United Behavioral Health

Coverage Determination Guideline: Trauma and Stressor-Related Disorders

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INTRODUCTION

Coverage Determination Guidelines are a set of objective and evidence-based behavioral health criteria used by Commercial plans that don't have a provision for medical necessity to standardize coverage determinations, promote evidence-based practices, and support members' recovery, resiliency, and wellbeing for behavioral health benefit plans that are managed by Optum®[1].

INSTRUCTIONS FOR USE

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

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

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

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

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

BENEFIT CONSIDERATIONS

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

[1] Optum is a brand used by United Behavioral Health and its affiliates.

COVERAGE RATIONALE

Available benefits for Trauma and Stress-Related Disorder 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
  - Trauma and stress-related disorders 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

A. Initial evaluation and best practices
- Optum recognizes the American Psychiatric Association's Practice Guidelines for the Psychiatric Evaluation of Adults (2016):
  - http://www.psychiatry.org > Psychiatrists > Practice > Clinical Practice Guidelines

B. Reactive Attachment Disorder (RAD) and Disinhibited Social Engagement Disorder (DSED)
- For a diagnosis of reactive attachment disorder (RAD):
  - The child must have a developmental age of at least 9 months (American Psychiatric Association, 2013), and;
  - The disturbance is evident before 5 years of age (American Psychiatric Association, 2013).
- For a diagnosis of disinhibited social engagement disorder (DSED):
  - The child must have a developmental age of at least 9 months (American Psychiatric Association, 2013).
  - Significant social neglect is a requirement for diagnosis of DSED (American Psychiatric Association, 2013).
- Assessment involves observation of the child interacting with primary caregivers, a history of the child's patterns of attachment behavior with these caregivers, and observation of the child's behavior with unfamiliar adults (American Academy of Child & Adolescent Psychiatry, 2016).
- A comprehensive history of the child's early caregiving environment should be gathered (e.g., from pediatricians, teachers, or caseworkers familiar with the child). Age-appropriate screens for developmental delays, speech and language assessment, and referral for pediatric examination and testing are often necessary (American Academy of Child & Adolescent Psychiatry, 2016).
- Differential diagnosis for an attachment disorder may include (American Psychiatric Association, 2013):
  - Autism spectrum disorder;
  - Intellectual disability;

    - Depressive disorders;
    - Attention-deficit/hyperactivity disorder
- Primary treatments for children with attachment disorders focus on creating positive interactions with caregivers (American Academy of Child & Adolescent Psychiatry, 2016).
    - Children with an attachment disorder who display aggressive and oppositional behavior may require adjunctive treatments, such as parent education or multisystemic therapy (American Academy of Child & Adolescent Psychiatry, 2016).
    - Pharmacological interventions should be approached cautiously, particularly in preschool-age children, as no psychopharmacological intervention trials for attachment disorders have been conducted (American Academy of Child & Adolescent Psychiatry, 2016).
    - Pharmacological interventions for comorbid disorders (e.g., mood disorders) may be indicated when a comprehensive assessment documents ongoing symptoms (American Academy of Child & Adolescent Psychiatry, 2016).
- Interventions involving physical restraint or coercion (e.g., therapeutic holding), reworking of trauma (e.g., rebirthing therapy), or that promote regression for reattachment have no empirical support and are associated with serious harm, including death (American Academy of Child & Adolescent Psychiatry, 2016).

C. Posttraumatic Stress Disorder (PTSD) and Acute Stress Disorder
- General assessment of individuals with symptoms of a stress disorder includes:
    - Assess for safety, signs of trauma, historical information regarding psychiatric, medical, military, family, past physical or sexual abuse, medication or substance use, social, and spiritual life, functional and mental status (VA/DOD, 2017).
    - Identify trauma history and duration; with patient consent, consider obtaining additional history from family/significant other (VA/DOD, 2017).
    - Identify existence of co-occurring disorders (VA/DOD, 2017).
- Children and adolescents can have symptoms that may be different than those seen in adults (National Institute of Mental Health, 2019).
- Acute stress disorder symptoms typically begin immediately after the trauma, but persist for at least 3 days and up to a month (American Psychiatric Association, 2013).
- The Clinician-Administered PTSD Scale (CAPS or CAPS-CA for children and adolescents), is considered the most effective for PTSD assessment and diagnosis for both military Veteran and civilian trauma survivors (United States Department of Veterans Affairs: National Center for PTSD, 2019).
- Individuals with posttraumatic stress disorder often meet diagnostic criteria for at least one other mental disorder (e.g., anxiety, substance use disorder, depression; American Psychiatric Association, 2013).
- Differential diagnosis for stress disorders may include (American Psychiatric Association, 2013).
    - Adjustment disorders;
    - Anxiety disorders and obsessive-compulsive disorder;
    - Major depressive disorder;
    - Personality disorders;
    - Dissociative disorders;
    - Conversion disorder;
    - Psychotic disorders;
    - Traumatic brain injury.
- If symptoms worsen, cognitive restructuring is recommended for individuals with acute stress disorder in preventing subsequent posttraumatic psychopathology (VA/DOD, 2017).

