Coverage Determination Guideline: Schizophrenia and Schizoaffective Disorders

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INTRODUCTION

Coverage Determination Guidelines are a set of objective and evidence-based behavioral health criteria used by Commercial plans that don’t have a provision for medical necessity to standardize coverage determinations, promote evidence-based practices, and support members’ recovery, resiliency, and wellbeing for behavioral health benefit plans that are managed by Optum®.

INSTRUCTIONS FOR USE

This guideline provides assistance in interpreting UnitedHealthcare Commercial benefit plans, and is used to make coverage determinations as well as to inform discussions about evidence-based practices and discharge planning for behavioral health benefit plans managed by Optum. When deciding coverage, the member’s specific benefits must be referenced.

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member’s benefits prior to using this guideline. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this guideline and the member’s specific benefit, the member’s specific benefit supersedes this guideline. Other clinical criteria may apply. Optum reserves the right, in its sole discretion, to modify its clinical criteria as necessary using the process described in Clinical Criteria.

This guideline is provided for informational purposes. It does not constitute medical advice.

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

Optum may develop clinical criteria or adopt externally-developed clinical criteria that supersede this guideline when required to do so by contract or regulation.

BENEFIT CONSIDERATIONS

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

1 Optum is a brand used by United Behavioral Health and its affiliates.
Available benefits for Schizophrenia and Schizoaffective Disorders include the following levels of care, procedures, and conditions:

- **Levels of Care**
  - Inpatient
  - Intensive Outpatient Program
  - Outpatient
  - Partial Hospital Program
  - Residential Treatment Facility

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

- **Conditions**
  - Schizophrenia and Schizoaffective disorder classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association* that are not excluded from coverage.

**Indications for Coverage**

Initial evaluation common criteria and best practices

- Optum recognizes the American Psychiatric Association’s (APA) Practice Guidelines for the Psychiatric Evaluation of Adults (2016):
  - [http://www.psychiatry.org > Psychiatrists > Practice > Clinical Practice Guidelines](http://www.psychiatry.org)

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 (APA, 2004).
- Psychiatric assessments for children and adolescents should include screening questions for psychosis (American Academy of Child & Adolescent Psychiatry (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).
- Early intervention is strongly recommended due to the negative consequences associated with untreated psychosis such as suicide attempt, aggression or violence (Addington et al., 2017).
- 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 (APA, 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 and best practices
- Optum recognizes the American Psychiatric Association’s Practice Guidelines for the Psychiatric Evaluation of Adults (2016):
  - [http://www.psychiatry.org > Psychiatrists > Practice > Clinical Practice Guidelines](http://www.psychiatry.org > Psychiatrists > Practice > Clinical Practice Guidelines)

E. Psychosocial Interventions
- Psychosocial interventions are typically provided in conjunction with pharmacotherapy and are focused on symptom improvement and stabilization for individuals with schizophrenia (APA, 2009).
- The goals of psychosocial interventions are to facilitate the individual’s engagement in treatment and prevent relapse (APA, 2009).
- A meta-analysis regarding cognitive remediation, a treatment that focuses on the cognitive difficulties in schizophrenia has shown a positive impact on negative symptoms (Cella, Preti, Edwards, Dow, & Wykes, 2017).
- There is strong evidence for the use of cognitive behavioral therapy (CBT) in individuals with a poor response to medication while continuing to experience symptoms of anxiety or depression (Norman, Lecomte, Addington, & Anderson, 2017).
- Approximately 30% of individuals with schizophrenia have a poor response or no response to antipsychotic medication. CBT is the most frequent recommended intervention in treatment resistant schizophrenia and has shown efficacy in reducing positive symptoms (Polese, Fornaro, Palermo, DeLuca, & de Bartolomeis, 2019).
- Family-focused interventions have shown strong evidence in reducing schizophrenia symptoms and also decreasing the likelihood of hospitalization (Norman et al., 2017).
- Integrated treatment that includes assertive community outreach, intensive case management, community mental health centers, family involvement programs, crisis resolution, supported employment, and supportive living arrangements reduces hospital days, increases adherence to treatment, and increases satisfaction with treatment (Addington, Anderson, Kelly, Lesage, & Summersville, 2017).
- A systematic review published by the Agency for Healthcare Research and Quality (AHRQ, 2017) found that individuals engaged in assertive community treatment were more likely to be living independently and less likely to be homeless.
- Coordinated specialty care (CSC) is a recovery-oriented treatment program for first episode psychosis that creates a personal treatment plan. CSC promotes shared decision-making and uses specialists for psychotherapy, medication management,
family education, work education, and case management (National Institute of Mental Health (NIMH), 2016).

