Health Net

National Medical Policy

Subject: **Panic Disorder Clinical Practice Guideline**

Policy Number: **NMP472**

Effective Date*: **December 2005**

Updated: **November 2007, May 2009, May 2010, May 2011**

This National Medical Policy is subject to the terms in the IMPORTANT NOTICE at the end of this document

Overview

Panic Disorder (PD) is a treatable condition that is estimated to affect about 6 million Americans. Women are twice as likely to be affected as men. The onset is usually in late adolescence or early adult life. The disorder is characterized by the sudden onset of a feeling of terror or panic, accompanied by physical symptoms such as heart palpitations, diaphoresis, nausea, chest pain and/or difficulty breathing. While many people experience one or two such attacks in their lives, they do not go on to develop the disorder. That occurs when the attacks come repeatedly and the patient develops a fear of the attacks themselves. This fear can lead the development of Panic Disorder with Agorophobia, a situation in which people begin to avoid the places where the attacks have occurred and over time their lives become increasingly restricted as to where they can go and what they can do. Left untreated, significant functional disability can occur.

It is estimated that 85% of PD patient's first present in a general medical setting, such as their primary care physician's office or hospital emergency room, but are often undiagnosed. Patients with Panic Disorders seek medical services more frequently than patients with other psychiatric disorders. Coordination of care with other medical providers is essential to reduce unnecessary or duplicative procedures or medications.[i]

Diagnostic Considerations

Check for:

When assessing a patient for panic disorder, check for the presence of these symptoms:

- Recurrent, unexpected panic attacks—a discrete period of intense fear or discomfort with ***4 or more*** of the following symptoms:
- Racing or pounding heartbeat

- Chest pains or discomfort
- Shortness of breath, sensation of smothering or feeling of choking
- Nausea or abdominal distress
- Sweating, flushes or chills
- Dizziness
- Tingling or numbness
- Trembling or shaking
- Fear of losing control or going crazy
- Fear of dying
- Feelings of unreality or depersonalization
- Symptoms typically develop abruptly and reach a peak within 10 minutes
- 1 month or more of persistent concern about having another attack *OR* worry about the implications or consequences of panic *OR* a significant behavioral change related to the attacks or fear of future attacks

Panic Disorder with <u>Agoraphobia</u> includes the above ***AND****:*

- there is anxiety about being in situations in which escape is difficult or help may not be available if a panic attack occurs ***AND****;*
- those situations are avoided or endured with marked distress.

RULE OUT:

Look for the presence of other factors, which may suggest a different or co-existing diagnosis, including

- Direct physiological effects of a medication or other substance (e.g., caffeine)
- General medical disorders that have panic-like symptoms (e.g., cardiovascular, pulmonary, neurological, endocrinological and gastrointestinal conditions)
- Depression[2]
- Bipolar disorder
- Substance abuse (including excessive use of caffeine)
- Personality disorders

Other possible diagnoses:

- Specific or social phobia
- Obsessive-Compulsive Disorder
- PTSD
- Separation Anxiety Disorder
- Generalized Anxiety

Other important assessment considerations:

- All patients presenting with a possible Panic Disorder should have a medical history and physical examination performed, with appropriate laboratory studies and imaging studies as indicated.
- Coordination of care with the patient's PCP is very important at the time of diagnosis and ongoing. Consider using the MHN Behavioral Health Coordination Form available <u>online</u>.

- Frequency and severity of panic attacks (Having the patient keep a diary of frequency and severity of attacks can be helpful in both the initial assessment and in monitoring progress)
- Severity of anticipatory anxiety
- Severity of agoraphobic symptoms
- Severity of impairment in work, school, and social functioning
- Presence of suicidal ideation and/or history of suicide attempts. Panic disorder and panic attacks are associated with elevated risk of suicidal ideation and attempts.
- Initial and ongoing assessment for co-morbid conditions, especially Depressive Disorders and Substance Abuse. Between 30-60% of patients with lifetime panic disorder have or have had a major depressive episode.
- Family History of Panic Disorder (since the risk of having Panic Disorder is significantly elevated if there is a first-degree relative with this diagnosis)
- Consider the use of a rating scale, such as the Panic Disorder Severity Scale, to establish a baseline and to monitor progress: **Panic Disorder Severity Scale** (PDSS)
- Co-Morbidity is common, with Panic Disorder patients usually having at least one other Anxiety Disorder. In clinical populations nearly a third of panic disorder patient meet criteria for social anxiety disorder.