- For PTSD in adults, evidence-based psychotherapy and/or evidence-based pharmacotherapy are recommended as first-line treatment options (National Institute of Mental Health, 2019; VA/DOD, 2017).
    - Individuals with PTSD should be treated by a psychiatrist or psychologist mental health provider who is experienced with PTSD (National Institute of Mental Health, 2019).
    - The most studied medications for treating PTSD include antidepressants (SSRIs, SNRIs), with the strongest support for fluoxetine, paroxetine, sertraline (SSRIs) or venlafaxine (SNRI) (Hoskins, et al., 2015; National Institute of Mental Health, 2019; VA/DOD, 2017).
    - Research indicates that the selective serotonin reuptake inhibitors (SSRIs) sertraline, paroxetine, fluoxetine, or the serotonin and norepinephrine reuptake inhibitor (SNRI), venlafaxine, have the strongest evidence of effectiveness when compared to the other SSRIs and SNRIs (APA, 2017; Hoskins et al., 2015; VA/DOD,2017).
- Effective psychotherapies tend to emphasize a few key components, including education about symptoms, teaching skills to help identify the triggers of symptoms, and skills to manage the symptoms (National Institute of Mental Health, 2019).
- Psychotherapies for adults that are recommended by the American Psychological Association (APA) are cognitive behavior therapy (CBT), cognitive processing therapy (CPT), and prolonged exposure therapy (PE). The APA also suggests brief eclectic psychotherapy (BEP), eye movement desensitization and reprocessing (EMDR), and narrative exposure therapy (NET) (APA, 2017).
- A systematic review of psychotherapies revealed that CBT treatments have a high strength of evidence for a reduction in PTSD related symptoms with moderate strength of evidence for CPT, EMDR, and NET therapies (Agency for Healthcare Research and Quality, 2018).
- Effective trauma-focused psychotherapies include:
    - CBT focuses on the relationships among thoughts, feelings, and behaviors. The goal is changing patterns of behaviors, thoughts, and feelings that lead to problems with functioning (APA, 2017).
    - CPT emphasizes cognitive restructuring dialogue to identify emotional aspects of the traumatic event (VA/DOD, 2017).
    - Exposure therapy helps people face and control their fear. This technique uses imagining, writing, or visiting the place of the traumatic event (National Institute of Mental Health, 2019).
    - EMDR utilizes imagery through narration of the worst image, emotion, and negative cognition of the traumatic event along with a healthy cognitive reappraisal (VA/DOD, 2017).
    - NET relies on imagined exposure through an oral narrative process that helps to integrate and find meaning in traumatic experiences across the lifespan (VA/DOD, 2017).
- When trauma-focused psychotherapies are not available, Stress inoculation training (SIT) is recommended (VA/DOD, 2017).
- Treating nightmares is an essential component of treating sleep disturbance in PTSD; the current data is inconclusive regarding Imagery Rehearsal Therapy (IRT) (VA/DOD, 2017).
- Cognitive Behavioral Therapy for Insomnia (CBT-I) currently offers the strongest evidence for treating sleep disturbances in PTSD (VA/DOD, 2017).
- Interventions for PTSD in children and adolescents:
    - For some children, PTSD symptoms may abate over a period of a few months (United States Department of Veterans Affairs: National Center for PTSD, 2018).
    - Cognitive behavioral therapy (CBT) is often viewed as the most effective approach for treating children (United States Department of Veterans Affairs: National Center for PTSD, 2018).

    - Trauma-focused CBT (TF-CBT) has the strongest empirical evidence for children with PTSD, particularly when children are distressed by memories of the trauma (United States Department of Veterans Affairs: National Center for PTSD, 2018).
    - TF-CBT includes direct discussion of the traumatic event (exposure), anxiety management techniques, and correction of inaccurate or distorted trauma-related thoughts (United States Department of Veterans Affairs: National Center for PTSD, 2018).
    - CBT for PTSD is often accompanied by psychoeducation and parental involvement (United States Department of Veterans Affairs: National Center for PTSD, 2018).
    - Play therapy can be used to treat young children with PTSD who are not able to deal with the trauma more directly (United States Department of Veterans Affairs: National Center for PTSD, 2018).
    - While EMDR has been shown to be effective in treating adults, research with children is not as strong (United States Department of Veterans Affairs: National Center for PTSD, 2018).
- Other interventions for PTSD
    - There is insufficient evidence to recommend for or against Dialectical Behavioral Therapy (DBT), Skills Training in Affect, Interpersonal Regulation (STAIR), Acceptance and Commitment Therapy, Seeking Safety, or supportive counseling (VA/DOD, 2017).
    - There is insufficient evidence to recommend for or against trauma-focused or non-trauma-focused couples therapy as first-line treatments for PTSD (VA/DOD, 2017).
    - There is insufficient evidence to recommend complementary and alternative medicine (CAM) approaches as first-line treatments for PTSD (VA/DOD, 2017).