F. Pharmacotherapy for Schizophrenia

• 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, 2013).

• Consider the following to improve the likelihood that pharmacotherapy will be beneficial (APA, 2004):
  o Age and developmental level of the member, especially when the member is a child/adolescent and the potential associated risks of medication choice;
  o The need to educate the member and, with the member’s documented consent, their family/social supports about pharmacotherapy;
  o 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;
  o 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.

• Antipsychotics are one of the most commonly prescribed categories of medications in the U.S. In adults, they are considered a primary treatment for schizophrenia (Olfson, King, & Schoenbaum, 2015).

• In the elderly population, antipsychotic use has been linked to increased risk of cerebrovascular events, fractures, acute kidney problems, and premature mortality (Olfson et al., 2015).

• First generation antipsychotics (FGAs) have more frequent extrapyramidal side effects (EPS) when compared to olanzapine, risperidone and clozapine (Zhang et al., 2013).

• In both a systematic review and meta-analysis, second generation antipsychotics (SGAs) showed significantly lower treatment discontinuation, less negative symptoms, less EPS and akathisia, however, SGAs caused more weight gain (Zhang et al., 2013).

• SGAs, also known as atypical antipsychotics, such as olanzapine, aripiprazole, risperidone, quetiapine, and ziprasidone had similar efficacy regarding function, quality of life, mortality, and adverse effects. Symptoms such as delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, and negative symptoms were more improved with olanzapine and risperidone asenapine, quetiapine, and ziprasidone. Evidence also showed symptoms improved more with paliperidone rather than lurasidone and iloperidone (AHRQ, 2017).

• Clozapine was the first atypical antipsychotic developed. Clozapine should be considered after the failure of 2 other antipsychotics for any reason (Nucifora, Mihaljevic, Lee, & Sawa, 2017).
  o Meta-analyses of antipsychotic medications have shown clozapine to have exceptional efficacy as compared to all other antipsychotics (Nucifora et al., 2017).
  o Clozapine is the only medication with the FDA-approved indication for decreasing recurrent suicidal behavior in schizophrenia and schizoaffective disorder (Nucifora et al., 2017).
  o Clozapine has been underutilized in the U.S. due to life-threatening side effects of agranulocytosis (severe neutropenia) which requires frequent blood monitoring (Nucifora et al., 2017).

• Medication nonadherence in schizophrenia is common and associated with factors such as co-morbidities, personal features, and treatment regimens. Second generation long-acting injectables (LAIs) address the issue of nonadherence and increases patient satisfaction (Pietrini et al., 2019).
  o Second generation LAIs are better tolerated, provide the opportunity for earlier detection of relapses, and reduce medication disputes between
caregivers and individuals with schizophrenia (Pietrini et al., 2019).

- Consider use of adjunctive medications to treat symptoms of co-occurring symptoms or to address drug interactions and side effects (APA, 2009).
- Monitor for common side effects such as extrapyramidal symptoms, cardiovascular events, diabetes, weight gain, and metabolic syndrome (AHRQ, 2017).
- Monitor for suicidal ideation as this is a major cause of death for individuals with schizophrenia (AHRQ, 2017).
- Relapse prevention is a major goal of treatment. Each relapse of schizophrenia leads to a progressive decline in the individual’s level of functioning (Pietrini et al., 2019).

G. Pharmacotherapy for Schizoaffective Disorder

- Antipsychotics are the current cornerstone for the treatment of Schizoaffective Disorder (Stroup et al., 2018).
  - Antidepressants and mood stabilizers may also be prescribed to treat depression and mania. Sedative-hypnotics are often prescribed, and usage increases with age (Stroup et al., 2018).
  - There is minimal current research that has focused exclusively on schizoaffective disorder (Stroup et al., 2018).
  - Medication nonadherence is common in individuals with schizoaffective disorder. There is research evidence that reports individuals with schizoaffective disorder are more likely to be rehospitalized than individuals with schizophrenia. Despite this, the overall prognosis is better for schizoaffective disorder than for schizophrenia (Joshi, Lin, Lingohr-Smith, Fu, & Muser, 2016).
  - Non-pharmacologic therapies such as CBT reduce symptoms and improve social functioning (APA, 2009).

