

Treatment of Reactive Attachment Disorder (RAD)

Guideline Number: BHCDG812016

Effective Date: November, 2013

Revision Date: July, 2016

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:

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the DSM, the essential feature of Reactive Attachment Disorder (RAD) is a consistent pattern of inhibited, emotionally withdrawn behavior toward adult caregivers as evidenced by the child rarely seeking or responding to comfort when distressed; and a persistent social and emotional disturbance with minimal social and emotional responsiveness, limited positive affect or episodes of irritability, sadness or fearfulness due to patterns of extremes of insufficient care. The disturbance is evident before age 5, the member has a developmental age of at least 9 month old, and criteria are not met for Autism Spectrum Disorder (*Diagnostic and Statistical Manual of Mental Disorders, 5th ed.*; American Psychiatric Association, 2013).
- Benefits are available for covered services that are not otherwise limited or excluded.
- Pre-notification is required for inpatient, residential treatment center, intensive outpatient, partial hospital/day treatment programs 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 the 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 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.
- Non-evidenced based attachment therapies that involve non-contingent physical restraint or coercion such as:
 - Rebirthing simulation
 - Binding
 - Holding
 - Forcing or withholding food or water

- Regressive/corrective techniques (e.g., bottle feeding, tightly wrapping, forced eye contact)

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 Reactive Attachment Disorder

- 2.1. The assessment of RAD requires evidence directly obtained from serial observations of the child interacting with his or her primary caregivers and history of the child's patterns of attachment behavior with these caregivers. A full assessment typically takes two to three visits (AACAP, 2015).
 - 2.1.1. The evaluation will begin with one or more interviews with the child's caregivers (Coates & Gaensbauer, 2009).
 - 2.1.1.1. In gathering this information, there will be opportunities to educate the parents about typical traumatic effects and to facilitate the parents' coming to understand the specific reactions their child is showing.
 - 2.1.2. Direct observations of the child's interactions with his/her primary caregivers.
 - 2.1.3. Direct observations of the child interacting with unfamiliar adults.
 - 2.1.4. Direct observations of parenting style and caregiving techniques and abilities.
 - 2.1.5. Observations should be structured using a method (e.g., The Clinical Observation of Attachment) that may include episodes of play, teaching, and separation/reunion and compare these observations between unfamiliar adults and the attachment figure.
 - 2.1.6. History of the child's patterns of attachment with caregivers since birth.

- 2.1.7. History of the child's comfort seeking beginning with the onset of stranger wariness and progressing through the time of assessment.
- 2.1.8. History of maltreatment, neglect, and exposure to traumatic events since birth. It may be necessary for the clinician to report any current suspicions or previously unreported abuse or neglect.
 - 2.1.8.1. There is high risk of developmental delays, speech and language deficits and untreated medical conditions in maltreated children. Medical screening may be indicated.
- 2.1.9. History of multiple living situations if applicable (e.g., foster home/institutional placement).
- 2.1.10. Information about the member's functioning across all settings through collateral sources such as pediatricians, teachers, caseworkers, or others familiar with the child.
- 2.1.11. Consideration of cultural nuances and norms regarding attachment (e.g., eye contact, personal space)
- 2.1.12. Determine the presence of the behavioral symptoms associated with disrupted attachment such as:
 - 2.1.12.1. Extreme lack of affection toward caregivers; or overly affectionate with unfamiliar adults.
 - 2.1.12.2. Lack of comfort seeking when hurt, frightened, ill; or comfort seeking in an ambivalent or inappropriate manner.
 - 2.1.12.3. Excessive dependence on caregivers; or inability to seek and use supportive attachment figures when needed.
 - 2.1.12.4. Lack of compliance with caregiver requests and demands; or fearful over-compliance to caregiver instructions.
 - 2.1.12.5. Failure to check back with caregiver in unfamiliar settings; or unwilling to leave caregiver to explore environment.
 - 2.1.12.6. Age-inappropriate caregiving behavior; or excessively bossy or punitive toward caregivers/others.
 - 2.1.12.7. Failure to reestablish interaction after separation; or obvious lack of affection or active ignoring.

