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®.

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.

1 Optum is a brand used by United Behavioral Health and its affiliates.
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.

Available benefits for attention-deficit/hyperactivity disorder 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

See the related behavioral clinical policy on neurofeedback for the treatment of behavioral disorders: http://www.providerexpress.com > Clinical Resources > Behavioral Clinical Policies

Available benefits for autism spectrum 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

See the related behavioral clinical policy on intensive behavioral therapy / applied behavior analysis for the treatment of autism spectrum disorder: http://www.providerexpress.com > Clinical Resources > Supplemental Clinical Criteria

Communication Disorder as a principal diagnosis, as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, may be excluded from the member’s benefit plan. Please check the member’s specific benefit plan requirements. When excluded from the benefit plan, indications for coverage are limited to circumstances where:
- Communication Disorder is a secondary diagnosis; and
- The principal diagnosis is a covered condition; and
- Treatment is primarily focused on the principal diagnosis; or
- Communication Disorder is covered by the member’s benefit plan.

When Communication Disorder is covered according to the member’s specific benefit plan and when mental health treatment is indicated, available benefits 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

Intellectual Disability as a principal diagnosis, as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association may be excluded from the member’s benefit plan. Please check the member’s specific benefit plan requirements. When excluded from the benefit plan, 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.

When Intellectual Disability is covered according to the member’s specific benefit plan and when mental health treatment is indicated, available benefits 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

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

Motor Disorder, as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, may be excluded from the member’s benefit plan. Please check the member’s specific benefit plan requirements. When excluded from the benefit plan, indications for coverage are limited to circumstances where:
• The Motor Disorder is a secondary diagnosis; and
• The principal diagnosis is a covered condition; and
• Treatment is primarily focused on the principal diagnosis; or
• Motor Disorder is covered by the member’s benefit plan.

When Motor Disorder is covered according to the member’s specific benefit plan and when mental health treatment is indicated, available benefits 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

Specific Learning Disorder as a principal diagnosis, as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, is excluded. Indications for coverage are limited to circumstances where:
• Specific Learning Disorder is a secondary diagnosis; and
• The principal diagnosis is a covered condition; and
• Treatment is primarily focused on the principal diagnosis.

Services for Specific Learning Disorder may qualify for special education and related services under the Individuals with Disabilities Education Act (IDEA) or covered by state waivers for such services.

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 specified otherwise (American Psychiatric Association, 2013).

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

Attention-Deficit Hyperactivity Disorder (ADHD)

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

- The American Academy of Pediatrics (AAP, 2019a) and the American Academy of Child & Adolescent Psychiatry (AACAP, 2007) recommend an evaluation for ADHD for any child or adolescent who displays symptoms of inattention, hyperactivity, or impulsivity in addition to academic or behavioral problems.
  - In the evaluation of ADHD, clinicians should include a screening of comorbid disorders such as anxiety, depression, oppositional defiant disorder, conduct disorders, substance use; developmental conditions such as learning and language disorders, autism spectrum disorders; and any physical complaints (AAP, 2019a; AACAP, 2007).
  - Clinical evidence demonstrates that ADHD and autism spectrum disorders are often diagnosed together (Thapar & Cooper, 2016).

- ADHD symptoms can appear as early as between the ages of 3 and 6, and can continue through adolescence and adulthood (National Institute of Mental Health [NIMH], 2019).
  - For an adolescent or adult to receive a diagnosis of ADHD, the symptoms should be present prior to age 12 (DSM-5, 2013; NIMH, 2019).
  - Adults presenting with symptoms of ADHD, who do not have a childhood diagnosis of ADHD, should be referred for assessment by a mental health specialist experienced in the diagnosis and treatment of ADHD (National Institute for Health and Care Excellence [NICE]. 2019).

- More than two-thirds of individuals with ADHD have at least one other coexisting condition, such as mood and behavior disorders or learning disabilities (AACAP, 2013a; Children and Adults with Attention-Deficit/Hyperactivity Disorder [CHADD], 2015).

B. Validated ADHD screening tests or assessments from parents, teachers, or individuals include, but not limited to (Kliegman et al., 2020, Chapter 49):

- Vanderbilt ADHD Diagnostic Rating Scale;
- ACTeRS Rating Scales;
- Achenbach Child Behavior Checklist (CBCL);
- Conners Scales (parent and teacher; CPRS-R, CTRS-R).