H. 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).
- Medications undergo significant alterations during pregnancy; dosages may need to be altered. A recent pregnancy study showed a significant decline in concentrations of quetiapine and aripiprazole, while concentrations of olanzapine were unchanged (Westin et al., 2018).

I. Pharmacotherapy Considerations for Older Adults

- Schizophrenia increases mortality risk with age that is two to three times more than the general population (Abdool, Supasitthumrong, Patel, Mulsant, & Rajji, 2019).
- 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):
  o 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.
  o The starting dose should be one quarter to one half of the usual adult starting dose.
  o The presence of co-occurring medical conditions or the use of multiple medications further complicates pharmacotherapy requiring close monitoring for potential risks and interactions.
  o Due to the cognitive changes that may accompany aging and Schizophrenia related cognitive effects, engagement and adherence to medication regimens should be closely evaluated.
  o Older adults treated with antipsychotics are more likely to encounter extrapyramidal symptoms, tardive dyskinesia, orthostasis, postural instability, falls, and cognitive impairment (Abdool et al., 2019).

**APPLICABLE CODES**

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

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>90785</td>
<td>Interactive complexity (list separately in addition to the code for primary procedure)</td>
</tr>
<tr>
<td>90791</td>
<td>Psychiatric diagnostic evaluation</td>
</tr>
<tr>
<td>90792</td>
<td>Psychiatric diagnostic evaluation with medical services</td>
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<tr>
<td>90832</td>
<td>Psychotherapy, 30 minutes with patient</td>
</tr>
<tr>
<td>90833</td>
<td>Psychotherapy, 30 minutes with patient when performed with an evaluation and management service(list separately in addition to the code for primary procedure)</td>
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<tr>
<td>90834</td>
<td>Psychotherapy, 45 minutes with patient</td>
</tr>
<tr>
<td>90836</td>
<td>Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)</td>
</tr>
<tr>
<td>90837</td>
<td>Psychotherapy, 60 minutes with patient</td>
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<tr>
<td>90838</td>
<td>Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)</td>
</tr>
<tr>
<td>90839</td>
<td>Psychotherapy for crisis; first 60 minutes</td>
</tr>
<tr>
<td>90840</td>
<td>Psychotherapy for crisis; each additional 30 minutes (list separately in addition to the code for primary service)</td>
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<tr>
<td>90845</td>
<td>Psychoanalysis</td>
</tr>
<tr>
<td>90846</td>
<td>Family psychotherapy (without the patient present), 50 minutes</td>
</tr>
<tr>
<td>90847</td>
<td>Family psychotherapy (conjoint psychotherapy) (with the patient present), 50 minutes</td>
</tr>
<tr>
<td>90849</td>
<td>Multiple-family group psychotherapy</td>
</tr>
<tr>
<td>90853</td>
<td>Group psychotherapy (other than of a multiple-family group)</td>
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<tr>
<td>90863</td>
<td>Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure)</td>
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</table>
| G0177           | Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or
Group psychotherapy other than of a multiple-family group, in a partial hospitalization setting, approximately 45 to 50 minutes

Interactive group psychotherapy, in a partial hospitalization setting, approximately 45 to 50 minutes

Behavioral health counseling and therapy, per 15 minutes

Behavioral health; residential (hospital residential treatment program), without room and board, per diem

Behavioral health; short-term residential (nonhospital residential treatment program), without room and board, per diem

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

Mental health partial hospitalization, treatment, less than 24 hours

Rehabilitation program, per 1/2 day

Crisis intervention service, per 15 minutes

Behavioral health day treatment, per hour

Psychiatric health facility service, per diem

Psychosocial rehabilitation services, per 15 minutes

Psychosocial rehabilitation services, per diem

Therapeutic behavioral services, per 15 minutes

Therapeutic behavioral services, per diem

Partial hospitalization services, less than 24 hours, per diem

Intensive outpatient psychiatric services, per diem

Family stabilization services, per 15 minutes

Crisis intervention mental health services, per hour

Crisis intervention mental health services, per diem

Diagnosis Codes | 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
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

REFERENCES


**REVISION HISTORY**

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<td>07/11/2018</td>
<td>• Annual Update: Updates to formatting, template, and references.</td>
</tr>
<tr>
<td>07/15/2019</td>
<td>• Annual Update: Updates to formatting and references.</td>
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