NEURODEVELOPMENTAL DISORDERS

Policy Number: BH727ND_032018

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Relevant Diagnoses

- Attention-Deficit/Hyperactivity Disorder
- Autism Spectrum Disorder
- Communication Disorder
- Intellectual Disability (Intellectual Developmental Disorder)
- Motor Disorder
- Specific Learning Disorder

Related Behavioral Clinical Policies & Guidelines:

- Complementary and Alternative Treatment (CAM)
- Neurofeedback for Behavioral Disorders
- Applied Behavior Analysis for the Treatment of Autism Spectrum Disorder
- School-Based Services
- Other Specified and Unspecified Disorders

BENEFIT CONSIDERATIONS

Before using this policy, 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.

COVERAGE RATIONALE

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 > Behavioral Clinical Policies

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.

EVIDENCE-BASED CLINICAL GUIDELINES

Attention-Deficit Hyperactivity Disorder (ADHD)

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
   - 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, 2016b).
     - For an adolescent or adult to receive a diagnosis of ADHD, the symptoms should be present prior to age 12 (National Institute of Mental Health, 2016b).
   - More than two-thirds of individuals with ADHD have at least one other coexisting condition, such as mood and behavior disorders or learning disabilities (CHADD, 2016).

B. Validated ADHD screening tests or assessments from parents, teachers, or individuals include (Felt, et al 2014):
   - National Initiative for Children's Healthcare Quality (NICHQ) Vanderbilt Assessment Scale;
   - ACTeRS Rating Scales;
   - Attention Deficit Disorder Evaluation Scale (ADDES);
   - Brown Rating Scales;
   - Child Behavior Checklist (CBCL);
   - Conners Scales (e.g., CPRS-R; CTRS-R).

C. Differential diagnosis for ADHD includes (American Psychiatric Association, 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 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. Primary treatments for ADHD include medication, psychotherapy, or a combination of treatments (National Institute of Mental Health, 2016b; Substance Abuse and Mental Health Services Administration, 2015).

1. Medication
    - The individual's health history should be reviewed with the provider prior to starting medication, particularly among those with existing health problems (National Insitute of Mental Health, 2016b; American Academy of Child & Adolescent Psychiatry, 2013a)
    - Stimulant medication is the first choice for treating individuals with ADHD (American Academy of Child & Adolescent Psychiatry, 2013a).
        - 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 (National Institute of Mental Health, 2016b).
        - Many individuals may experience mild side effects while taking stimulant medication, such as reduced appetite, weight loss, difficulty sleeping, and headaches (American Academy of Child & Adolescent Psychiatry, 2013a).
    - 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 (American Academy of Child & Adolescent Psychiatry, 2013a).
        - Non-stimulant medication side effects may include hypotension, dizziness, drowsiness, and fatigue (American Academy of Child & Adolescent Psychiatry, 2013a).

2. Psychotherapy
    - Psychosocial treatments primarily focus on reducing ADHD-related behaviors, reinforcing desired behaviors, and developing positive habits (American Academy of Child & Adolescent Psychiatry, 2013a)
        - Behavioral therapy can help teach the individual to monitor his or her own behavior and give onself praise or rewards for acting in a desired way (National Institute of Mental Health, 2016b)
        - Cognitive behavioral therapy can teach an individual how to be aware of one's own thoughts and feelings and to improve focus and concentration (National Institute of Mental Health, 2016b)
        - Parenting skills training (PST) teaches parents the skills needed to encourage and reward positive behaviors in their children (National Institute of Mental Health, 2016b)
    - 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 (American Academy of Child & Adolescent Psychiatry, 2013a)

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 (American Academy of Child & Adolescent Psychiatry, 2013a).
    - Children who have ADHD along with other mental health conditions, such as depression or anxiety, may be especially helped by combined therapy (American Academy of Child & Adolescent Psychiatry, 2013a).
    - Some children receiving combination treatment may be able to take lower doses of medication (American Academy of Child & Adolescent Psychiatry, 2013a).

F. Monitoring of Medication Therapy
    - Medication dosage should be regularly monitored and adjusted for each individual (American Academy of Child & Adolescent Psychiatry, 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 (American Academy of Child & Adolescent Psychiatry, 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 (American Academy of Child & Adolescent Psychiatry, 2013a)
        - The individual's appetite, height, and weight should be monitored while on ADHD medication, and changes should be reported to the provider (American Academy of Child & Adolescent Psychiatry, 2013a)

    - If symptoms have not improved for an appropriate period of time, prescribing another medication or adjusting the dose may be necessary (American Academy of Child & Adolescent Psychiatry, 2013a)
- Reducing the medication dose and monitoring symptoms may be indicated as a child matures (American Academy of Child & Adolescent Psychiatry, 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 (American Academy of Child & Adolescent Psychiatry, 2013a)
    - Parent and teacher rating scales are useful to identify the recurrence of symptoms after medication has been adjusted or discontinued (American Academy of Child & Adolescent Psychiatry, 2013a)

G. Other interventions
- Neurofeedback for the treatment of ADHD is unproven. See the related Behavioral Clinical Policy for neurofeedback at: http://www.providerexpress.com > Clinical Resources > Behavioral Clinical Policies.
- Other unproven treatments for ADHD include special diets, herbal supplements, homeopathic treatments, vision therapy, and auditory stimulation (American Academy of Child & Adolescent Psychiatry, 2013a).