C. Differential diagnosis for ADHD includes (Diagnostic and Statistical Manual of Mental Disorders 5th ed.; DSM-5; APA, 2013):

- Oppositional defiant disorder;
- Intermittent explosive disorder;
- Other neurodevelopmental disorders;
- Reactive attachment disorder;
- Anxiety disorders;
- Depressive disorders, including disruptive mood dysregulation disorder;
- Bipolar disorder;
- Substance use disorders;
- Personality disorders.

D. Treatment planning

- 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. Primary treatments for ADHD include medication, psychotherapy, or a combination of treatments (AAP, 2019a; NIMH, 2019).

- The most effective treatment plans utilize a collaborative approach among the child, family, school, and treatment providers (AAP, 2019a).
1. Medication
   - The individual’s physical health history should be reviewed with the provider prior to starting medication, particularly among those with existing health problems (AACAP, 2013a; NIMH, 2019).
   - Either short or long acting stimulant medication is the first choice for treating individuals with ADHD (AACAP, 2007; AACAP, 2013a; NICE, 2019).
     - Under medical supervision, stimulant medications are largely considered safe when prescribed to healthy children; however, there can be risks and side effects, especially when misused or taken in excess of the prescribed dose (AACAP, 2013a; NIMH, 2019).
     - Many individuals may experience mild side effects while taking stimulant medication, such as appetite suppression, weight loss, difficulty sleeping, and headaches (AACAP, 2013a; NICE, 2019).
   - Non-stimulant medication may be an appropriate alternative for individuals who do not respond well to, or cannot tolerate the side effects of, stimulant medication (AACAP, 2013a).
     - Non-stimulant medication side effects may include hypotension, dizziness, drowsiness, and fatigue (AACAP, 2013a).

2. Psychotherapy
   - Psychosocial treatments primarily focus on reducing ADHD-related behaviors, reinforcing desired behaviors, and developing positive habits (AACAP, 2013a).
     - Behavioral therapy can help teach the individual to monitor his or her own behavior and give oneself praise or rewards for acting in a desired way (NIMH, 2019).
     - Cognitive behavioral therapy targets both the behavioral aspects of ADHD and the thought processes that contribute to the individual’s behavioral problems (AACAP, 2013a).
     - Parenting skills training (PST) teaches parents the skills needed to encourage and reward positive behaviors in their children (NIMH, 2019).
     - Parent skills training can help adults learn how to prevent and address unwanted behaviors such as interrupting, aggression, not completing tasks, and not complying with requests (AAP, 2019a).
   - While generally not shown to be as effective as medication in treating the core symptoms of ADHD, psychosocial treatments may be recommended as initial treatment in children below the age of 6, when the symptoms of ADHD are mild, or when this type of treatment is preferred by the family (AACAP, 2013a; AAP, 2019a).

3. Combination of treatments
   - Combining behavioral treatment with medication can be useful in helping to manage and modify problem behaviors at home and at school (AACAP, 2013a).
   - Children who have ADHD along with other mental health conditions, such as depression or anxiety, may be especially helped by combined therapy (AACAP, 2013a).
   - Some children receiving combination treatment may be able to take lower doses of medication (AACAP, 2013a).

F. Monitoring of Medication Therapy
   - Medication dosage should be regularly monitored and adjusted for each individual (AACAP, 2013a).
     - Providers often use checklists and rating scales to evaluate an individual, determine a correct medication dosage, and monitor symptoms, functioning, and side effects over time (AACAP, 2013a).
     - Families may need to complete a patient history and submit other teacher- and parent-based forms to provide a baseline for medication, severity of symptoms and behavior, and side effect monitoring. This enables the provider to better adjust or switch medications as needed (AACAP, 2013a).
Families and parents should be informed that the initial medication titration process may take several weeks to complete, medication changes can be adjusted on a weekly basis, and subsequent changes may be required (AAP, 2019b).

The individual’s appetite, height, and weight should be monitored while on ADHD medication, and changes should be reported to the provider (AACAP, 2013a; NICE, 2019).

- NICE guidelines (2019) recommend weight measurements of every 3 months for children under the age of 10.
- If symptoms have not improved for an appropriate period of time, prescribing another medication or adjusting the dose may be necessary (AACAP, 2013a).

