



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®<sup>1</sup>.

### 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.**

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<sup>1</sup> Optum is a brand used by United Behavioral Health and its affiliates.

## COVERAGE RATIONALE

Available benefits for anxiety 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

### Indications for Coverage

#### A. Initial evaluation

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

Optum recognizes the American Academy of Child and Adolescent Psychiatry (AACAP) Practice Parameters for the evaluation of children and adolescents:

- <http://www.aacap.org> > Practice Parameters

#### 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 (*Diagnostic and Statistical Manual of Mental Disorders* 5th ed.; DSM-5; APA, 2013) and;
  - The disturbance is evident before 5 years of age (DSM-5, 2013).
- For a diagnosis of disinhibited social engagement disorder (DSED):
  - The child must have a developmental age of at least 9 months (DSM-5, 2013).
  - Significant social neglect that results in a persistent lack of emotional needs is a requirement for diagnosis of DSED (DSM-5, 2013).
  - DSED is often described as indiscriminate friendliness or indiscriminate sociability (Guyon-Harris et al., 2018).
- 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 [AACAP], 2016).
  - Upon assessment it has been observed that children with reactive attachment disorder do not seek out sanctuary with their caregivers when distressed. In comparison, those with disinhibited social engagement disorder seek out numerous individuals who might become potential caregivers; it is this lack of selectivity in social engagement that is notable (Boris & Renk, 2017).
- A comprehensive history of the child's early caregiving environment should be gathered (e.g., from pediatricians, teachers, foster caregivers 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 (AACAP, 2016; Boris & Renk, 2017).
  - An important feature of assessment of attachment in children should include observational data from various caregiver-child interactions (Boris & Renk, 2017).
- Differential diagnosis for an attachment disorder may include (DSM-5, 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. The primary goal is to assist caregivers in recognizing that the child's behavior signifies attachment needs that remain unmet (AACAP, 2016; Boris & Renk, 2017).
  - Children with an attachment disorder who display aggressive and oppositional behavior may require adjunctive treatments, such as parent education or multisystemic therapy (AACAP, 2016).
  - Pharmacological interventions should be approached cautiously, particularly in preschool-age children, as no psychopharmacological intervention trials for attachment disorders have been conducted (AACAP, 2016).
  - Pharmacological interventions for comorbid disorders (e.g., mood disorders) may be indicated when a comprehensive assessment documents ongoing symptoms (AACAP, 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 (AACAP, 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 corroborative 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 [NIMH], 2019).
- Acute stress disorder symptoms typically begin immediately after the trauma but persist for at least 3 days and up to a month (DSM-5, 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 such as anxiety, substance use disorder, and depression (DSM-5, 2013).
- Differential diagnosis for stress disorders may include (DSM-5, 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 (NIMH, 2019; VA/DOD, 2017).
  - Individuals with PTSD should be treated by a psychiatrist or psychologist mental health provider who is experienced with PTSD (NIMH, 2019);

- The most studied medications for treating PTSD include antidepressants (selective serotonin reuptake inhibitors [SSRIs], serotonin norepinephrine reuptake inhibitors [SNRIs]), with the strongest support for fluoxetine, paroxetine, and venlafaxine (Agency for Healthcare Research and Quality [AHRQ], 2018; NIMH, 2019; 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 (NIMH, 2019).
- Psychotherapies for adults that are recommended by the American Psychological Association (2017) 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).
- 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 (AHRQ, 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 (American Psychological Association, 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 (NIMH, 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 & 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 (DSM-5, 2013).
  - ⊖ Symptoms of adjustment disorder do not fit the diagnostic criteria for another mental disorder or exacerbation of any preceding mental disorder (DSM-5, 2013).
- There is currently no validated screening tool solely for adjustment disorder (Zelviene & Kazlauskas, 2018).
- Differential diagnosis for attachment disorders may include (DSM-5, 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 & Kazlauskas, 2018).
  - Assessing for an adjustment disorder diagnosis can be difficult due to establishing the distinction from normal stress reactions versus pathological responses (Bachem & Casey, 2018).
- Subtypes of adjustment disorder include anxiety and depression (Maercker & Lorenz, 2018).
- Due to the self-limiting element of adjustment disorder, brief psychological treatments are the preferred treatment option (Casey et al., 2020).
- Pharmacological treatment has a limited role apart from symptomatic treatment of anxiety and insomnia. While there have been limited randomized controlled trials of antidepressants for adjustment disorder with depression, they are frequently prescribed (Casey et al., 2020).

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## REVISION HISTORY

Date	Action/Description
05/09/2017	<ul style="list-style-type: none"> <li>• Version 1 - Annual Review</li> </ul>
05/08/2018	<ul style="list-style-type: none"> <li>• Annual Update: Updates to formatting, codes, checked references</li> </ul>
06/17/2019	<ul style="list-style-type: none"> <li>• Annual Update: Updates to formatting, codes, references</li> </ul>
10/19/2020	<ul style="list-style-type: none"> <li>• Annual Update: Updates to references, removed coding grids</li> </ul>