

NEUROCOGNITIVE DISORDERS

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Relevant Diagnoses:

- Delirium
- Major neurocognitive disorder
- Mild neurocognitive disorder
- Dementia

INSTRUCTIONS FOR USE

This Coverage Determination Guideline provides assistance in interpreting and administering behavioral health benefit plans that are managed by Optum, and U.S. Behavioral Health Plan, California (doing business as OptumHealth Behavioral Solutions of California (“Optum-CA”). When deciding coverage, the member-specific benefit plan document must be referenced. The terms of the member-specific benefit plan document [e.g., Certificate of Coverage (COC), Schedule of Benefits (SOB), and/or Summary Plan Description (SPD)] may differ greatly from the standard benefit plan upon which this Coverage Determination Guideline is based. In the event of a conflict, the member’s specific benefit plan document supersedes this Coverage Determination Guideline.

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the COC/SPD prior to using this Coverage Determination Guideline. Other Policies and Coverage Determination Guidelines may apply. Optum reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary.

This Coverage Determination 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.

BENEFIT CONSIDERATIONS

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

Pre-Service Notification

Admissions to an inpatient, residential treatment center, intensive outpatient, or a partial hospital/day treatment program require pre-service notification. Notification of a scheduled admission must occur at least five (5) business days before admission. Notification of an unscheduled admission (including emergency admissions) should occur as soon as is reasonably possible. Benefits may be reduced if Optum is not notified of an admission to these levels of care. Check the member’s specific benefit plan document for the applicable penalty and provision for a grace period before applying a penalty for failure to notify Optum as required.

Additional Information

The lack of a specific exclusion for a service does not necessarily mean that the service is covered. For example, depending on the specific plan requirements, services that are inconsistent with Level of Care Guidelines and/or

prevailing medical standards and clinical guidelines may be excluded. Please refer to the member's benefit document for specific plan requirements.

Essential Health Benefits for Individual and Small Group

For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits ("EHBs"). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs, the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this policy, it is important to refer to the member-specific benefit document to determine benefit coverage.

COVERAGE RATIONALE

Available benefits for neurocognitive 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

The requested service or procedure must be reviewed against the language in the member's benefit document. When the requested service or procedure is limited or excluded from the member's benefit document, or is otherwise defined differently, it is the terms of the member's benefit document that prevails.

Per the specific requirements of the plan, health care services or supplies may not be covered when inconsistent with generally accepted standards and clinical guidelines:

- [Optum Level of Care Guidelines](#)
- [UnitedHealthcare Benefit Plan Definitions](#)
- [Evidence-Based Clinical Guidelines](#)

All services must be provided by or under the direction of a properly qualified behavioral health provider.

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 guideline 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 policies and guidelines may apply.

CPT Code	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

CPT Code	Description
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)

HCPCS Code	Description
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
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
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

DSM Classification	ICD-10 Diagnosis Code	ICD-10 Description
Neurocognitive Disorders	F01.50*	Vascular dementia without behavioral disturbance
	F01.51*	Vascular dementia with behavioral disturbance
	F02.80*	Dementia in other diseases classified elsewhere without behavioral disturbance
	F02.81*	Dementia in other diseases classified elsewhere with behavioral disturbance

***Follow Code First Medical rules. Pay above in any position with medical in the primary.**

LEVEL OF CARE GUIDELINES

Optum / OptumHealth Behavioral Solutions of California Level of Care Guidelines are available at:

The Level of Care Guidelines are a set of objective and evidence-based behavioral health guidelines used to standardize coverage determinations, promote evidence-based practices, and support members' recovery, resiliency, and wellbeing.

UNITEDHEALTHCARE BENEFIT PLAN DEFINITIONS

For plans using 2001 and 2004 generic UnitedHealthcare COC/SPD, unless otherwise specified *Covered Health Service(s)*

Those health services provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance abuse, or their symptoms.

A Covered Health Service is a health care service or supply described in *Section 1: What's Covered--Benefits as a Covered Health Service*, which is not excluded under *Section 2: What's Not Covered--Exclusions*.

For plans using 2007 and 2009 generic UnitedHealthcare COC/SPD, unless otherwise specified *Covered Health Service(s)*

Those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance abuse, or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Described in the *Certificate of Coverage* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in the *Certificate of Coverage* under *Section 2: Exclusions and Limitations*.

In applying the above definition, "scientific evidence" and "prevailing medical standards" shall have the following meanings:

- "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
- "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

For plans using 2011 and more recent generic UnitedHealthcare COC/SPD, unless otherwise specified

Covered Health Care Service(s) - health care services, including supplies or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Care Service in the *Certificate* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
- Not excluded in the *Certificate* under *Section 2: Exclusions and Limitations*.

Medically Necessary - health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following as determined by us or our designee.

- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Doctor specialty society recommendations or professional standards of care may be considered. We have the right to consult expert opinion in

determining whether health care services are Medically Necessary. The decision to apply Doctor specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

We develop and maintain clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services.

EVIDENCE-BASED CLINICAL GUIDELINES

A. Initial evaluation common criteria and best practices

- See “*Common Criteria and Best Practices for All Levels of Care*”, available at: <https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html>
- 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. Screening and Assessment

- The evaluation of Major and Mild Neurocognitive Disorders should include the assessment of:
 - Current cognitive functioning with the use Major and Mild Neurocognitive Disorders screenings and tools that can measure changes in symptoms or status over time (NICE, 2006).
 - Attention and concentration, orientation, short and long-term memory, executive functioning and language should be evaluated (NICE, 2006).
 - Consider instruments such as the Mini Mental State Examination (MMSE) or the 6-Item Cognitive Impairment Test (6-CIT) (NICE, 2006).
 - Take into account other factors that may affect performance on scales, including educational level, skills, prior level of functioning and attainment, language, sensory impairment, psychiatric illness and physical or neurological problems (NICE, 2006).
- Level of impairment/progression of symptoms and dependency on others for daily activities (APA, 2007).
- Co-occurring conditions, especially those that may mimic or exacerbate symptoms of Major and Mild Neurocognitive Disorders such as Schizophrenia, Depression and Delirium (APA, 2007).
- Laboratory testing to include a full blood count, vitamin B12 and thyroid tests. Some members may require toxicology, HIV neuro-imaging and other testing as indicated (NICE, 2006).
- Perform a midstream urine test if Major and Mild Neurocognitive Disorders are suspected.
- A complete evaluation of Major and Mild Neurocognitive Disorders symptoms should provide:
 - A clear medical picture prior to introducing any interventions, especially psychotropic medications (APA, 2007).
 - A clear history of the onset and progression of behavioral symptoms from family members, caregivers, the primary care physician and other medical and/or behavioral health providers (APA, 2007).
 - A baseline level of functioning to determine the effectiveness of past and current interventions (NICE, 2006).
 - Information about the member’s ability to make informed decisions about their treatment in partnership with their providers. If the member does not have the capacity to make decisions, an authorized representative may provide informed consent on their behalf (NICE, 2006).
 - Members and authorized representatives are to be informed of safe and effective treatment alternatives, potential risks and benefits of treatment and be willing and able to follow the treatment plan including safety precautions (LOGGs, 2017).
 - Information as to the ability of the member’s family/caregiver or authorized representative to participate in the member’s treatment and level of distress that may interfere with their ability to support the member (NICE, 2006).
 - The risk of abuse and/or neglect (NICE, 2006).

C. Differential diagnosis for neurocognitive disorders includes (American Psychiatric Association, 2013):

- Assessment of members suspected of having Major and Mild Neurocognitive Disorders should include a thorough differential diagnosis to rule out the following:
 - Depressive Disorders
 - Delirium due to medications, general medical conditions and surgeries (APA, 2007).
 - Delirium is characterized by a reduced ability to maintain attention, with fluctuating cognitive deficits, whereas deficits related to Dementia are stable and progressive over time.
 - A close evaluation of medications for comorbid disorders may reveal and clarify a diagnosis of Delirium vs. Major and Mild Neurocognitive Disorders.
 - In the event that Delirium is diagnosed, referral for the appropriate medical attention should be initiated.