Reducing the medication dose and monitoring symptoms may be indicated as a child matures (AACAP, 2013a):

- Signs that a child may need to have medication reduced or eliminated may include: symptom-free for more than a year while on medication, continual improvement on a constant dosage, behavior is appropriate despite a missed dose, and/or newfound ability to concentrate;
- Parent and teacher rating scales are useful to identify the recurrence of symptoms after medication has been adjusted or discontinued.

G. Other interventions

- Other unproven treatments for which there is insufficient empirical evidence for the treatment of ADHD include special diets, large doses of vitamins, herbal supplements, homeopathic treatments, vision therapy, and auditory stimulation (AAP, 2019b; AACAP, 2013a).

Communication Disorder

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

- Types of communication disorders where mental health treatment may be indicated include language disorders, speech sound disorders, fluency disorders (stuttering), and social (pragmatic) communication disorders (DSM-5, 2013).

- The pediatric clinician is called on to verify delays in language and speech development and to decide whether further evaluation and management is warranted (Marrus & Hall, 2017).
  - It is important for the clinician to recognize early signs of disorder and delay. Early intervention is associated with the best treatment outcomes (Marrus & Hall, 2017).
  - A multidisciplinary evaluation is often warranted to distinguish between developmental delay from abnormal patters or sequences of development (Liu et al., 2018).
  - Significant communication disorder can be indicated as early as 9 months old when the infant may display little or no interest in sound and not babbling or cooing and certainly by 18 months with these characteristics (O’Hare, 2017).
  - Early onset of struggling with language is considered a risk factor for impaired literacy skills, memory skills, and nonverbal abilities (Marrus & Hall, 2017).

B. Differential diagnosis for communication disorder is challenging and requires a comprehensive multidisciplinary evaluation of speech and language abilities, physical and neurologic status, cognitive and emotional profile, and family history and social environment (Liu et al., 2018), and includes (Diagnostic and Statistical Manual of Mental Disorders 5th ed.; DSM-5; APA, 2013):

- Normal variations in language or normal speech dysfluencies;
- Hearing or other sensory impairment;
- Intellectual disability (intellectual developmental disorder);
- Neurological disorders;
- Language regression;
- Structural deficits (e.g., cleft palate);
• Dysarthria;
• Selective mutism;
• Autism spectrum disorder;
• Social anxiety disorder.

C. Treatment of communication disorder:
• Speech-language pathologists typically treat the wide range of language and speech disorders (O’Hare, 2017):
  o Language/speech delays and disorders, treated early and appropriately, generally improve over time;
  o Long-term management of children who have language and speech delays should include monitoring of academic, emotional, and behavioral functioning in addition to parent-training;
  o Children with language problems affecting grammar, meaning, and conversational skills may have a higher prevalence of mental health disorders over time.

Intellectual Disability (Intellectual Developmental Disorder)

A. Initial evaluation
• Optum recognizes the American Psychiatric Association’s Practice Guidelines for the Psychiatric Evaluation of Adults (2016):
  o http://www.psychiatry.org > Psychiatrists > Practice > Clinical Practice Guidelines
• ID is characterized by deficits in cognition and adaptive function, with onset during the developmental period, typically less than 5 years old (Marrus & Hall, 2017).
• Children with intellectual disabilities often require a comprehensive evaluation to identify strengths and needs, including medical tests and in areas such as neurology, psychology, psychiatry, and special education (AACAP, 2018).
  o A comprehensive evaluation that includes a birth/prenatal and family history in addition to information on the course and timing of development such as language, motor, social-emotional, and adaptive functioning will lead to an effective treatment plan (Marrus & Hall, 2017).
  o Children diagnosed with ID commonly have comorbid medical conditions, such as cataracts, vision and hearing impairments, congenital heart disease, constipation, obesity, and sleep disorders, which may decrease quality of life but can increase challenging behaviors (Marrus & Hall, 2017).

B. Differential diagnosis for intellectual disability includes (Diagnostic and Statistical Manual of Mental Disorders 5th ed.; DSM-5; APA, 2013):
• Major and mild neurocognitive disorders;
• Communication disorders;
• Specific learning disorder;
• Autism spectrum disorder.