2.1.12.8. Willingness to leave caregiver and go with a stranger without protest.

3. Diagnosis

- 3.1. A RAD diagnosis is characterized by a pattern of disturbed and developmentally inappropriate attachment behaviors, and the child rarely or minimally turns to an attachment figure for comfort (DSM-5, 2013).
- 3.2. There is absent or undeveloped attachment between the child and caregivers. It is believed that these children have the capacity to form attachments but have had limited opportunities to do so in early development (DSM-5, 2013).
- 3.3. Children with RAD often have diminished or absent expression of positive emotions and the capacity for emotional regulation is often compromised (DSM-5, 2013).
- 3.4. A diagnosis should not be made in children unable to form selective attachments, thus there is a requirement that the child be at least 9 months of age (DSM-5, 2013).
- 3.5. Due to the association of RAD with social neglect, RAD often co-occurs with developmental delays of cognition and language (DSM-5, 2013).
- 3.6. It is important to remember that a diagnosis of RAD cannot be assumed simply because a child has been abused or neglected. Many children are resilient even in the face of harsh adversity (Hornor, 2008).
- 3.7. As a part of establishing a diagnosis, measuring the severity of symptoms, and measuring the patient's progress over time, clinicians may use one or more of the following evidence-based tools (AACAP, 2005; Optum Standardized Testing Grid, 2014):
 - 3.7.1. Behavior Assessment System for Children (BASC-R; BASC-2)
 - 3.7.2. Behavior Assessment System for Children-Self Report Version (BASC-SAP)
 - 3.7.3. Behavior Assessment System for Children-Teacher Version and Parent Version (BASC-TRS; BASC-PRS)
 - 3.7.4. Child Behavior Checklist (CBCL)
 - 3.7.5. Parenting Stress Index (PSI-3)
 - 3.7.6. Trauma Symptom Checklist for Children (TSCC)
- 3.8. Differential Diagnosis:

- 3.8.1. Comorbidities and symptom overlap with other conditions are often present with RAD. The differential diagnosis should take into account the possible presence of the following conditions prior to confirming RAD (AACAP, 2005):
 - 3.8.1.1. Post-Traumatic Stress Disorder
 - 3.8.1.2. Anxiety Disorders
 - 3.8.1.3. Oppositional Defiant Disorder
 - 3.8.1.4. Attention-Deficit/Hyperactivity Disorder
 - 3.8.1.5. Fetal Alcohol Syndrome/Effects
 - 3.8.1.6. Speech and Language Delays
 - 3.8.1.7. Pervasive Developmental Disorders
 - 3.8.1.8. Untreated Medical Conditions
 - 3.8.1.9. Suicidal ideation or attempts

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.
 - 4.5.3. 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

1. The most important intervention for young children diagnosed with RAD and who lack an attachment to a caregiver is for the clinician to advocate for providing the child with an emotional available attachment figure (AACAP, 2015).
 - 1.1. This includes decreasing the use of institutional care and promoting opportunities for sensitive caregiving and psychological investment in the child.
2. Although the diagnosis of RAD is based on symptoms displayed by the child, assessing caregiver attitudes toward and perceptions about the child is important for treatment selection (AACAP, 2015).
3. Because children diagnosed with RAD are presumed to have grossly disturbed internal models for relating to others, effective treatment must focus on creating positive interactions with caregivers (AACAP, 2016).

- 3.1. This includes working through the caregiver, with the caregiver and child together, and with the child individually (AACAP, 2016).
- 3.2. The advantage of working through the caregiver is for the therapist to avoid being the focus of the child's attachment behavior, while give the caregivers the message that they are capable of managing the child.
4. There are two established models for dyadic work:
 - 4.1.1. **Infant-Parent Psychotherapy (Infant-Parent Psychotherapy/ Child-Parent Psychotherapy /Toddler-Parent Psychotherapy)** is defined as a manualized dyadic (parent/child) intervention that integrates psychodynamic, attachment, trauma, cognitive behavioral, and social learning theories, and has been used primarily with impoverished and traumatized families with children younger than 5-years-old (AACAP, 2005).
 - 4.1.1.1. Sessions take place either in the home or in an office playroom and are typically unstructured, include both parent and child together, and use play, language and physical contact to promote reciprocity and exploration; to contain, process and redirect negative affect; to resolve conflict; and to clarify feelings.
 - 4.1.1.2. The goal of child-parent psychotherapy is to restore a sense of safety, trust and reciprocity in the parent-child relationship.
 - 4.1.2. **Interaction Guidance** is a strengths-based intervention in which the focus is on observable interactions, communication and relationship between the child and caregiver, rather than on either alone (AACAP, 2005).
 - 4.1.2.1. The therapist helps the caregiver appreciate the emotional experience of the child and its connection to the emotional experience of the caregiver.
 - 4.1.2.2. The focus on parenting strengths is reflected using positive reinforcement and processing moments of frustration and disengagement to reshape behavior.

