INSTRUCTIONS FOR USE

This Coverage Determination Guideline provides assistance in interpreting behavioral health benefit plans that are managed by Optum. This Coverage Determination Guideline is also applicable to behavioral health benefit plans managed by Pacificare Behavioral Health and U.S. Behavioral Health Plan, California (doing business as Optum of California (“Optum-CA”).

When deciding coverage, the enrollee specific document must be referenced. The terms of an enrollee’s document (e.g., Certificates of Coverage (COCs), Schedules of Benefits (SOBs), or Summary Plan Descriptions (SPDs)) may differ greatly from the standard benefit plans upon which this guideline is based. 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 document and the COC/SPD, the enrollee's specific benefit document supersedes these guidelines.

All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements that supersede the COC/SPD and the plan benefit coverage prior to use of this guideline. Other coverage determination guidelines and clinical guideline may apply.

Optum reserves the right, in its sole discretion, to modify its coverage determination guidelines and clinical guidelines as necessary.

While this Coverage Determination Guideline does reflect Optum’s understanding of current best practices in care, it does not constitute medical advice.

Key Points

• Intellectual Disability as a principal diagnosis as defined in the current edition of the

Intellectual Disability
Diagnostic and Statistical Manual of the American Psychiatric Association is typically excluded. Indications for coverage are limited to circumstances where:

- Intellectual Disability is a secondary diagnosis; and
- The principal diagnosis is a covered condition; and
- Treatment is primarily focused on the principal diagnosis; or
- Intellectual Disability is covered by the member’s benefit plan.

- According to the DSM, Intellectual Disability is a disorder with the presence during the developmental period, of both intellectual and adaptive functioning deficits in conceptual, social, and practical domains. The following 3 criteria must be met: (Diagnostic and Statistical Manual of Mental Disorders, 5th ed.; DSM-5; American Psychiatric Association, 2013):
  - Deficits in intellectual functions such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by clinical assessment and individualized, standardized intelligence testing;
  - Deficits in adaptive functioning that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community.
  - Recognition that intellectual and adaptive deficits are present during childhood/adolescence.

- A principal diagnosis is defined as the condition that after a complete evaluation is determined to be chiefly responsible for the member seeking treatment and also becomes the focus of clinical attention during treatment. When a person has multiple diagnoses, the first disorder listed is assumed to be the principal diagnosis unless the provider otherwise specifies (DSM-5, p. 22, 2013).

- In the event that the benefit plan document provides coverage for Intellectual Disability, covered services should be consistent with available best practices and generally accepted standards of medical practice (Optum Level of Care Guidelines (LOCGs), 2016).

- Services for Intellectual Disability may qualify for special education and related services under the Individuals with Disabilities Education Act (IDEA) (Individuals with Disability Education Act Amendments of 1997 (IDEA, 1997) or covered by state waivers for such services.

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**PART I: BENEFITS**

Before using this guideline, please check enrollee’s specific plan document and any federal or state mandates, if applicable.

**Benefits**

Benefits include the following services:

- Diagnostic evaluation and assessment
- Treatment planning
- Referral services
- Medication management
- Individual, family, therapeutic group and provider-based case management services
- Crisis intervention

**Covered Services**

**Covered Health Service(s) – 2001**
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.

**Covered Health Service(s) – 2007 and 2009**
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 this Certificate of Coverage under Section 1: Covered Health Services and in the Schedule of Benefits.
- Not otherwise excluded in this 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.

**Limitations and Exclusions**

Services for Intellectual Disability as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association are typically excluded.

Additional Information: The lack of a specific exclusion of a service does not imply that the service is covered.

PART II: CLINICAL BEST PRACTICE CONSIDERATIONS

In the event the member’s Intellectual Disability or its treatments are covered, the provider should take into consideration the following current and available clinical best practices.

1. Evaluation

1.1. A comprehensive evaluation of the member’s presenting symptoms, level of development, communication skills, associated handicaps, life experiences, education, and family and sociocultural factors forms the basis for an accurate diagnosis, identifies co-occurring conditions, and provides the foundation for the treatment plan (AACAP, 1999).