Treatment Considerations

General Treatment Considerations

- Panic Disorder often has a direct impact on disability, resulting in increased absenteeism, decreased productivity and reduced ability to carry out daily activities. Monitoring improvements in functioning, as well as in symptoms, should be part of evaluating treatment effectiveness.
- Treatment compliance should be addressed directly. Panic Disorder patients tend to stop treatment when they become anxious about somatic sensations from medications or confronting fearful internal or external cues during CBT.
- Different symptoms of Panic Disorder often resolve at different times. Full panic attacks may be controlled, but "sub threshold" panic attacks may continue. Anticipatory anxiety (i.e., worry about future attacks) tends to decrease after panic attacks are controlled. Agoraphobia (i.e., phobic avoidance), if present, is often the last to be positively impacted by treatment.

Level of Care

- If there is a high risk of danger to self or others or grave disability, consider inpatient hospitalization.
- Unstable patients may respond to structured, multi-disciplinary treatment (IOP, Day Treatment) that emphasizes skills training, family involvement, psychoeducation and psychiatric management. MHN care managers offer assistance finding such programs.
- Outpatient level of care is used almost exclusively

General Factors to Consider in the Use of Medications

- SSRIs, SNRIs, tricyclic antidepressants, benzodiazepines (only appropriate as monotherapy in the absence of a comorbid mood disorder) and/or cognitive-behavioral psychotherapy (CBT) have been shown generally to be equally effective in the acute phase (first 12 weeks) of treatment
- Recent research with Panic Disorder patients suggests that medication may produce the quickest initial response (although by 12 weeks CBT is equally effective); combined treatment may be better than either medication or CBT alone; and response to CBT may be more durable than the response to medication.
- Short term use (3 to 4 weeks) of benzodiazepines while initiating antidepressant medication or CBT should be considered if symptoms are too disabling to wait for a response to the other treatments. Although many clinicians express concern about the potential for tolerance and abuse of benzodiazepines, there is little evidence of dose escalation for most patients with anxiety disorders. However, long-term use of benzodiazepines may cause sedation, coordination problems, amnesia, and emergent depression. Benzodiazepine users may also be at increased risk of road traffic accidents. Finally, approximately 25-50% of patients with anxiety disorders, including PD, are substance abusers and use of benzodiazepines with such patients is problematic.

Medications

- Consider a medication evaluation if there has been:
    - a previous positive response to medications
    - an incomplete response to CBT
- SSRIs and SNRIs are considered first line treatment since they are generally well tolerated, target co-morbid conditions (which are often present), and are easier to administer than other medications. [6]
- Tricyclics, while also considered first-line agents, are often more difficult for patients to tolerate and have greater toxicity in overdose.
- MAOIs, while effective in Panic Disorder, are no longer considered first line due to poor safety and tolerability.
- Selection of an SSRI or SNRI antidepressant to which a Panic Disorder patient has had prior positive response is recommended.
- Panic Disorder patients are often extremely sensitive to and fearful of somatic sensations. Therefore, starting doses of SSRIs/SNRIs may need to be lower than those used for depressed patients. Titration to therapeutic levels may also need to progress more slowly.
- Patients should be screened for a history of mania before initiating treatment with an antidepressant. For those with a history of mania consideration should be given to using a mood stabilizer before initiating an antidepressant. A patient self-report screening instrument with good psychometric properties is the Mood Disorder Questionnaire (MDQ) http://www.dbsalliance.org/pdfs/MDQ.pdf.
- A positive response to antidepressant medication typically occurs within 6 weeks but additional time may be required to stabilize the response.
- Benzodiazepines may be used when very rapid control of symptoms is critical, or for an acute anxiety reaction. They are not appropriate for first-line treatment because PD is a chronic condition needing appropriate long-term

management. Use of benzodiazepines in this manner may be problematic for the reasons noted above.