D. Adjustment Disorders
- When assessing individuals, the stressor or stressful event is not required to be remarkably threatening or terrible (Maercker and Lorenz, 2018).
- For a diagnosis of adjustment disorder:
    - The disturbance begins within 3 months of onset of a stressor and lasts no longer than 6 months after the stressor or its consequences have ceased (American Psychiatric Association, 2013).
    - Symptoms of adjustment disorder do not fit the diagnostic criteria for major depression, persistent complex bereavement disorder, personality disorders, anxiety, and PTSD (Osborn, Raetz, & Kost, 2014).
- There is no validated screening tool solely for adjustment disorder (Osborn et al., 2014; Zelviene and Kazlauskas, 2018).
- If symptoms continue beyond 6 months, major depressive disorder or posttraumatic stress disorder should be considered as a diagnosis (Osborn et al., 2014).
- Differential diagnosis for adjustment disorders may include (American Psychiatric Association, 2013):
    - Major depressive disorder;
    - Posttraumatic stress disorder and acute stress disorder;
    - Personality disorders;
    - Psychological factors affecting other medical conditions;
    - Normative stress reactions
- Adjustment disorder is a frequently used diagnosis in clinical practice (Zelviene and Kazlauskas, 2018).
- Many other disorders (e.g., substance use disorder or anxiety) can co-occur with adjustment disorder (Osborn et al., 2014).
- Brief psychological treatments (e.g., problem-solving therapy) are the preferred treatment option for individuals with adjustment disorders (Osborn et al., 2014).
- Pharmacological treatment has a limited role apart from symptomatic treatment of anxiety and insomnia. While there have been no randomized controlled trials of antidepressants

for adjustment disorder with depression, they are frequently prescribed (Osborn et al., 2014).

APPLICABE CODES

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

Diagnosis Codes	Description
F43.0	Acute stress reaction
F43.9	Reaction to severe stress, unspecified
F43.10	Post-traumatic stress disorder, unspecified
F43.11	Post-traumatic stress disorder, acute
F43.20	Adjustment disorder, unspecified
F43.21	Adjustment disorder, with depressed mood
F43.22	Adjustment disorder, with anxiety
F43.23	Adjustment disorder, with mixed anxiety and depressed mood
F43.24	Adjustment disorder, with disturbance of conduct
F43.25	Adjustment disorder, with mixed disturbance of emotions and conduct
F94.1	Reactive attachment disorder
F94.2	Disinhibited attachment disorder of childhood

Procedure Codes	Description
90785	Interactive complexity (list separately in addition to the code for primary procedure)
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
90832	Psychotherapy, 30 minutes with patient
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
90840	Psychotherapy for crisis; each additional 30 minutes (list separately in addition to the code for primary service)
90846	Family psychotherapy (without the patient present), 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)
G0177	Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)
G0410	Group psychotherapy other than of a multiple-family group, in a partial hospitalization setting, approximately 45 to 50 minutes
G0411	Interactive group psychotherapy, in a partial hospitalization setting, approximately 45 to 50 minutes
H0004	Behavioral health counseling and therapy, per 15 minutes
H0015	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling, crisis intervention, and activity therapies or education
H0017	Behavioral health; residential (hospital residential treatment program), without room and board, per diem
H0018	Behavioral health; short-term residential (nonhospital residential treatment program), without room and board, per diem
H0019	Behavioral health; long-term residential (nonmedical, nonacute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem
H0025	Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)
H0035	Mental health partial hospitalization, treatment, less than 24 hours
H2001	Rehabilitation program, per 1/2 day
H2011	Crisis intervention service, per 15 minutes
H2012	Behavioral health day treatment, per hour
H2013	Psychiatric health facility service, per diem
H2017	Psychosocial rehabilitation services, per 15 minutes
H2018	Psychosocial rehabilitation services, per diem
H2019	Therapeutic behavioral services, per 15 minutes
H2020	Therapeutic behavioral services, per diem
H2033	Multisystemic therapy for juveniles, per 15 minutes
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

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REVISION HISTORY

Date	Action/Description
05/09/2017	• Version 1 - Annual Review
05/08/2018	• Annual Update: Updates to formatting, codes, checked references
06/17/2019	• Annual Update: Updates to formatting, codes, references