1.2. According to the American Academy of Child and Adolescent Psychiatry (1999), the approaches and techniques used to evaluate and diagnose a behavioral health condition of a member diagnosed with Intellectual Disability may need to be modified in accordance with the member’s level of development and communication skills. Consider the following:

   1.2.1. Allow ample time for the behavioral health evaluation including time needed to put the member at ease.

   1.2.2. Utilize information from the member’s caregiver in addition to direct behavioral observation. Typically, the poorer the member’s communication skills, the more the provider may need to rely on other sources of information.

   1.2.3. Adapt the verbal examination to suit the member’s communication skills by using clear and concrete language, structure, reassurance and support.

   1.2.4. Use assistive devices or interpreters for members with sensory impairments such as blindness or deafness.

1.3. When Intellectual Disability is suspected, referral for evaluation may be indicated to establish the diagnosis and evaluate the member’s needs for additional supports and services. Evaluation for Intellectual Disability often includes (Pivalizza & Lalani, 2016):

   1.3.1. Comprehensive developmental assessment (may be part of EPST testing),
1.3.2. Standardized testing of intellectual and adaptive functioning and
1.3.3. Assessment of behaviors.

1.4. Following are a number of standardized screening tools available to
assist with the evaluation. When a screening test suggests
developmental delay, referral for further evaluation is needed
(Pivalizza & Lalani, 2016):

1.4.1. Ages and Stages Questionnaires (ASQ)
1.4.2. Bayley Infant Neurodevelopmental Screener (BINS)
1.4.3. Brigance Screens-II
1.4.4. Denver Developmental Screening Test-II (DDST-II)
1.4.5. Infant-Toddler Checklist for Language and Communications
1.4.6. Parents' Evaluation of Developmental Status (PEDS)

1.5. Problems that are commonly associated with Intellectual Disability
include seizure disorders, motor impairments, and vision, hearing, and
other sensory impairments, as well as disorders such as autism,
attention deficit hyperactivity disorder (ADHD), depression and anxiety,
and self-stimulating or self-injurious behaviors. There is also increased
risk of being victimized or abused (Pivalizza & Lalani, 2016).

1.6. Disorders that may co-occur with Intellectual Disability or need to be
ruled out include (Pivalizza & Lalani, 2016):

1.6.1. Autism may co-occur with Intellectual Disability. The social and
communication deficits that characterize Autism must be
distinguished from the developmentally delayed social and
communication deficits that typically affect children with Intellectual
Disability.

1.6.2. ADHD may co-occur with Intellectual Disability. ADHD must be
distinguished from situational inattentiveness at school, inability to
comprehend and follow rules and expectations, or the effect of
medication.

1.6.3. Learning Disabilities and learning difficulties in general and
academic learning commonly occur with Intellectual Disability.
These are pertinent to consider even if they are attributed to the
Intellectual Disability.

1.6.4. Eating Disorders may include Pica (eating substances that are not
food) and Rumination (regurgitation of undigested food into the
mouth, during or shortly after eating).
1.6.5. Depression, Anxiety, and PTSD are common comorbid conditions. Depression may be manifested as aggressive or irritable externalizing behaviors. Depression and/or Anxiety can be triggered by relocation, caregiver changes, and effects of medication (e.g., beta blockers, neuroleptic drugs) or associated conditions (e.g., hypothyroidism). It may be difficult to assess children for these problems due to limited communication skills.

1.6.6. Children with Intellectual Disability are at increased risk of being victimized, manipulated, neglected and abused, including sexual abuse. They may be vulnerable to abuse because of cognitive, learning and communication deficits.

1.6.7. Movement Disorders such as stereotyped behaviors, stimulating movement and motor mannerisms, including tic disorders, are common in severe Intellectual Disability.

1.6.8. Self-injurious behavior frequently occurs. Self-injurious and aggressive behaviors can also occur in individuals who have limited communication who are experiencing stress, depression or anxiety, or may result from side effects of sedative-hypnotic and neuroleptic medications.

2. Interventions

2.1. The overall goals of the management of Intellectual Disability are to strengthen areas of reduced function, provide ongoing family support, prevent or minimize further deterioration in the child’s cognitive-adaptive function relative to peers, and promote optimal individual functioning in society. Interventions should begin early and be sustained. Goals should be appropriate and achievable (Pivalizza, 2016).