5. Pharmacotherapy

- 5.1. No psychopharmacological intervention trials for RAD have been conducted. However, pharmacological interventions for comorbid disorders, such as PTSD, and related anxiety disorders, disruptive behavior disorders, and mood disorders, may be indicated when comprehensive assessment documents ongoing symptoms (AACAP, 2015).
- 5.2. Symptom specific treatment with psychotropic medications for severe emotional dysregulation is suggested if benefits outweigh risks (Potter, et al., 2009).

- 5.3. Parents may need psychoeducation about specific symptoms that medications are meant to alleviate and parents should be assisted in developing realistic expectations about the risks and limitations of medications in treating certain behaviors (Potter, et al., 2009).

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.
 - 1.1. The provider and, whenever possible, the member updates the initial discharge plan during the admission ensuring that:
 - 1.1.1. An appropriate discharge plan is in place prior to discharge;
 - 1.1.2. The discharge plan is designed to mitigate the risk that the “why now” factors which precipitated admission will reoccur;
 - 1.1.3. The member agrees with the discharge plan.
 - 1.2. For members continuing treatment, the discharge plan includes:
 - 1.2.1. The discharge date;
 - 1.2.2. The post-discharge level of care, and the recommended forms and frequency of treatment;
 - 1.2.3. The names of the providers who will deliver treatment;
 - 1.2.4. The date of the first appointment including the date of the first medication management visit;
 - 1.2.5. The name, dose and frequency of each medication;
 - 1.2.6. A prescription sufficient to last until the first medication management visit is provided;
 - 1.2.7. An appointment for necessary lab tests is provided;
 - 1.2.8. Resources to assist the member with overcoming barriers to care such as lack of transportation or child care;
 - 1.2.9. Recommended self-help and community support services;
 - 1.2.10. Information about what the member should do in the event of a crisis prior to the first appointment.
 - 1.2.11. 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.

- 1.2.12. The provider shares the discharge plan and all pertinent clinical information with the providers at the next level of care prior to discharge.
- 1.2.13. 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.
- 1.2.14. Notification of the Care Advocate that the member is discontinuing treatment may trigger outreach and assistance to the member.
- 1.2.15. The provider coordinates discharge with agencies and programs such as the school or court system with which the member is involved.
- 1.3. For members not continuing treatment, the discharge plan includes:
 - 1.3.1. The discharge date;
 - 1.3.2. Recommended self-help and community support services;
 - 1.3.3. Information about what the member should do in the event of a crisis or to resume services.
 - 1.3.4. 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

(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

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 use disorders, and other problems that may be the focus of clinical attention. Unless otherwise noted, the current edition of the DSM applies.

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.

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.

Reactive Attachment Disorder According to the DSM, the essential feature of Reactive Attachment Disorder (RAD) is markedly disturbed and developmentally inappropriate social relatedness in most contexts, beginning before age 5 associated with severe neglect of the member's physical and emotional needs, and/or repeated changes of primary caregivers

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.

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 (90785)	Psychiatric diagnostic evaluation (interactive)
90832	Psychotherapy, 30 minutes with patient and/or family
90832 plus interactive add-on code (90785)	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
313.89	F94.1	Reactive Attachment Disorder

Limited to place of service (POS)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Limited to specific provider type?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

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
11/2013	L. Urban	Version 1-Final
10/2014	L. Urban	Version 2-Final
10/2015	L. Urban	Version 3-Final
7/2016	L. Urban	Version 4-Final