- Agitation as a result of infection (urinary tract infection), dehydration, untreated or undertreated pain, recent surgery, constipation, myocardial infarction, or physical or emotional discomfort (APA, 2007);
 - Member's acute medical problems should be treated by appropriate medical services.
 - Typical physical signs and symptoms (fever as a result of infection or pain due to myocardial infarction) may not be manifested in elderly members when medical conditions are present (APA, 2007); and
 - Sensory deficits may worsen psychiatric and/or cognitive symptoms (APA, 2007).
- D. Treatment planning common criteria and best practices
- See "*Common Criteria and Best Practices for All Levels of Care*", available at: <https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html>
 - 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
- E. Psychosocial Interventions
- The evidence does not recommend one psychosocial intervention over another and also suggests interventions be focused on improving/maintaining cognition, functioning, adaptive behavior, and quality of life (APA Watch, 2014).
 - Typically, psychosocial interventions are used as an adjunct to pharmacotherapy to include:
 - Behavioral interventions should be aimed at reducing the presenting behavioral disturbances with the active participation of caregivers (APA, 2007).
 - Emotional oriented treatment such as supportive psychotherapy can be implemented to address issues of loss in the early stages of Major and Mild Neurocognitive Disorders and helping members adjust to their illness (APA, 2007).
 - Cognitive behavioral therapy for symptoms of anxiety or depression may be considered for members with milder forms of Major and Mild Neurocognitive Disorders along with family members (NICE, 2006).
 - Interventions may incorporate the use of items from the past to include photographs, voice recordings, music or letters aimed at stimulating the member senses, reducing anxiety and challenging behaviors, and boosting cognition and mood (APA, 2007).
 - The member's living environment should allow for the opportunity to exercise, socialize and participate in other recreational activities to help stimulate the member's cognition and mood outside of the therapeutic environment (NICE, 2006).
 - Environmental Manipulation to compensate for the member's deficits may help simplify daily life, reduce agitation and increase safety. Examples include using low light, lowering furniture, posting signs, safety latches, and the use of monitors and allowing for the patient to move easily within the living environment (NICE, 2006).
 - All interventions and chosen treatments should take into account the member's cognitive impairment (i.e., attention, concentration, orientation, short and long-term memory, executive functioning and language) and should be modified as appropriate (APA, 2007).
 - Because the behavioral symptoms of Major and Mild Neurocognitive Disorders tend to change over time, intervention choices may also change to target current symptoms, with the ultimate goal of maximizing function in the context of existing deficits (APA, 2007).
 - Interventions should also target new symptoms after the introduction of a new medication or change in dosage of an existing medication (APA, 2007).
 - The effects of chosen interventions should continue to be monitored over time and adjusted to changes in the member's status (APA, 2007).
- F. General Pharmacotherapy
- Non-pharmacological, psychosocial interventions should be used until a clear medical picture of the member can be established and to ensure medications are necessary (NICE, 2006).
 - Medications must be used with caution in older members who may have altered levels of absorption, distribution, metabolism, the elimination of many medications, and are more likely to experience adverse side effects (APA, 2007)
 - Falls are common and potentially serious elderly individuals with Major and Mild Neurocognitive Disorders. Falls can lead to hip fracture, head trauma, and a variety of other injuries, including subdural hematomas, which may further worsen cognitive function (APA, 2007).
 - One of the most effective ways to prevent falls includes withdrawing medications that are associated with falls, central nervous system sedation, or cardiovascular side effects (especially orthostatic hypotension), when appropriate (APA, 2007).
 - Medications used to treat other medical and behavior co-occurring conditions may further complicate the effects of many medications, requiring low starting doses, small increases and long intervals between dose increments (NICE, 2006).
 - Prior to beginning treatment, baseline symptoms should be measured and include administration of the MMSE (NICE, 2006), the CIT-6 and other global, functional and behavioral assessments (APA, 2007).

- A reassessment should occur at least every 6 months after the initiation of treatment and adjustments should be made accordingly (APA, 2007).
- G. Discharge planning common criteria and best practices
- See "Common Criteria and Best Practices for All Levels of Care":
<https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html>

REFERENCES*

1. American Psychiatric Association. *Practice guidelines for the psychiatric evaluation of adults* (3rd ed.). Arlington, VA: American Psychiatric Publishing; 2016.
2. American Psychiatric Association. *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing; 2013.
3. American Psychiatric Association, Clinical Practice Guideline for the Treatment of Alzheimer's Disease and other Dementias, 2007.
4. American Psychiatric Association, Clinical Practice Guideline for the Treatment of Alzheimer's Disease and other Dementias, Guideline Watch, 2014.
5. National Institute for Health and Clinical Excellence, Dementia: Supporting People with Dementia and Their Carers, 2006.
6. Association for Ambulatory Behavioral Healthcare, Standards and Guidelines for Partial Hospital Programs, 2008.
7. Center for Medicaid and Medicare Local Coverage Determination, Psychiatric Inpatient Hospitalization, 2014.
8. Center for Medicaid and Medicare Local Coverage Determination for Psychiatric Partial Hospitalization Program, 2014.
9. Optum Level of Care Guidelines, 2017.

*Additional reference materials can be found in the reference section(s) of the applicable Level of Care Guidelines

ADDITIONAL RESOURCES

Clinical Protocols

Optum maintains clinical protocols that include the Level of Care Guidelines and Best Practice Guidelines which describe the scientific evidence, prevailing medical standards, and clinical guidelines supporting our determinations regarding treatment. These clinical protocols are available to Covered Persons upon request, and to Physicians and other behavioral health care professionals on www.providerexpress.com.

Peer Review

Optum will offer a peer review to the provider when services do not appear to conform to this guideline. The purpose of a peer review is to allow the provider the opportunity to share additional or new information about the case to assist the Peer Reviewer in making a determination including, when necessary, to clarify a diagnosis.

Second Opinion Evaluations

Optum facilitates obtaining a second opinion evaluation when requested by an member, provider, or when Optum otherwise determines that a second opinion is necessary to make a determination, clarify a diagnosis or improve treatment planning and care for the member.

Referral Assistance

Optum provides assistance with accessing care when the provider and/or member determine that there is not an appropriate match with the member's clinical needs and goals, or if additional providers should be involved in delivering treatment.

HISTORY/REVISION INFORMATION

Date	Action/Description
08/08/2017	• Version 1 – Annual Review