

SCHIZOPHRENIA & SCHIZOAFFECTIVE DISORDERS

Policy Number: BH727SSDCDG_072017

Effective Date: July, 2017

Table of Contents	Page
INSTRUCTIONS FOR USE	1
BENEFIT CONSIDERATIONS	1
COVERAGE RATIONALE	2
APPLICABLE CODES	2
LEVEL OF CARE GUIDELINES	4
UNITEDHEALTHCARE BENEFIT PLAN DEFINITIONS	4
EVIDENCE-BASED CLINICAL GUIDELINES	5
REFERENCES	7
ADDITIONAL RESOURCES	8
HISTORY/REVISION INFORMATION	8

Relevant Diagnoses:

- Schizophrenia
- Schizoaffective disorder
- Catatonia

INSTRUCTIONS FOR USE

This Coverage Determination Guideline provides assistance in interpreting and administering behavioral health benefit plans that are managed by Optum, and U.S. Behavioral Health Plan, California (doing business as OptumHealth Behavioral Solutions of California (“Optum-CA”). When deciding coverage, the member-specific benefit plan document must be referenced. The terms of the member-specific benefit plan document [e.g., Certificate of Coverage (COC), Schedule of Benefits (SOB), and/or Summary Plan Description (SPD)] may differ greatly from the standard benefit plan upon which this Coverage Determination Guideline is based. In the event of a conflict, the member’s specific benefit plan document supersedes this Coverage Determination Guideline.

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the COC/SPD prior to using this Coverage Determination Guideline. Other Policies and Coverage Determination Guidelines may apply. Optum reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary.

This Coverage Determination Guideline is provided for informational purposes. It does not constitute medical advice.

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

BENEFIT CONSIDERATIONS

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

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.

Additional Information

The lack of a specific exclusion for a service does not necessarily mean that the service is covered. For example, depending on the specific plan requirements, services that are inconsistent with Level of Care Guidelines and/or

prevailing medical standards and clinical guidelines may be excluded. Please refer to the member's benefit document for specific plan requirements.

Essential Health Benefits for Individual and Small Group

For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits ("EHBs"). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs, the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this policy, it is important to refer to the member-specific benefit document to determine benefit coverage.

COVERAGE RATIONALE

Available benefits for schizophrenia and schizoaffective disorders include the following services:

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

The requested service or procedure must be reviewed against the language in the member's benefit document. When the requested service or procedure is limited or excluded from the member's benefit document, or is otherwise defined differently, it is the terms of the member's benefit document that prevails.

Per the specific requirements of the plan, health care services or supplies may not be covered when inconsistent with generally accepted standards and clinical guidelines:

[Optum Level of Care Guidelines](#)

[UnitedHealthcare Benefit Plan Definitions](#)

[Evidence-Based Clinical Guidelines](#)

All services must be provided by or under the direction of a properly qualified behavioral health provider.

APPLICABLE CODES

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

CPT Code	Description
90785	Interactive complexity (list separately in addition to the code for primary procedure)
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
90832	Psychotherapy, 30 minutes with patient
90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service(list separately in addition to the code for primary procedure)
90834	Psychotherapy, 45 minutes with patient
90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)
90837	Psychotherapy, 60 minutes with patient
90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)
90839	Psychotherapy for crisis; first 60 minutes

CPT Code	Description
90840	Psychotherapy for crisis; each additional 30 minutes (list separately in addition to the code for primary service)
90845	Psychoanalysis
90846	Family psychotherapy (without the patient present), 50 minutes
90847	Family psychotherapy (conjoint psychotherapy) (with the patient present), 50 minutes
90849	Multiple-family group psychotherapy
90853	Group psychotherapy (other than of a multiple-family group)
90863	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure)