C. Treatment of intellectual disability:
• Results from tests and consultations should be gathered by the provider to, along with the family and school, develop a comprehensive treatment and education plan (AACAP, 2018).
• Many intellectual disabilities are without a cure; there are often methods to treat their symptoms such as behavioral, occupational, physical, and speech-language therapy (National Institute of Child Health and Human Development, 2016).
  o Evidence shows that parent-training approaches can improve disruptive behaviors (Marrus & Hall, 2017).
• Other behavioral disorders may interfere with the child’s progress (AACAP, 2018):
  o Early diagnosis of these disorders can lead to early treatment;
  o Medications can be helpful as one part of overall treatment and management in these individuals.
Motor Disorders

A. Initial evaluation
   • Optum recognizes the American Psychiatric Association’s Practice Guidelines for the Psychiatric Evaluation of Adults (2016):
     o http://www.psychiatry.org > Psychiatrists > Practice > Clinical Practice Guidelines
   • Optum recognizes the American Academy of Child & Adolescent Psychiatry’s Practice Parameter for the Assessment and Treatment of Children and Adolescents with Tic Disorders – including Tourette’s disorder and persistent motor or vocal tic disorder (2013b):
     o http://www.aacap.org > Practice Parameters

B. Differential diagnosis for motor disorders includes (Diagnostic and Statistical Manual of Mental Disorders 5th ed.; DSM-5; APA, 2013):
   • Normal development;
   • Motor impairments due to another medical condition;
   • Intellectual disability (intellectual developmental disorder);
   • Attention-deficit/hyperactivity disorder;
   • Autism spectrum disorder;
   • Joint hypermobility syndrome;
   • Obsessive-compulsive and related disorders;
   • Abnormal movements that may accompany other medical conditions;
   • Other neurological and medical conditions.

C. Treatment of motor disorders:
   • Treatment for chronic tic disorders (CTDs), including Tourette’s disorder and persistent motor or vocal tic disorder, should address the levels of impairment and distress caused by the tics and any comorbid diagnoses (AACAP, 2013b).
   • Behavioral interventions for CTDs provide a non-pharmacological option and should be considered when tics cause impairment, are moderate in severity, or if behavioral-responsive psychiatric comorbidities are present (AACAP, 2013b).
     o The behavioral intervention with strongest empirical evidence is habit reversal training (HRT).
   • Medications for CTDs should be considered for moderate to severe tics that cause severe impairment in quality of life or when medication responsive psychiatric comorbidities are present and the medication targets both tic symptoms and comorbid conditions (AACAP, 2013b).
   • Deep brain stimulation, repetitive magnetic stimulation, special diets, and dietary supplements lack scientific evidence for the treatment of CTDs and are not recommended (AACAP, 2013b)

Specific Learning Disorder
   This section is applicable in the event that the member’s Specific Learning Disorder or its treatments are covered:

A. Initial evaluation
   • Optum recognizes the American Psychiatric Association’s Practice Guidelines for the Psychiatric Evaluation of Adults (2016):
     o http://www.psychiatry.org > Psychiatrists > Practice > Clinical Practice Guidelines
   • Learning difficulties in children should be evaluated by a provider who can assess the different issues affecting the child and coordinate with school professionals and others (AACAP, 2019).
   • Characteristics of specific learning disorder (SLD) are (Curtin et al., 2019):
     o Academic difficulty in a subject area compared with peers regardless of applicable instruction;
     o SLD is separate from cognitive disability or intellectual disability;
     o SLD includes a variety of learning difficulties determined through psychoeducational assessment.
Clinicians should be aware of common comorbidities that occur with SLD (Curtin et al., 2019):

- Anxiety disorders
- Behavioral disorders
- Depressive disorders
- Motor delays or disorders
- Neurodevelopmental disabilities
- Second specific learning disability
- Social-emotional problems
- Speech-language delays or disorders
- Substance abuse

B. Differential diagnosis for specific learning disorder includes (Diagnostic and Statistical Manual of Mental Disorders 5th ed.; DSM-5; APA, 2013):

- Normal variations in academic attainment
- Intellectual disability (intellectual developmental disorder)
- Learning difficulties due to neurological or sensory disorders
- Neurocognitive disorders
- Attention-deficit/hyperactivity disorder
- Psychotic disorders

C. Treatment of learning disorder:

- Learning disabilities have no cure; however, early intervention can provide tools and strategies to lessen their effects (National Institute of Child Health and Human Development, 2018).
  - In certain cases, individual or family psychotherapy may be recommended (AACAP, 2019).
  - Medication may be prescribed for hyperactivity or distractibility (AACAP, 2019).