- Discontinuation of benzodiazepines frequently results in significant withdrawal symptoms (which occur less frequently and are milder when medications are gradually tapered or when patients are on long half-life rather than short half-life benzodiazepines). Use of CBT may also facilitate successful medication discontinuation and prevent relapse.
- The duration of the maintenance phase has not yet been established for PD. Until there is additional evidence, medications should be continued for 6-12 months following symptom remission (and possibly longer if there is a history of symptom relapse after prior discontinuation).
- Abrupt discontinuation of an SSRI Or SNRI frequently results in an uncomfortable withdrawal syndrome. Patients should be cautioned regarding this.

Psychotherapy

- Consider including psychotherapy if there:
    - has been a previous positive response to psychotherapy
    - is an incomplete response to an adequate trial of medication
    - are excessive medical risks of medication
    - is evidence that coping skills are inadequate to manage psychosocial stressors
- Individual or group cognitive behavioral therapy (CBT) has been shown to be effective.
    - Behavioral exposure and systematic desensitization are especially effective for agoraphobia.
    - A positive response to treatment usually occurs within 6 to 8 weeks. A typical course of treatment in research protocols is 12 weeks.
    - Recent research suggests that active patient involvement with between-session assignments can lead to effective outcomes in fewer sessions.

- Panic-focused psychodynamic therapy (PFPP) has been shown to be effective in some studies, but at this time should only be considered if CBT has failed.

Psychoeducational Components

- Panic Disorder has a chronic, fluctuating course. Therefore, strong consideration should be given to psychoeducational interventions early in treatment.
- Patients and family members, when appropriate, should be educated about symptoms, course of illness and the possibility of residual anxiety during or after treatment terminates.
- PD patients should be taught about the use of relaxation/meditation; cognitive restructuring; anxiety support groups; newsletters and online newsgroups, and about the possible beneficial effects of involvement in national anxiety associations.

- Education should also include the promotion of healthy behaviors, including exercise, good sleep hygiene and decreased use of substances such as caffeine, tobacco and alcohol.

Resources for Patients
Websites

- http://www.nimh.nih.gov/health/publications/anxiety-disorders/complete-index.shtml#pub2
- http://www.nimh.nih.gov/health/topics/panic-disorder/index.shtml
- http://helpguide.org/mental/panic_disorder_anxiety_attack_symptom_treatment.htm
- http://www.mayoclinic.com/health/panic-attacks/DS00338
- http://familydoctor.org/online/famdocen/home/common/mentalhealth/anxiety/137.html
- http://www.adaa.org/living-with-anxiety/ask-and-learn/screenings/screening-panic-disorder
- Self Test: http://www.adaa.org/understanding-anxiety/panic-disorder-agoraphobia

Books:

Mind over mood: Change how you feel by changing the way you think by Dennis Greenberger & Christine Podesky. The Guilford Press, 1995

Mastery of Your Anxiety and Panic, Workbook. 4th Edition (Craske and Barlow, The Oxford Press, paperback, 2006)

When Panic Attacks, by David Burns. Morgan Road Books, 2006.

Support:

- Anxiety Disorder Association of America (info, newsletter, conference for professionals and patient/consumers). [www.adaa.org] Phone: 240-485-1001
- National Institute of Mental Health: Patient information phone number: (866) 615-NIMH (6464)

Resources for Clinicians

http://www.bap.org.uk/pdfs/Anxiety_Disorder_Guidelines.pdf

http://www.nice.org.uk/nicemedia/pdf/CG022quickrefguideamended.pdf

Panic Disorder Severity Scale **(PDSS)**

http://www.ncpsychiatry.org/Anxiety%20Algorithm%20Folder.pdf

http://www.psychiatryonline.com/pracGuide/pracGuideChapToc_9.aspx

Review History:

December 2005	Initial Approval Medical Advisory Council
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May 2011	Update Approved by MHN Clinical Leadership Committee
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4. American Psychiatric Association. Assessment and Treatment of Patients with Suicidal Behaviors (2003) http://www.psychiatryonline.com/pracGuide/pracGuideTopic_14.aspx
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Important Notice