HCPCS Code	Description
G0177	Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)
G0410	Group psychotherapy other than of a multiple-family group, in a partial hospitalization setting, approximately 45 to 50 minutes
G0411	Interactive group psychotherapy, in a partial hospitalization setting, approximately 45 to 50 minutes
H0004	Behavioral health counseling and therapy, per 15 minutes
H0017	Behavioral health; residential (hospital residential treatment program), without room and board, per diem
H0018	Behavioral health; short-term residential (nonhospital residential treatment program), without room and board, per diem
H0019	Behavioral health; long-term residential (nonmedical, nonacute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem
H0035	Mental health partial hospitalization, treatment, less than 24 hours
H2001	Rehabilitation program, per 1/2 day
H2011	Crisis intervention service, per 15 minutes
H2012	Behavioral health day treatment, per hour
H2013	Psychiatric health facility service, per diem
H2017	Psychosocial rehabilitation services, per 15 minutes
H2018	Psychosocial rehabilitation services, per diem
H2019	Therapeutic behavioral services, per 15 minutes
H2020	Therapeutic behavioral services, per diem
S0201	Partial hospitalization services, less than 24 hours, per diem
S9480	Intensive outpatient psychiatric services, per diem
S9482	Family stabilization services, per 15 minutes
S9484	Crisis intervention mental health services, per hour
S9485	Crisis intervention mental health services, per diem

ICD-10 Diagnosis Code	ICD-10 Description
F20.0	Paranoid schizophrenia
F20.1	Disorganized schizophrenia
F20.2	Catatonic schizophrenia
F20.3	Undifferentiated schizophrenia
F20.5	Residual schizophrenia
F20.81	Schizophreniform disorder
F20.89	Other schizophrenia

ICD-10 Diagnosis Code	ICD-10 Description
F20.9	Schizophrenia, unspecified
F21	Schizotypal disorder
F25.0	Schizoaffective disorder, bipolar type
F25.1	Schizoaffective disorder, depressive type
F25.8	Other schizoaffective disorders
F25.9	Schizoaffective disorder, unspecified

LEVEL OF CARE GUIDELINES

Optum / OptumHealth Behavioral Solutions of California Level of Care Guidelines are available at:
<https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html>

The Level of Care Guidelines are a set of objective and evidence-based behavioral health guidelines used to standardize coverage determinations, promote evidence-based practices, and support members' recovery, resiliency, and wellbeing.

UNITEDHEALTHCARE BENEFIT PLAN DEFINITIONS

For plans using 2001 and 2004 generic UnitedHealthcare COC/SPD, unless otherwise specified

Covered Health Service(s)

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*.

For plans using 2007 and 2009 generic UnitedHealthcare COC/SPD, unless otherwise specified

Covered Health Service(s)

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 the *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.

For plans using 2011 and more recent generic UnitedHealthcare COC/SPD, unless otherwise specified

Covered Health Care Service(s) - health care services, including supplies or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Care Service in the *Certificate* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
- Not excluded in the *Certificate* under *Section 2: Exclusions and Limitations*.

Medically Necessary - health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following as determined by us or our designee.

- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Doctor specialty society recommendations or professional standards of care may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Doctor specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

We develop and maintain clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services.

EVIDENCE-BASED CLINICAL GUIDELINES

A. Initial evaluation common criteria and best practices

- See "*Common Criteria and Best Practices for All Levels of Care*", available at: <https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html>
- Optum recognizes the American Psychiatric Association's Practice Guidelines for the Psychiatric Evaluation of Adults (2016):
 - <http://www.psychiatry.org> > Psychiatrists > Practice > Clinical Practice Guidelines

B. Screening and Assessment

- Rating scales such as the Brief Psychiatric Rating Scale (BPRS), Positive Symptoms Rating Scale (PSRS) and the Brief Negative Symptom Assessment (BNSA) may be useful for assessing the member's presenting symptoms, and to periodically measure the member's response to treatment (Texas Medication Algorithm Project (TMAP), 2008).
- Psychiatric assessments for children and adolescents should include screening questions for psychosis (AACAP, 2013).
- Diagnostic accuracy may be improved by using a structured diagnostic interview that is designed for youth and includes a module for psychotic illnesses (AACAP, 2013).
- Risk factors (e.g., early onset, risk of harm, family history of Schizophrenia, isolation, unsuccessful treatment at a lower level of care) should be identified (APA, 2004).
- Strengths and resilience factors should be identified (e.g., family or peer supports, illness management skills) (APA, 2004).

