an assessment step, in which the client identifies the most significant item to be addressed during the session.
 - 2.8.3.3. The assessment step is followed by a viewing step, in which the client examines the incident, including aspects such as the time and duration of an incident, awareness of and connectedness to each incident, and a verbal report of the incident.
 - 2.8.3.4. At the completion of the session, it is expected that the client will be able to talk calmly about the traumatic incident with a sense of autonomy and without a return of the symptoms caused by the incident.

2.9. Second-Line Psychotherapeutic Treatments for Children and Adolescents

- 2.9.1. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
 - 2.9.1.1. In TF-CBT, the clinician typically provides stress-management skills in preparation for the exposure-based interventions that are aimed at providing mastery over trauma reminders (AACAP, 2010).

- 2.9.1.2. TF-CBT was designed for children with PTSD in addition to depression, anxiety, and other trauma-related difficulties such as shame and self-blame (AACAP, 2010).
- 2.9.1.3. TF-CBT is typically delivered individually to children and their non-perpetrator parents, although it has also been provided in group formats (AACAP, 2010).
- 2.9.2. Eye Movement Desensitization and Reprocessing (EMDR)
 - 2.9.2.1. Although some deviations exist between the adult and child forms of EMDR, the child form being more similar to cognitive therapy than the adult version, it is an effective second-line treatment in pediatric PTSD (AACAP, 2010).

Discharge Planning

1. The provider and, whenever possible, the member develops an initial discharge plan at the time of admission, and estimates the length of treatment.
2. The provider and, whenever possible, the member updates the initial discharge plan during the admission ensuring that:
 - 1.1. An appropriate discharge plan is in place prior to discharge;
 - 1.2. The discharge plan is designed to mitigate the risk that the “why now” factors which precipitated admission will reoccur;
 - 1.3. The member agrees with the discharge plan.
3. For members continuing treatment, the discharge plan includes:
 - 3.1. The discharge date;
 - 3.2. The post-discharge level of care, and the recommended forms and frequency of treatment;
 - 3.3. The names of the providers who will deliver treatment;
 - 3.4. The date of the first appointment including the date of the first medication management visit;
 - 3.5. The name, dose and frequency of each medication;
 - 3.6. A prescription sufficient to last until the first medication management visit is provided;
 - 3.7. An appointment for necessary lab tests is provided;
 - 3.8. Resources to assist the member with overcoming barriers to care such as lack of transportation of child care;
 - 3.9. Recommended self-help and community support services;
 - 3.10. Information about what the member should do in the event of a crisis prior to the first appointment.

- 3.11. The first treatment appointment and medication management visit are scheduled to occur within a timeframe that is commensurate with the risk that the “why now” factors which led to admission will reoccur.
 - 3.12. The provider shares the discharge plan and all pertinent clinical information with the providers at the next level of care prior to discharge.
 - 3.13. The provider shares the discharge plan and all pertinent clinical information with the Care Advocate to ensure that necessary prior authorizations or notifications are completed prior to discharge.
 - 3.14. Notification of the Care Advocate that the member is discontinuing treatment may trigger outreach and assistance to the member.
 - 3.15. The provider coordinates discharge with agencies and programs such as the school or court system with which the member is involved.
4. For members not continuing treatment, the discharge plan includes:
 - 4.1. The discharge date;
 - 4.2. Recommended self-help and community support services;
 - 4.3. Information about what the member should do in the event of a crisis or to resume services.
 - 4.4. The provider explains the risk of discontinuing treatment when the member refuses treatment or repeatedly does not adhere with the treatment plan.

PART III: LEVEL OF CARE CRITERIA

Common Admission Criteria for All Levels of Care

1. Admission Criteria

- 1.1. The member is eligible for benefits.

AND

- 1.2. The member’s condition and proposed services are covered by the benefit plan.

AND

- 1.3. Services are within the scope of the provider’s professional training and licensure.