2.2. Most individuals with Intellectual Disability require a broad range of interventions that should be applied early to improve short-term and long-term outcomes, including the following services (Pivalizza, 2016):

2.2.1. Speech and language therapy
2.2.2. Occupational therapy
2.2.3. Physical therapy and rehabilitation, including mobility and postural support
2.2.4. Family counseling and support
2.2.5. Behavioral intervention
2.2.6. Educational assistance
2.3. According to the American Academy of Child and Adolescent Psychiatry, the principles of treatment are the same as for a member with or without Intellectual Disability, but techniques may need to be modified in accordance with the member’s level of development and ability to communicate. When introducing interventions consider the following (AACAP, 1999):

2.3.1. Collaborate with the member’s caregiver to target symptoms and develop treatment goals so that the provider and caregiver have a common perspective for gauging response to treatment.

2.3.2. Use an approach that is active, directive and flexible, using concrete interventions as means for promoting change.

2.3.3. Closely monitor the member’s response to pharmacotherapy and use a less aggressive regimen when increasing or decreasing psychotropic medications. Although medication effects generally are the same as for persons without Intellectual Disability, dose-response may differ. For example, persons with Down syndrome may be very sensitive to anticholinergic agents.

2.3.4. Coordination among providers and caregivers is essential when a member with Intellectual Disability requires a range of behavioral health, medical and community support services.

2.4. Behavior management techniques may be implemented for members diagnosed with Intellectual Disability. Interventions are selected according to the member's level of development, displayed problem behavior, desired behavior, and the member's responsiveness to management techniques. Some of the more common behavior management techniques used include (Pivalizza, 2016):

2.4.1. Active intervention to reduce antecedents (triggers) of problem behaviors;

2.4.2. Reinforcement of acceptable behavior by providing positive attention or desired reinforcer;

2.4.3. Purposeful "ignoring" of behaviors to encourage their non-use (as long as the behavior is not dangerous);

2.4.4. Redirecting attention to extinguish problem behaviors;

2.4.5. Reinforcing behaviors incompatible with problem behaviors (e.g., placing hands in an appropriate position or activity that replaces their use in a problem behavior);

2.4.6. Prompt removal of the child from an activity when a targeted problem behavior occurs ("time out");
2.4.7. The positive use of strengths to develop social skills, problem-solve, develop self-esteem, develop communication strategies, and improve independence;

2.4.8. Interventions should be pertinent to the member’s needs and abilities, behaviors, antecedents, psychiatric disorder, environmental conflicts, perceptions, and expectations;

2.4.9. Group psychotherapy may be a useful adjunct to individualized sessions for members who have sufficient communication and cognitive functioning to participate in a group setting.

PART II: 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 ubhonline.

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 enrollee, 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 enrollee determine that there is not an appropriate match with the enrollee’s clinical needs and goals, or if additional providers should be involved in delivering treatment.

DEFINITIONS

Diagnostic and Statistical Manual of the American Psychiatric Association (DSM) A manual produced by the American Psychiatric Association which provides the diagnostic criteria for mental health and substance use disorders, and other problems that may be the focus of clinical attention. Unless otherwise noted, the current edition of the DSM applies.
**Intellectual Disability** According to the DSM, Intellectual Disability is a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains.

**Mental Illness** Those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under the Policy.

**REFERENCES**


2. American Academy of Child and Adolescent Psychiatry, Practice Parameters for the Assessment and Treatment of Children, Adolescents, and Adults with Mental Retardation and Comorbid Mental Disorders, 1999. Retrieved from [http://www.aacap.org/galleries/PracticeParameters/Mr.pdf](http://www.aacap.org/galleries/PracticeParameters/Mr.pdf)


**CODING**

The Current Procedural Terminology (CPT) codes and HCPCS codes listed in this guideline are for reference purposes only. Listing of a service code in this guideline does not imply that the service described by this code is a covered or non-covered health service. Coverage is determined by the benefit document.

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Limited to place of service (POS)?

- [ ] YES
- [x] NO

Limited to specific provider type?

- [ ] YES
- [x] NO

Limited to specific revenue codes?

- [ ] YES
- [x] NO

**HISTORY**

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The enrollee's specific benefit documents supersede these guidelines and are used to make coverage determinations. These Coverage Determination Guidelines are believed to be current as of the date noted.