C. Differential diagnosis for schizophrenia and schizoaffective disorders includes (American Psychiatric Association, 2013):

- Major Depressive Disorder or Bipolar Disorder with psychotic or catatonic features;
- Schizoaffective Disorder
- Schizophreniform Disorder and Brief Psychotic Disorder
- Delusional Disorder;
- Schizotypal Personality Disorder;
- Obsessive-Compulsive Disorder and Body Dysmorphic Disorder;
- Posttraumatic Stress Disorder;
- Autism Spectrum Disorder
 - Autism and pervasive developmental disorders are distinguished from schizophrenia by the absence of psychotic symptoms and by the predominance of the characteristic deviant language patterns, aberrant social relatedness, or repetitive behaviors (AACAP, 2013).
- Other conditions associated with a psychotic episode.
 - Full-blown mania in teenagers often presents with florid psychosis, including hallucinations, delusions, and thought disorder (AACAP, 2013)

- Central nervous system infections, delirium, neoplasms, endocrine disorders, genetic syndromes, autoimmune disorders, and toxic exposures (AACAP, 2013).
- Psychotic symptoms as a result of substance abuse to include dextromethorphan, lysergic acid diethylamide, hallucinogenic mushrooms, psilocybin, peyote, cannabis, stimulants, and inhalants (AACAP, 2013).
 - When drug abuse precedes the development of schizophrenia, it is difficult to gauge whether the psychosis represents independent drug effects or the unmasking of the underlying illness in an individual with other neurobiological vulnerabilities (AACAP, 2013).

D. Treatment planning common criteria and best practices

- See “*Common Criteria and Best Practices for All Levels of Care*”, available at: <https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locq.html>
- Optum recognizes the American Psychiatric Association’s Practice Guidelines for the Psychiatric Evaluation of Adults (2016):
 - <http://www.psychiatry.org> > Psychiatrists > Practice > Clinical Practice Guidelines

E. Psychosocial Interventions

- Psychosocial interventions are typically provided as in conjunction with pharmacotherapy and are focused on symptom improvement and stabilization for Schizophrenia and Schizoaffective Disorder (APA, 2009).
- The aims of psychosocial interventions are to facilitate the member’s engagement in treatment, as well as to decrease risk and promote resilience (APA, 2009).
- Significant social support is required by most schizophrenic patients. Schizophrenic patients constitute nearly one third of all homeless individuals. They usually require help with basic social, occupational, and interaction skills (Ferri’s Clinical Advisor, 2016).
- Family stress can precipitate relapse and re-hospitalization. Family interventions can reduce morbidity (Ferri’s Clinical Advisor, 2016).
- Cognitive behavioral therapy can reduce the severity of both psychotic and negative symptoms (Ferri’s Clinical Advisor, 2016).
- Integrated treatment that includes assertive community treatment, family involvement programs, and social skills training reduces the severity of both psychotic and negative symptoms, reduces comorbid substance misuse, reduces hospital days, increases adherence to treatment, and increases satisfaction with treatment (Ferri’s Clinical Advisor, 2016).

F. Pharmacotherapy

Pharmacotherapy Considerations for Schizophrenia & Schizoaffective Disorder

- Pharmacotherapy recommendations for children and adolescents are similar to the adult recommendations, although age and developmental risks and benefits of each medication should be considered prior to use with children and adolescents (AACAP, 2001).
- Consider the following to improve the likelihood that pharmacotherapy will be beneficial:
 - Age and developmental level of the member, especially when the member is a child/adolescent and the potential associated risks of medication choice.
 - The need to educate the member and, with the member’s documented consent, their family/social supports about pharmacotherapy (APA, 2004);
 - Alternatives to medications that have not proven successful, have resulted in serious side effects, are likely to produce drug interactions, or are otherwise not in line with the member’s preferences (APA, 2004);
 - Avoiding overly complicated regimens (e.g., when a member is also being treated with medications for other behavioral health or medical conditions) will be beneficial (APA, 2004);