AND

1.4. The member's current condition cannot be safely, efficiently, and effectively assessed and/or treated in a less intensive level of care due to acute changes in the member's signs and symptoms and/or psychosocial and environmental factors (i.e., the "why now" factors leading to admission).

1.4.1. Failure of treatment in a less intensive level of care is not a prerequisite for authorizing coverage.

AND

1.5. The member's current condition can be safely, efficiently, and effectively assessed and/or treated in the proposed level of care. Assessment and/or treatment of acute changes in the member's signs and symptoms and/or psychosocial and environmental factors (i.e., the "why now" factors leading to admission) require the intensity of services provided in the proposed level of care.

AND

1.6. Co-occurring behavioral health and medical conditions can be safely managed.

AND

1.7. Services are:

1.7.1. Consistent with generally accepted standards of clinical practice;

1.7.2. Consistent with services backed by credible research soundly demonstrating that the services will have a measurable and beneficial health outcome, and are therefore not considered experimental;

1.7.3. Consistent with Optum's best practice guidelines;

1.7.4. Clinically appropriate for the member's behavioral health conditions based on generally accepted standards of clinical practice and benchmarks.

AND

1.8. There is a reasonable expectation that services will improve the member's presenting problems within a reasonable period of time.

1.8.1. Improvement of the member's condition is indicated by the reduction or control of the acute signs and symptoms that necessitated treatment in a level of care.

- 1.8.2. Improvement in this context is measured by weighing the effectiveness of treatment against evidence that the member's signs and symptoms will deteriorate if treatment in the current level of care ends. Improvement must also be understood within the broader framework of the member's recovery, resiliency and wellbeing.

AND

- 1.9. Treatment is not primarily for the purpose of providing social, custodial, recreational, or respite care.

2. Common Continued Service Criteria for All Levels of Care

- 2.1. The admission criteria continue to be met and active treatment is being provided. For treatment to be considered "active" services must be:
 - 2.1.1. Supervised and evaluated by the admitting provider;
 - 2.1.2. Provided under an individualized treatment plan that is focused on addressing the "why now" factors, and makes use of clinical best practices;
 - 2.1.3. Reasonably expected to improve the member's presenting problems within a reasonable period of time.

AND

- 2.2. The "why now" factors leading to admission have been identified and are integrated into the treatment and discharge plans.

AND

- 2.3. Clinical best practices are being provided with sufficient intensity to address the member's treatment needs.

AND

- 2.4. The member's family and other natural resources are engaged to participate in the member's treatment as clinically indicated.

3. Common Discharge Criteria for All Levels of Care

- 3.1. The continued stay criteria are no longer met. Examples include:
 - 3.1.1. The "why now" factors which led to admission have been addressed to the extent that the member can be safely transitioned to a less intensive level of care, or no longer requires care.
 - 3.1.2. The "why now" factors which led to admission cannot be addressed, and the member must be transitioned to a more intensive level of care.
 - 3.1.3. Treatment is primarily for the purpose of providing social, custodial, recreational, or respite care.

- 3.1.4. The member requires medical-surgical treatment.
- 3.1.5. The member is unwilling or unable to participate in treatment and involuntary treatment or guardianship is not being pursued.

Outpatient

Assessment and diagnosis and active behavioral health treatments that are provided in an ambulatory setting. The course of treatment in Outpatient is focused on addressing the “why now” factors that precipitated admission (e.g., changes in the member’s signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the “why now” factors that precipitated admission no longer require treatment.

1. Admission Criteria

1.1. (See Common Criteria for All Levels of Care)

AND

1.2. The member is not in imminent or current risk of harm to self, others, and/or property.

AND

1.3. Acute changes in the member’s signs and symptoms, and/or psychosocial and environmental factors (i.e., the “why now” factors leading to admission) have occurred, and the member’s current condition can be safely, efficiently, and effectively assessed and/or treated in this setting.