H. 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**

Communication Disorder

A. Initial evaluation common criteria and best practices
- 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 (American Psychiatric Association, 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 (Feldman, 2005).
    - It is important for the clinician to recognize early signs of disorder and delay (Feldman, 2005)

B. Differential diagnosis for communication disorder can be challenging during the preschool years (Simms & Ming, 2015), and includes (American Psychiatric Association, 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 (Feldman, 2005)
    - Language/speech delays and disorders, treated early and appropriately, generally improve over time (Feldman, 2005)
    - Long-term management of children who have language and speech delays should include monitoring of academic, emotional, and behavioral functioning (Feldman, 2005)
- Children with language problems affecting grammar, meaning, and conversational skills may have a higher prevalence of mental health disorders over time (Feldman, 2005)
- Children presenting with a psychiatric disorder may have undiagnosed problems of communication that warrant comprehensive evaluation (Feldman, 2005)

Intellectual Disability (Intellectual Developmental Disorder)

A. Initial evaluation common criteria and best practices
- 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
- Intellectual disability originates before the age of 18 (American Association of Intellectual and Developmental Disabilities, 2013)
- Children with intellectual disabilities often require a comprehensive evaluation to idenfity strengths and needs, including medical tests and in areas such as neurology, psychology, psychiatry, and special education (American Academy of Child & Adolescent Psychiatry, 2013b).

B. Differential diagnosis for intellectual disability includes (American Psychiatric Association, 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 (American Academy of Child & Adolescent Psychiatry, 2013b)
- Many intellectual disabilites have no cure, but there are often ways to treat their symptoms (National Institute of Child Health and Human Development, 2012).
- Other behavioral disorders may interfere with the child's progress (American Academy of Child & Adolescent Psychiatry, 2013b).
  - Early diagnosis of these disorders can lead to early treatment;
  - Medications can be helpful as one part of overall treatment and management in these individuals.

Motor Disorders

A. Initial evaluation common criteria and best practices
- 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
- 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 (2013d):
  - http://www.aacap.org > Practice Parameters

B. Differential diagnosis for motor disorders includes (American Psychiatric Association, 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 conditions (American Academy of Child & Adolescent Psychiatry, 2013d).
- Behavioral interventions for CTDs should be considered when tics cause impairment, are moderate in severity, or if behavioral-responsive psychiatric comorbidities are present (American Academy of Child & Adolescent Psychiatry, 2013d).
  - The behavioral intervention with strongest empirical support 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 (American Academy of Child & Adolescent Psychiatry, 2013d).

- Deep brain stimulation, repetitive magnetic stimulation, special diets, and dietary supplements lack empirical support for the treatment of CTDs and are not recommended (American Academy of Child & Adolescent Psychiatry, 2013d)

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 common criteria and best practices
- 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
- 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 (American Academy of Child & Adolescent Psychiatry, 2013c)

B. Differential diagnosis for specific learning disorder includes (American Psychiatric Association, 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, but early intervention can provide tools and strategies to lessen their effects (National Institute of Child Health and Human Development, 2014)
  - In some cases, individual or family psychotherapy may be recommended (American Academy of Child & Adolescent Psychiatry, 2013c).
  - Medication may be prescribed for hyperactivity or distractibility (American Academy of Child & Adolescent Psychiatry, 2013c).

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 ~~and/or family member~~ 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
H0025	Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)
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

ICD-10 Diagnosis Code	Description
F90.2	Attention-deficit hyperactivity disorder; combined type
F90.0	Attention-deficit hyperactivity disorder; predominately inattentive type
F90.1	Attention-deficit hyperactivity disorder, predominantly hyperactive type
F84.0	Autistic disorder
F80.9	Developmental disorder of speech and language, unspecified
F80.0	Phonological disorder

ICD-10 Diagnosis Code	Description
F80.81	Childhood-onset fluency disorder
F98.5	Adult-onset fluency disorder
F80.82	Social Pragmatic Communication Disorder
F70	Mild intellectual disabilities
F71	Moderate intellectual disabilities
F72	Severe intellectual disabilities
F73	Profound intellectual disabilities
F88	Other disorders of psychological development
F82	Specific developmental disorder of motor function
F98.4	Stereotyped movement disorders
F95.2	Tourette's disorder
F95.1	Chronic motor or vocal tic disorder
F95.0	Transient tic disorder
F81.0	Specific reading disorder
F81.81	Disorder of written expression
F81.2	Mathematics disorder

LEVEL OF CARE GUIDELINES

Optum / OptumHealth Behavioral Solutions of California Level of Care Guidelines are available at: https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html

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.

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

HISTORY/REVISION INFORMATION

Date	Action/Description
11/2016	• Version 1 – Draft
3/14/2018	• Annual Review: Formatting, references, coding updates. Removed Autism content, this can be found in the related Behavioral Clinical Policy.