Acute Pharmacotherapy for Schizophrenia

- Acute psychosis is usually adequately controlled with antipsychotic agents (Ferri’s Clinical Advisor, 2016).
 - Few differences in effectiveness exist between first-generation antipsychotics (e.g., haloperidol, perphenazine, fluphenazine, chlorpromazine) and second-generation antipsychotics (e.g., risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole, clozapine, lurasidone) for nonrefractory patients (Ferri’s Clinical Advisor, 2016).
 - First-generation antipsychotics are slightly more likely than second-generation antipsychotics to cause a parkinsonian state and eventual tardive dyskinesia (rate of tardive dyskinesia, 15% to 30%). Antiparkinsonian drugs (e.g., benztropine, amantadine) are used to ameliorate the parkinsonism (Ferri’s Clinical Advisor, 2016).
 - Risperidone has been shown to be superior to haloperidol for the prevention of acute psychotic relapse (Ferri’s Clinical Advisor, 2016).

- Sedatives (i.e., benzodiazepines and, to a lesser degree, barbiturates) can be used transiently if a patient is in an agitated state (Ferri's Clinical Advisor, 2016).
- Consider a first or second generation antipsychotic as a first-line treatment (Psychopharmacological Treatment Recommendations for Schizophrenia (PORT), 2009).
- Consider switching to a different first or second generation antipsychotic as a second-line treatment (Texas Medication Algorithm Project (TMAP), 2008).
- Consider clozapine as a third-line treatment. Use of clozapine may be especially appropriate for members with recurrent suicidality, members who have a co-occurring substance use disorder, or when positive symptoms have persisted for more than 2 years (TMAP, 2008).
- Consider combining a first or second generation antipsychotic with clozapine or ECT as a fourth line treatment or for treatment resistance (TMAP, 2008).
- Consider use of long-acting injectable (depot) antipsychotic medications when the course of the member's condition or current presentation make it likely that relapse will occur after discharge/discontinuation of treatment (TMAP, 2008).
- Concurrent use of multiple first or second generation antipsychotics is typically not indicated (TMAP, 2009).
- Consider use of adjunctive medications to treat symptoms of co-occurring symptoms or to address drug interactions and side effects (APA, 2009).
- Monitor the member's response to treatment closely and adjust dosage accordingly:
 - Adjusting the dosage to a therapeutic level may proceed more slowly during a first episode when there isn't an established history of treatment (TMAP, 2008).
 - Monitor for common side effects such drowsiness, dizziness, metabolic changes (e.g., hyperglycemia, diabetes mellitus), tardive dyskinesia, or extrapyramidal side effects (PORT, 2009).