2. Continued Service Criteria

2.1. (See Common Criteria for All Levels of Care)

3. Discharge Criteria

3.1. (See Common Criteria for All Levels of Care)

4. Clinical Best Practices

4.1. Evaluation & Treatment Planning

4.1.1. (See Common Clinical Best Practices for All Levels of Care)

4.1.2. The frequency and duration of outpatient visits allows for safe, efficient, and effective achievement of treatment goals, and supports the member’s recovery and resiliency. Initially, the frequency of visits varies from weekly in routine cases to several times a week. As the member’s functional status improves, the frequency of visits decreases to meet the member’s current needs and treatment goals. Factors that may impact frequency and duration include:

4.1.2.1. The goals of treatment;

4.1.2.2. The member’s preferences;

4.1.2.3. Evidence from clinical best practices which supports frequency and duration;

4.1.2.4. The need to monitor and manage imminent risk of harm to self, others, and/or property.

4.1.3. The provider informs the member of the process to be followed in the event of an after-hours emergency such as the availability of on-call services. The process is not solely reliant on the Emergency Room.

4.2. Discharge Planning

4.2.1. (See Common Clinical Best Practices for All Levels of Care)

Intensive Outpatient Program

A structured program that maintains hours of service for at least 9 hours per week for adults and 6 hours per week for children/adolescents during which assessment and diagnostic services, and active behavioral health treatment are provided to members who are experiencing moderate signs and symptoms that result in significant personal distress and/or significant psychosocial and environmental issues. The purpose of services is to monitor and maintain stability, decreasing moderate signs and symptoms, increase functioning, and assist members with integrating into community life.

The course of treatment in an Intensive Outpatient Program is focused on addressing the “why now” factors that precipitated admission (e.g., changes in the member’s signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the member’s condition can be safely, efficiently and effectively treated in a less intensive level of care.

An Intensive Outpatient Program can be used to treat mental health conditions or can specialize in the treatment of co-occurring mental health and substance-related disorders.

When supported by the benefit plan, coverage may be available for Intensive Outpatient Program services that are coupled with overnight housing.

1. Admission Criteria

1.1. (See Common Criteria for All Levels of Care)

AND

1.2. The member is not in imminent or current risk of harm to self, others, and/or property.

AND

1.3. Assessment and diagnosis and/or treatment planning requires observation and interaction a minimum of 9 hours per week for adults and 6 hours per week for children/adolescents. Examples include:

1.3.1. Assessment requires frequent interaction with the member and observation of the member with others.

1.3.2. The treatment plan must be frequently changed which requires that the provider have face-to-face interactions with the member several times a week.

OR

1.4. The member requires engagement and support which requires extended interaction between the member and the program. Examples include:

1.4.1. The member requires a coordinated transition back into the community after treatment in Inpatient or a Residential Treatment Center.

1.4.2. The member has been unable to access or utilize family or other natural resources on their own.

OR

1.5. The member requires a structured environment to practice and enhance skills. This requires face-to-face interactions several times a week that cannot be provided in a less intensive setting. Examples of skills include those that help the member:

1.5.1.1. Maintain their current living situation;

1.5.1.2. Return to work or school.

OR

1.6. The member requires a structured environment to complete goals and develop a plan for post-discharge services in a less intensive setting. Examples of assistance include:

1.6.1.1. Assistance with developing the skills needed to self-manage medications.

1.6.1.2. Assistance with making progress toward goals in spite of an environment that does not support recovery and/or limited community support services.