General Purpose
Health Net's National Medical Policies (the "Policies") are developed to assist Health Net in administering plan benefits and determining whether a particular procedure, drug, service or supply is medically necessary. The Policies are based upon a review of the available clinical information including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the drug or device, evidence-based guidelines of governmental bodies, and evidence-based guidelines and positions of select national health professional organizations. Coverage determinations are made on a case-by-case basis and are subject to all of the terms, conditions, limitations, and exclusions of the member's contract, including medical necessity requirements. Health Net may use the Policies to determine whether under the facts and circumstances of a particular case, the proposed procedure, drug, service or supply is medically necessary. The conclusion that a procedure, drug, service or supply is medically necessary does not constitute coverage. The member's contract defines which procedure, drug, service or supply is covered, excluded, limited, or subject to dollar caps. The policy provides for clearly written, reasonable and current criteria that have been approved by Health Net's National Medical Advisory Council (MAC). The clinical criteria and medical policies provide guidelines for determining the medical necessity criteria for specific procedures, equipment, and services. In order to be eligible, all services must be medically necessary and otherwise defined in the member's benefits contract as described this "Important Notice" disclaimer. In all cases, final benefit determinations are based on the applicable contract language. To the extent there are any conflicts between medical policy guidelines and applicable contract language, the contract language prevails. Medical policy is not intended to override the policy that defines the member's benefits, nor is it intended to dictate to providers how to practice medicine.

Policy Effective Date and Defined Terms.
The date of posting is not the effective date of the Policy. The Policy is effective as of the date determined by Health Net. All policies are subject to applicable legal and regulatory mandates and requirements for prior notification. If there is a discrepancy between the policy effective date and legal mandates and regulatory requirements, the requirements of law and regulation shall govern. * In some states, new or revised policies require prior notice or posting on the website before a policy is deemed effective. For information regarding the effective dates of Policies, contact your provider representative. The Policies do not include definitions. All terms are defined by Health Net. For information regarding the definitions of terms used in the Policies, contact your provider representative.

Policy Amendment without Notice.
Health Net reserves the right to amend the Policies without notice to providers or Members. In some states, new or revised policies require prior notice or website posting before an amendment is deemed effective.

No Medical Advice.
The Policies do not constitute medical advice. Health Net does not provide or recommend treatment to members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

No Authorization or Guarantee of Coverage.
The Policies do not constitute authorization or guarantee of coverage of particular procedure, drug, service or supply. Members and providers should refer to the Member contract to determine if exclusions, limitations, and dollar caps apply to a particular procedure, drug, service or supply.

Policy Limitation: Member's Contract Controls Coverage Determinations.
The determination of coverage for a particular procedure, drug, service or supply is not based upon the Policies, but rather is subject to the facts of the individual clinical case, terms and conditions of the member's contract, and requirements of applicable laws and regulations. The contract language contains specific terms and conditions, including pre-existing conditions, limitations, exclusions, benefit maximums, eligibility, and other relevant terms and conditions of coverage. In the event the Member's contract (also known as the benefit contract, coverage document, or evidence of coverage) conflicts with the Policies, the Member's contract shall govern. Coverage decisions are the result of the terms and conditions of the Member's benefit contract. The Policies do not replace or amend the Member's contract. If there is a discrepancy between the Policies and the Member's contract, the Member's contract shall govern.

Policy Limitation: Legal and Regulatory Mandates and Requirements.
The determinations of coverage for a particular procedure, drug, service or supply is subject to applicable legal and regulatory mandates and requirements. If there is a discrepancy between the Policies and legal mandates and regulatory requirements, the requirements of law and regulation shall govern.

Policy Limitations: Medicare and Medicaid.
Policies specifically developed to assist Health Net in administering Medicare or Medicaid plan benefits and determining coverage for a particular procedure, drug, service or supply for Medicare or Medicaid members shall not be construed to apply to any other Health Net plans and members. The Policies shall not be interpreted to limit the benefits afforded Medicare and Medicaid members by law and regulation.