Pharmacotherapy for Continuous Schizophrenia

- Relapse prevention is a major goal of treatment. Antipsychotic agents usually must be continued at the same doses that controls psychosis. Long-acting injectable preparations given biweekly or monthly can be used (Ferri's Clinical Advisor, 2016).
- Most patients frequently switch among antipsychotics and there is considerable individual variability with regard to antipsychotic response and vulnerability to specific adverse effects (Ferri's Clinical Advisor, 2016).
- Clozapine is more effective than other agents for treatment-refractory patients. However, it requires monitoring to prevent life-threatening adverse effects. Olanzapine may also be more effective than less expensive first-generation drugs but has substantial adverse metabolic effects (Ferri's Clinical Advisor, 2016).
- Neurocognitive improvement associated with antipsychotic treatment among patients with schizophrenia is small and does not differ between first-generation and second-generation antipsychotics.
- Antiparkinsonian agents may also need to be continued for the long term (Ferri's Clinical Advisor, 2016).
- Tardive dyskinesia can occur in as many as 30% of patients with the long-term use of neuroleptics (Ferri's Clinical Advisor, 2016).
- The negative symptoms of schizophrenia can resemble depression. In addition, depressive disorders may occur in schizophrenic patients. Antidepressant treatment of the negative symptoms is usually not effective. However, antidepressants can improve the symptoms of a comorbid depressive episode (Ferri's Clinical Advisor, 2016).
- Mood stabilizers (e.g., lithium, valproate, carbamazepine) are of little use unless the patient has a comorbid impulse control disorder (Ferri's Clinical Advisor, 2016).
- Specific antipsychotic medications have been associated with weight gain (i.e., olanzapine and clozapine) and QT prolongation. Hyperlipidemia and diabetes mellitus are associated with second-generation antipsychotics, and hyperprolactinemia is associated with first-generation antipsychotics. (Risperidone, a second-generation antipsychotic, can also produce hyperprolactinemia.) Clozapine is associated with agranulocytosis. Metabolic status and weight should be screened before the start of treatment and at regular intervals (Ferri's Clinical Advisor, 2016).
- Patients with schizophrenia have a higher lifetime incidence of suicide, with 20% attempting on one or more occasions and 5% to 6% completing suicide. Comorbid use of substances and hopelessness are associated risk factors. Clozapine has shown the ability to decrease the incidence of suicidal attempts in schizophrenia patients (Ferri's Clinical Advisor, 2016).
- Several 1st and 2nd generation antipsychotics are available in long-acting injectable preparations that may be helpful (Ferri's Clinical Advisor, 2016).

Pharmacotherapy for Schizoaffective Disorder

- Atypical or second generation antipsychotics use is the current standard for the treatment of Schizoaffective Disorder with the following considerations (Current Psychiatry, 2010).

- Selecting an appropriate atypical antipsychotic requires adequate member/provider dialogue, member education, treatment adherence and ongoing assessment and management of adverse effects (Current Psychiatry, 2010).
- The use of a mood stabilizer may be introduced as an adjunct to antipsychotic use when depressive or bipolar symptoms are present and symptoms do not fully respond to antipsychotic treatment alone (Current Psychiatry, 2010).
- The use of an antidepressant may be considered as an adjunct to antipsychotic use when depressive symptoms persist following the stabilization of psychosis, monitoring for a rapid switch from depression to mania and/or mixed state after antidepressant treatment (Current Psychiatry, 2010).
- Regardless of level of care, pharmacotherapy should continue for 8-12 weeks to determine medication efficacy (Current Psychiatry, 2010).
- Monitor for changes in the balance between psychotic symptoms and affective/mood symptoms. An initial Schizoaffective Disorder subtype is frequently unstable and may progress to Schizophrenia or Major Depression/Mania with Psychotic features (Current Psychiatry, 2010).
- Non-pharmacologic therapies should be used in combination with pharmacotherapy to achieve the greatest benefit (Current Psychiatry, 2010).
- Other treatment options such as ECT or clozapine may be initiated if the member is nonresponsive to multiple trials or targeted interventions (Current Psychiatry, 2010).

Pharmacotherapy During Pregnancy

- A pregnancy test for women of child bearing potential should be considered as there may be risks to an unborn fetus and breast-fed infant due to the effects of medications (APA, 2004).
- If pregnancy is confirmed, the provider should encourage and monitor prenatal care to reduce the risk of adverse outcomes such as low birth weight and still birth as a result of inadequate prenatal care and treatments that are contraindicated (APA, 2004).
- The provider should closely measure the risks and benefits of pharmacotherapy throughout the course of a member's pregnancy, making adjustments as needed (APA, 2004).
- Although the risk varies according to medication, the first trimester and withdrawal risk at the time of birth appear to be the periods of highest risk (APA, 2004).
- Due to metabolic effects of atypical antipsychotic medication use, there is an increased risk of gestational diabetes requiring metabolic monitoring throughout the pregnancy (APA, 2004).
- Benzodiazepines and mood stabilizers pose the highest risk of fetal malformations and behavioral effects (APA, 2004).
- There is evidence to support that there may be milder symptoms during pregnancy but an increased risk of exacerbated symptoms in the postpartum period (APA, 2004).