Criteria for Overnight Housing Coupled with an Intensive Outpatient Program

1.7. Overnight housing is covered by the benefit plan.

AND

1.8. The treatment setting is separate from the housing.

AND

1.9. An unsupportive or high-risk living situation is undermining the member's recovery.

OR

1.10. Routine attendance at the Intensive Outpatient Program is hindered by the lack of transportation.

2. Continued Service Criteria

2.1. (See Common Criteria for All Levels of Care)

3. Discharge Criteria

3.1. (See Common Criteria for All Levels of Care)

4. Clinical Best Practices

4.1. Evaluation & Treatment Planning

4.1.1. (See Common Clinical Best Practices for All Levels of Care)

4.1.2. The responsible provider and the treatment team complete the initial evaluation commensurate with the member's needs, no later than three (3) treatment days after admission.

4.1.3. During admission, a psychiatrist is available to consult with the program during and after normal program hours.

4.2. Discharge Planning

4.2.1. (See Common Clinical Best Practices for All Levels of Care)

Partial Hospitalization Program

A structured program that maintains hours of service for at least 20 hours per week during which assessment and diagnostic services, and active behavioral health treatment are provided to members who are experiencing serious signs and symptoms that result in significant personal distress and/or significant psychosocial and environmental issues. The purpose of services is to stabilize and reduce acute signs and symptoms, increase functioning, and assist a member with integrating into community life.

The course of treatment in a Partial Hospital Program is focused on addressing the “why now” factors that precipitated admission (e.g., changes in the member’s signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the member’s condition can be safely, efficiently and effectively treated in a less intensive level of care.

A Partial Hospital Program can be used to treat mental health conditions or can specialize in the treatment of co-occurring mental health and substance-related disorders.

When supported by the benefit plan, coverage may be available for Partial Hospital Program services that coupled with overnight housing.

1. Admission Criteria

1.1. (See Common Criteria for All Levels of Care)

AND

1.2. The member is not in imminent or current risk or harm to self, others, and/or property.

AND

1.3. Assessment and diagnosis and/or treatment planning requires observation and interaction for at least 20 hours per week. Examples include:

1.3.1. Assessment requires frequent interaction with the member, and observation of the member with others.

1.3.2. The treatment plan must be changed frequently which requires that the provider have face-to-face interactions with the member several times a week.

OR

1.4. The member requires engagement and support which requires extended interaction between the member and the program. Examples include:

1.4.1. The member requires a coordinated transition back into the community after treatment in Inpatient or a Residential Treatment Center, such as engagement with wraparound services or natural resources.

1.4.2. The member has been unable to access or utilize family or other natural resources on their own.

OR

1.5. The member requires a structured environment to practice and enhance skills. This requires face-to-face interactions several times a week that cannot be provided in a less intensive setting. Examples of skills include those that help the member:

1.5.1. Maintain their current living situation;

1.5.2. Return to work or school.

OR

1.6. The member requires a structured environment to complete goals and develop a plan for post-discharge services in a less intensive setting. Examples of assistance include:

1.6.1.1. Assistance with developing the skills needed to self-manage medications.

1.6.1.2. Assistance with making progress toward goals in spite of an environment that does not support recovery and/or limited community support services.

Criteria for Overnight Housing Coupled with a Partial Hospital Program

1.7. Overnight housing is covered by the benefit plan.

AND

1.8. The treatment setting is separate from the housing.

AND

1.9. An unsupportive or high-risk living situation is undermining the member's recovery.

OR

1.10. Routine attendance at the Partial Hospital is hindered by the lack of transportation.

1. Continued Service Criteria

1.1. (See Common Criteria for All Levels of Care)

2. Discharge Criteria

2.1. (See Common Criteria for All Levels of Care)

3. Clinical Best Practices

3.1. Evaluation & Treatment Planning

3.1.1. (See Common Clinical Best Practices for All Levels of Care)

- 3.1.2. The psychiatrists and the treatment team complete the initial evaluation commensurate with the member's needs, no later than 24 hours following admission.
 - 3.1.3. During admission, a psychiatrist is available to consult with the program during and after normal business hours.
 - 3.1.4. A psychiatrist sees the member commensurate with the member's needs, with no less than weekly visits.
- 3.2. Discharge Planning
- 3.2.1. (See Common Clinical Best Practices for All Levels of Care)

Residential Treatment Center

A sub-acute facility-based program which delivers 24-hour/7-day assessment and diagnostic services, and active behavioral health treatment to members who do not require the intensity of nursing care, medical monitoring and physician availability offered in Inpatient.