**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 policy 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 clinical criteria may apply.

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>90785</td>
<td>Interactive complexity (list separately in addition to the code for primary psychiatric procedure)</td>
</tr>
<tr>
<td>90791</td>
<td>Psychiatric diagnostic evaluation</td>
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<tr>
<td>90792</td>
<td>Psychiatric diagnostic evaluation with medical services</td>
</tr>
<tr>
<td>90832</td>
<td>Psychotherapy, 30 minutes with patient</td>
</tr>
<tr>
<td>90833</td>
<td>Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)</td>
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<td>Psychotherapy, 45 minutes with patient</td>
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<td>90836</td>
<td>Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)</td>
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<td>90837</td>
<td>Psychotherapy, 60 minutes with patient</td>
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<tr>
<td>90838</td>
<td>Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the code for primary procedure)</td>
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<td>90839</td>
<td>Psychotherapy for crisis; first 60 minutes</td>
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<tr>
<td>90840</td>
<td>Psychotherapy for crisis; each additional 30 minutes (list separately in addition to the code for primary service)</td>
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<tr>
<td>90846</td>
<td>Family psychotherapy (without the patient present), 50 minutes</td>
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<td>HCPCS Code</td>
<td>Description</td>
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<tr>
<td>G0177</td>
<td>Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)</td>
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<td>G0410</td>
<td>Group psychotherapy other than of a multiple-family group, in a partial hospitalization setting, approximately 45 to 50 minutes</td>
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<tr>
<td>G0411</td>
<td>Interactive group psychotherapy, in a partial hospitalization setting, approximately 45 to 50 minutes</td>
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<tr>
<td>H0004</td>
<td>Behavioral health counseling and therapy, per 15 minutes</td>
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<td>H0017</td>
<td>Behavioral health; residential (hospital residential treatment program), without room and board, per diem</td>
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<td>H0018</td>
<td>Behavioral health; short-term residential (nonhospital residential treatment program), without room and board, per diem</td>
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<tr>
<td>H0019</td>
<td>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</td>
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<td>H0025</td>
<td>Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)</td>
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<td>H0035</td>
<td>Mental health partial hospitalization, treatment, less than 24 hours</td>
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<td>H2001</td>
<td>Rehabilitation program, per 1/2 day</td>
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<tr>
<td>H2011</td>
<td>Crisis intervention service, per 15 minutes</td>
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<td>H2012</td>
<td>Behavioral health day treatment, per hour</td>
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<td>H2013</td>
<td>Psychiatric health facility service, per diem</td>
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<td>H2017</td>
<td>Psychosocial rehabilitation services, per 15 minutes</td>
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<td>Psychosocial rehabilitation services, per diem</td>
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<td>H2033</td>
<td>Multisystemic therapy for juveniles, per 15 minutes</td>
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<td>S0201</td>
<td>Partial hospitalization services, less than 24 hours, per diem</td>
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<td>Intensive outpatient psychiatric services, per diem</td>
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<td>S9482</td>
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<td>S9484</td>
<td>Crisis intervention mental health services, per hour</td>
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<tr>
<th>Diagnosis Codes</th>
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<td>Mild intellectual disabilities</td>
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<td>Moderate intellectual disabilities</td>
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<td>Profound intellectual disabilities</td>
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<td>Social Pragmatic Communication Disorder</td>
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<td>Disorder of written expression</td>
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<td>Specific developmental disorder of motor function</td>
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<td>F88</td>
<td>Other disorders of psychological development</td>
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<td>Attention-deficit hyperactivity disorder, predominantly hyperactive type</td>
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<td>Transient tic disorder</td>
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<td>Chronic motor or vocal tic disorder</td>
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<td>Tourette’s disorder</td>
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<td>Adult-onset fluency disorder</td>
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**REVISION HISTORY**

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<th>Date</th>
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<tr>
<td>03/14/2018</td>
<td>• Annual Review: Formatting, references, coding updates. Removed Autism content, this can be found in the related Behavioral Clinical Policy.</td>
</tr>
<tr>
<td>05/20/2019</td>
<td>• Annual Review: Formatting and reference updates</td>
</tr>
<tr>
<td>06/15/2020</td>
<td>• Annual Review: references/sourcing updates</td>
</tr>
</tbody>
</table>