Client | HMSA: PQSR 2007
---|---
Measure Title | FAMILY THERAPY OR FAMILY-BASED INTERVENTION FOR CHILDREN AND ADOLESCENTS WHO SUFFER FROM PSYCHIATRIC DISORDERS
Disease State | Psychiatry
Indicator Classification | Disease Management
Strength of Recommendation | B
Clinical intent | To ensure that eligible members newly diagnosed with substance abuse, conduct disorder, mood disorder, anxiety disorder, or a psychosomatic disorder receive family therapy services within a clinically appropriate time frame.

Physician Specialties (suggested) | Refer to PQSR 2007 Specialty Matrix

Clinical Rationale

### Disease Burden
- According to a World Health Organization (WHO) report on mental health, the prevalence of childhood and adolescent mental health disorders range from 12 to 22% worldwide.[1]

### Reason for Indicated Intervention or Treatment
- Children and adolescents who suffer from certain psychological and psychiatric disorders may achieve better clinical outcomes when family therapy is part of their therapeutic regime.[2-15]

### Evidence supporting Intervention or Treatment
- A meta-analysis of 1571 adult and children drug abusers, involving approximately 3500 patients and family members, showed that family therapy was favored over individual counseling or therapy, peer group therapy, and family psycho-education, and was effective as a stand-alone treatment modality.[3] A smaller study supports the feasibility of this type of intervention.[16]
- A meta-analysis of 8 randomized controlled trials involving 749 children and adolescents with conduct disorder and/or delinquency showed that family and parenting interventions significantly reduced the amount of time spent by juvenile delinquents in institutions (weighted mean difference 51.34 days), and significantly decreased the risk of re-arrests (relative risk 0.66).[2]
- The evidence for participating in family therapy for patients with major depression is not as clear. Even though a randomized controlled trial of 107 patients with major depression demonstrated that systemic behavioral family therapy resulted in reductions in suicidality and functional impairment that were equal to that of cognitive behavior therapy and individual non-directive supportive therapy, cognitive behavior therapy led to higher rates of remission than family therapy alone.[5]
- A randomized controlled trial of 79 children aged 7 to 14 suffering from childhood anxiety revealed that when cognitive-behavioral therapy (CBT) was coupled with family management, 95.6% of children no longer had anxiety at 12 months, compared to 70.3% undergoing only CBT.[4] A pilot study comparing CBT to attachment based family therapy showed no significant differences and suggested that these are both promising treatments for anxious adolescents. [13]
• A controlled trial of 124 run-away youth reported that ecologically based family therapy resulted in greater reductions in overall substance abuse compared with service as usual. [17]

• A study of 48 participants (8-19 years old) suggested that cognitive based family therapy (either individual or group) was successful in providing either complete remission or markedly reduced symptoms for children with obsessive compulsive disorder at 18 months post-treatment (79.1% either maintained treatment gains or improved further). [11]

• In an intent-to-treat, early intervention involving 86 patients and their families, 73% showed significant intra-individual improvement in their addiction status, and both drug-dependent children and their mothers improved with regard to other goal criteria.[9]

• Systematic reviews of the literature for common childhood psychosomatic complaints such as bladder and bowel control problems and recurrent abdominal pain have demonstrated that children benefit most from family-based psychosocial interventions for enuresis [6], from combined family-based behavioral therapy, laxative use and increased dietary fiber for encopresis [7], and from behavioral family therapy for recurrent abdominal pain.[8]

Clinical Recommendations

• In its practice guidelines, the American Academy of Child and Adolescent Psychiatry (AACAP) recommends family therapy or family-based interventions as part of the treatment for substance use, conduct, attention deficit and hyperactivity disorder (ADHD), bipolar, depressive, anxiety, and obsessive compulsive disorders.[18-24]

• For enuresis, the AACAP recommends psychotherapy only when a specific psychological issue is associated with the symptom onset, or when a struggle between parent and child is maintaining the symptom.[25]

• There are no specific AACAP guidelines about the role of family therapy in the treatment of other psychosomatic complaints.

Source
Health Benchmarks, Inc. Note this measure was officially dropped in program year 2007.