The course of treatment in a Residential Treatment Center is focused on addressing the “why now” factors that precipitated admission (e.g., changes in the member’s signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the member’s condition can be safely, efficiently and effectively treated in a less intensive level of care.

1. Admission Criteria

1.1. (See Common Criteria for All Levels of Care)

AND

1.2. The member is not in imminent or current risk of harm to self, others, and/or property.

AND

1.3. The “why now” factors leading to admission cannot be safely, efficiently or effectively assessed and/or treated in a less intensive setting due to acute changes in the member’s signs and symptoms and/or psychosocial and environmental factors. Examples include:

1.3.1. Acute impairment of behavior or cognition that interferes with activities of daily living to the extent that the welfare of the member or others is endangered.

1.3.2. Psychosocial and environmental problems that are likely to threaten the member’s safety or undermine engagement in a less intensive level of care without the intensity of services offered in this level of care.

1.4. Treatment is not primarily for the purpose of providing custodial care. Services are custodial when they are any of the following:

1.4.1. Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).

1.4.2. Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.

- 1.4.3. Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

2. Continued Service Criteria

- 2.1. (See Common Criteria for All Levels of Care)

AND

- 2.2. Treatment is not primarily for the purpose of providing custodial care. Services are custodial when they are any of the following:

- 2.2.1. Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- 2.2.2. Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- 2.2.3. Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

3. Discharge Criteria

- 3.1. (See Common Criteria for All Levels of Care)

4. Clinical Best Practices

- 4.1. Evaluation & Treatment Planning

- 4.1.1. (See Common Clinical Best Practices for All Levels of Care)
- 4.1.2. The psychiatrist in conjunction with the treatment team completes the initial evaluation commensurate with the member's needs, no later than 24 following admission.
- 4.1.3. During admission, a psychiatrist is available to consult with the program during and after normal program hours. A psychiatric consultation occurs at least weekly commensurate with the member's needs.

- 4.2. Discharge Planning

- 4.2.1. (See Common Clinical Best Practices for All Levels of Care)
- 4.2.2. The first treatment appointment and medication management visit are scheduled to occur within a timeframe that is commensurate with the risk that the "why now" factors which led to admission will reoccur, but no later than 7 days from discharge.

Inpatient

A structured hospital-based program which provides 24-hour/7-day nursing care, medical monitoring, and physician availability; assessment and diagnostic services, active behavioral health treatment, and specialty medical consultation with an immediacy needed to avoid serious jeopardy to the health of the member or others.

The course of treatment in an inpatient setting is focused on addressing the “why now” factors that precipitated admission (e.g., changes in the member’s signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the member’s condition can be safely, efficiently and effectively treated in a less intensive level of care.

1. Admission Criteria

1.1. (See Common Criteria for All Levels of Care)

AND

1.2. The “why now” factors leading to admission, and /or the member’s history of response to treatment suggest that there is imminent or current risk of harm to self, others, and/or property which cannot be safely, efficiently, and effectively managed in a less intensive level of care. Examples include:

1.2.1. A life-threatening suicide attempt;

1.2.2. Self-mutilation, injury or violence toward others or property;

1.2.3. Threat of serious harm to self or others;

1.2.4. Command hallucinations directing harm to self or others.

OR

1.3. The “why now” factors leading to admission suggest that the member’s condition cannot be safely, efficiently, and effectively treated in a less intensive setting due to a physical complication. Example include:

1.3.1. A physical cause for the member’s signs and symptoms cannot be ruled out in a less intensive setting.

1.3.2. A severe medication side effect requires the level of monitoring and intervention available in an inpatient setting.