Pharmacotherapy Considerations for Older Adults

- It is recommended that older adults receive a combination of pharmacotherapy and psychosocial interventions (APA, 2004).
- Several age-related physiological factors may influence medication choice. The following should be considered (APA, 2004):
 - Reduced cardiac output and organ blood flow and reduced metabolism and fat content impact the rate of absorption resulting in prolonged drug effects and greater sensitivity to medications.
 - The starting dose should be one quarter to one half of the usual adult starting dose.
 - The presence of co-occurring medical conditions or the use of multiple medications further complicates pharmacotherapy requiring close monitoring for potential risks and interactions.
 - Due to the cognitive changes that may accompany aging and Schizophrenia related cognitive effects, engagement and adherence to medication regimens should be closely evaluated.
 - Second generation antipsychotics are generally preferred over first generation antipsychotic medications due to the risk of extrapyramidal effects such as tardive dyskinesia.
 - There may be a higher risk of falls with the use of second generation antipsychotics.

G. Discharge planning common criteria and best practices

- See "Common Criteria and Best Practices for All Levels of Care":
<https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html>

REFERENCES*

1. American Psychiatric Association. *Practice guidelines for the psychiatric evaluation of adults* (3rd ed.). Arlington, VA: American Psychiatric Publishing; 2016.

2. American Psychiatric Association. *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing; 2013.
3. American Academy of Child and Adolescent Psychiatry, Practice Parameter for the Assessment and Treatment of Children and Adolescents with Schizophrenia, 2013.
4. American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, 2013.
5. American Psychiatric Association, Practice Guideline for the Treatment of Schizophrenia, 2004
6. American Psychiatric Association, Practice Guideline for the Treatment of Schizophrenia, Guideline Watch, 2009
7. Association for Ambulatory Behavioral Healthcare, Standards and Guidelines for Partial Hospital Programs, 2008.
8. Behavioral Health Sciences, Medicare and Medicaid, A Review of Evidence Based Practices, 2007.
9. Centers for Medicaid and Medicare Local Coverage Determination, Psychiatric Inpatient Hospitalization, 2012. <http://www.cms.gov/medicare-coverage-database/indexes/lcd-alphabetical-index.aspx?bc=AgAAAAAAAAAAAA&>
10. Centers for Medicaid and Medicare Local Coverage Determination for Psychiatric Partial Hospitalization Program, 2013. <http://www.cms.gov/medicare-coverage-database/indexes/lcd-alphabetical-index.aspx?bc=AgAAAAAAAAAAAA&>
11. Current Psychiatry, Differential Diagnosis and Therapeutic Management of Schizoaffective Disorder, 2010.
12. Ferri, F. Ferri's Clinical Advisor, Disease Overview for Schizophrenia, 2016. Retrieved from www.clinicalkey.com, July, 2015.
13. Generic UnitedHealthcare Certificate of Coverage, 2001.
14. Generic UnitedHealthcare Certificate of Coverage, 2007.
15. Generic UnitedHealthcare Certificate of Coverage, 2009.
16. Generic UnitedHealthcare Certificate of Coverage, 2011.
17. Level of Care Guidelines, 2014.
18. National Institute for Health and Clinical Excellence, Treatment and Management of Schizophrenia in Adults, 2010
19. PORT Psychopharmacological Treatment Recommendations, Schizophrenia, 2009.
20. Substance Abuse and Mental Health Services Administration, Illness Management and Recovery Practitioner Guide, 2009.
21. Substance Abuse and Mental Health Services Administration, Illness Management and Recovery, Evidence-Based Practices Knowledge Informing Transformation, 2009.
22. Texas Medication Algorithm Project, 2008.

*Additional reference materials can be found in the reference section(s) of the applicable Level of Care Guidelines

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 www.providerexpress.com.

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 member, 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 member determine that there is not an appropriate match with the member's clinical needs and goals, or if additional providers should be involved in delivering treatment.

HISTORY/REVISION INFORMATION

Date	Action/Description
07/11/2017	• Version 1