Denominator
Continuously enrolled members ages 17 years or younger by the end of the measurement year, who had a diagnosis of substance abuse, conduct disorder, mood disorder, anxiety disorder, or a psychosomatic disorder, and who had at least two visits with a psychiatrist/psychologist/child psychiatrist during the first ten months of the measurement year.

Relevant Billing Codes:

ICD-9-CM diagnosis codes: 291.89, 293.84 296.0x-296.8x, 300.0x, 300.3x, 303.xx-305.xx, 307.1x, 308.0, 309.24, 312.xx-313xx, 314.00, 314.01
<table>
<thead>
<tr>
<th><strong>Denominator Exclusion</strong></th>
<th>Members with a diagnosis of substance abuse, conduct disorder, mood disorder, anxiety disorder, or psychosomatic disorder in the year prior to the measurement year.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Relevant Billing Codes:</strong></td>
<td>ICD-9-CM diagnosis codes: 291.89, 293.84 296.0x-296.8x, 300.0x, 300.3x, 303.xx-305.xx, 307.1x, 308.0, 309.24, 312.xx-313xx, 314.00, 314.01</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td>Members with at least one encounter for family therapy from 1 day to 2 months after the index diagnosis of a psychiatric disorder.</td>
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<tr>
<td><strong>Relevant Billing Codes:</strong></td>
<td>CPT-4 codes: 90846-90849, 99510</td>
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<tr>
<td><strong>Interpretation of Score</strong></td>
<td>High score implies better performance</td>
</tr>
<tr>
<td><strong>Physician Attribution</strong></td>
<td>Score all physicians (in the selected specialties) who saw the member within 2 months after the index diagnosis (including the index date) of a psychiatric disorder.</td>
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</tbody>
</table>


**Indicator Classification** (Adapted from Health Plan Employer Data Information Set (HEDIS®) technical specifications)

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Diagnosis</td>
<td>Measures applicable to patients receiving diagnostic workups for a symptom or condition that delineate appropriate laboratory or radiological testing to be performed (e.g. evaluation of thyroid nodule; pregnancy test in patients with vaginal bleeding or abdominal pain)</td>
</tr>
<tr>
<td>Effectiveness of Care</td>
<td></td>
</tr>
<tr>
<td>Prevention</td>
<td>Measures applicable to asymptomatic individuals that are designed to prevent the onset of the targeted condition (e.g. immunizations).</td>
</tr>
<tr>
<td>Screening</td>
<td>Measures applicable to asymptomatic patients who have risk factors or pre-clinical disease, but in whom the condition has not become clinically apparent (e.g. pap smears; screening for elevated blood pressure).</td>
</tr>
<tr>
<td>Disease Management</td>
<td>Measures applicable to individuals diagnosed with a condition that are part of the treatment or management of the condition (e.g. cholesterol reduction in patients with diabetes; radiation therapy following breast conserving surgery; appropriate follow-up after acute event).</td>
</tr>
<tr>
<td>Medication Monitoring</td>
<td>Measures applicable to patients taking medications with narrow therapeutic windows and/or potential preventable significant side effects or adverse reactions (e.g. thyroid stimulating hormone (TSH) testing after levothyroxine dose change; hepatic enzyme monitoring for patients using antimycotic pharmacotherapy)</td>
</tr>
<tr>
<td>Medication Adherence</td>
<td>Measures applicable to patients taking medications for chronic conditions that are designed to assess patient adherence to medication (e.g. adherence to lipid lowering medication).</td>
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<tr>
<td>Utilization</td>
<td>Measures applicable to patients receiving treatment for a symptom or condition that advocate appropriate utilization of laboratory and pharmaceutical resources (e.g. conservative use of imaging for low back pain; inappropriate use of antibiotics for viral upper respiratory infection).</td>
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</tbody>
</table>
FIGURE 2. Algorithm for determining the strength of a recommendation based on a body of evidence (applies to clinical recommendations regarding diagnosis, treatment, prevention, or screening). While this algorithm provides a general guideline, authors and editors may adjust the strength of recommendation based on the benefits, harms, and costs of the intervention being recommended. (USPSTF = U.S. Preventive Services Task Force)