OR

1.4. The “why now” factors leading to admission cannot be safely, efficiently, and effectively assessed and/or treated in a less intensive setting due to acute changes in the member’s signs and symptoms, and/or psychosocial and environmental factors. Examples include:

- 1.4.1. Acute impairment of behavior or cognition that interferes with activities of daily living to the extent that the welfare of the member or others is endangered.
- 1.4.2. Psychosocial and environmental problems that threaten the member's safety or undermines engagement in a less intensive level of care.

OR

- 1.5. The "why now" factors which led to admission to Crisis Stabilization & Assessment or 23-Hour Observation cannot be addressed, and the member must be admitted to inpatient.

2. Continued Service Criteria

- 2.1. (See Common Criteria for All Levels of Care)

AND

- 2.2. Treatment is not primarily for the purpose of providing custodial care. Services are custodial when they are any of the following:
 - 2.2.1. Non-health-related services, such as assistance with Activities of Daily Living (examples include feeding, dressing, bathing, transferring and ambulating).
 - 2.2.2. Health-related services that are provided for the primary purpose of meeting the personal needs of the member or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
 - 2.2.3. Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

3. Discharge Criteria

- 3.1. (See Common Criteria for All Levels of Care)

4. Clinical Best Practices

- 4.1. Evaluation & Treatment Planning
 - 4.1.1. (See Common Clinical Best Practices for All Levels of Care)
 - 4.1.2. The psychiatrist in conjunction with the treatment team completes the initial evaluation commensurate within 24 hours of admission.
 - 4.1.3. During admission, the psychiatrist sees the member at least 5 times per week, and supervises and evaluates the treatment program to determine the extent to which treatment goals are being realized and whether changes in the treatment plan are needed.
- 4.2. Discharge Planning
 - 4.2.1. (See Common Clinical Best Practices for All Levels of Care)

- 4.2.2. The first treatment appointment and medication management visit are scheduled to occur within a timeframe that is commensurate with the risk that the “why now” factors which led to admission will reoccur, but no later than 7 days from discharge.

PART IV: ADDITIONAL RESOURCES

Clinical Protocols

Optum maintains clinical protocols that include the Level of Care Guidelines and Best Practice Guidelines which describe the scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding treatment. These clinical protocols are available to Covered Persons upon request, and to Physicians and other behavioral health care professionals on ubhonline

Peer Review

Optum will offer a peer review to the provider when services do not appear to conform to this guideline. The purpose of a peer review is to allow the provider the opportunity to share additional or new information about the case to assist the Peer Reviewer in making a determination including, when necessary, to clarify a diagnosis

Second Opinion Evaluations

Optum facilitates obtaining a second opinion evaluation when requested by an enrollee, provider, or when Optum otherwise determines that a second opinion is necessary to make a determination, clarify a diagnosis or improve treatment planning and care for the member.

Referral Assistance

Optum provides assistance with accessing care when the provider and/or enrollee determine that there is not an appropriate match with the enrollee’s clinical needs and goals, or if additional providers should be involved in delivering treatment.

PART V: DEFINITIONS

Cognitive Behavioral Therapy (CBT) A classification of therapies that are predicated on the idea that behavior and feelings are caused by thoughts.

Diagnostic and Statistical Manual of the American Psychiatric Association (DSM) A manual produced by the American Psychiatric Association which provides the diagnostic criteria for mental health and substance-related disorders, and other problems that may be the focus of clinical attention. Unless otherwise noted, the current edition of the DSM applies.

Eye Movement Desensitization and Reprocessing (EMDR) is a type of psychotherapy treatment that was originally designed to alleviate the distress associated with traumatic memories and facilitates the accessing and processing of traumatic memories to bring these to an adaptive resolution.

Exposure Therapy (ET) helps members with PTSD reduce the fear associated with their experience through repetitive, therapist-guided confrontation of feared places, situations, memories, thoughts, and feelings.

