**Coverage Determination Guideline: Other Conditions That May Be A Focus of Clinical Attention ( Previously V-Code Conditions)**

**Document Number:** BH803OCFCA0720  
**Effective Date:** July 20, 2020

**Table of Contents**
- Introduction
- Instructions for Use
- Benefit Considerations
- Coverage Rationale
- References
- Revision History

**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.

- Other Conditions That May Be a Focus of Clinical Attention are a secondary diagnosis; and
- The primary diagnosis is a covered condition; and
- Treatment is principally focused on the primary diagnosis.

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

The following are examples of circumstances under which mental health treatment for Other Conditions That May Be a Focus of Clinical Attention (V-Code Condition) are excluded (not an all-inclusive list):

- The problem is the focus of diagnosis or treatment and the individual has no behavioral health condition (e.g., a partner relational problem in which neither partner has symptoms that meet criteria for a behavioral health condition).
- The individual has a behavioral health condition, but it is unrelated to the presenting problem (e.g., a partner relational problem in which one of the partners has an incidental behavioral health condition), and the problem – not the behavioral health condition – is the focus of diagnosis or treatment.

According to the DSM, the diagnostic category Other Conditions That May Be a Focus of Clinical Attention includes conditions and problems that may be a focus of clinical attention or that may otherwise affect the diagnosis, course, prognosis, or treatment of a behavioral health condition. Other Conditions That May Be a Focus of Clinical Attention are not considered behavioral health diagnoses. They are meant to draw attention to additional issues that may be encountered during treatment (Diagnostic and Statistical Manual of Mental Disorders, 5th ed.; DSM-5; American Psychiatric Association, 2013).

A “primary diagnosis” (i.e., principal diagnosis) is defined as the condition that after a complete evaluation is determined to be the chief cause for treatment and also becomes the focus of treatment. When a person has multiple diagnoses, the first disorder listed is assumed to be the primary diagnosis unless the provider otherwise spec (DSM-5, 2013). Other Conditions That May Be a Focus of Clinical Attention are only covered as a “secondary diagnosis,” (i.e., a diagnosis that is not the principal focus of treatment).

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.

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

REFERENCES


Generic UnitedHealthcare Certificate of Coverage, 2001
Generic UnitedHealthcare Certificate of Coverage, 2007
Generic UnitedHealthcare Certificate of Coverage, 2009
Generic UnitedHealthcare Certificate of Coverage, 2011
Generic UnitedHealthcare Certificate of Coverage, 2017
**Generic UnitedHealthcare Certificate of Coverage, 2018**

**Generic UnitedHealthcare Certificate of Coverage, 2019**

**Generic UnitedHealthcare Certificate of Coverage, 2020**

### REVISION HISTORY

<table>
<thead>
<tr>
<th>Date</th>
<th>Action/Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>05/09/2017</td>
<td>• Version 1 – Annual Review</td>
</tr>
<tr>
<td>05/09/2018</td>
<td>• Annual Update: Updates to formatting, references checked</td>
</tr>
<tr>
<td>06/17/2019</td>
<td>• Annual Update: Updates to formatting, references checked</td>
</tr>
<tr>
<td>07/20/2020</td>
<td>• Annual Review: Update to references, removal of Applicable Codes section.</td>
</tr>
</tbody>
</table>