Imagery Rehearsal Therapy (IRT) is a type of cognitive behavior therapy aimed to help members alter their nightmares while they are awake. IRT methods attempt to change the content of the patient's nightmare to promote mastery over the threat, thereby altering the meaning, importance, and orientation to the nightmare.

Mental Illness Those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under the Policy.

Posttraumatic Stress Disorder is exposure to a traumatic experience involving actual or threatened injury of self or others with a response of intense fear that is persistently re-experienced via distressing recollections, dreams, or reenactments.

Prevailing Medical Standards and Clinical Guidelines means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

Scientific Evidence means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.

Stress Inoculation Training (SIT) is a type of CBT that can be thought of as a set of skills for managing anxiety and stress. This treatment was developed for the management of anxiety symptoms and adapted for treating women rape trauma survivors.

Trauma-Focused Therapy is a cognitive behavioral treatment that involves individual sessions with the child and parent as well as joint parent-child sessions. TFT (1) directly addresses children's traumatic experiences, (2) includes parents in treatment in some manner as important agents of change, and (3) focus not only on symptom improvement but also on enhancing functioning, resiliency, and/or development.

PART VI: REFERENCES

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PART VII: CODING

The Current Procedural Terminology (CPT) codes and HCPCS codes listed in this guideline are for reference purposes only. Listing of a service code in this guideline does not imply that the service described by this code is a covered or non-covered health service. Coverage is determined by the benefit document.

Limited to specific CPT and HCPCS codes?	X Yes <input type="checkbox"/> No
90791	Psychiatric diagnostic evaluation
90791 plus interactive add-on code (90875)	Psychiatric diagnostic evaluation (interactive)
90832	Psychotherapy, 30 minutes with patient and/or family
90832 plus interactive add-on code (90875)	Psychotherapy, 30 minutes with patient and/or family (interactive)
90832 plus pharmacological add-on code (90863)	Psychotherapy, 30 minutes with patient and/or family (pharmacological management)
90834	Psychotherapy, 45 minutes with patient and/or family member
90834 plus interactive add-on code (90785)	Psychotherapy, 45 minutes with patient and/or family member (interactive)
90834 plus pharmacological add-on code (90863)	Psychotherapy, 45 minutes with patient and/or family member (pharmacological management)
90837	Psychotherapy, 60 minutes with patient and/or family member
90837 plus interactive add-on code (90785)	Psychotherapy, 60 minutes with patient and/or family member (interactive)
90837 plus pharmacological add-on code (90863)	Psychotherapy, 60 minutes with patient and/or family member (pharmacological management)
90839	Psychotherapy for crisis, first 60 minutes
90839 plus interactive add-on code (90785)	Psychotherapy for crisis, first 60 minutes (interactive)
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)
90853 plus interactive add-on code (90785)	Group psychotherapy (other than of a multiple-family group) (interactive)
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
H0015	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

H0035	Mental health partial hospitalization, treatment, less than 24 hours
S0201	Partial hospitalization services, less than 24
S9480	Intensive outpatient psychiatric services, per die

DSM-5 Codes	ICD-10 Codes	Applicable Diagnoses
309.81	F43.10	Posttraumatic Stress Disorder (specify with dissociative symptoms or delayed expression)

Limited to place of service (POS)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
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Limited to specific provider type?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
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Limited to specific revenue codes?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
100-160	(Range describes various all-inclusive inpatient services)
900-919	(Range describes various unbundled behavioral health treatments/services)
1000-1005	(Range describes various sites that provider 24-hour services)

PART VIII: HISTORY

Revision Date	Name	Revision Notes
10/2013	L. Urban	Version 1-Final
10/2014	L. Urban	Version 2-Final
4/2015	L. Urban	Version 3-Final
10/2015	L. Urban	Version 3-Final Revised
7/2016	L. Urban	Version 4-Final