OTHER CONDITIONS THAT MAY BE A FOCUS OF CLINICAL ATTENTION (PREVIOUSLY V-CODE CONDITIONS)

Policy Number: BH727OCFCACDG_032017
Effective Date: May, 2017

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 guideline, 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, 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

Other Conditions That May Be a Focus of Clinical Attention as primary diagnoses defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association are excluded. Indications for coverage are limited to circumstances where (Certificate of Coverage, 2001, 2007, 2009, 2011):

- 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.

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

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

LEVEL OF CARE GUIDELINES
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.

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.

<table>
<thead>
<tr>
<th>ICD-10 Diagnosis Code</th>
<th>ICD-10 Description</th>
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<tbody>
<tr>
<td>E66.9</td>
<td>Obesity, unspecified</td>
</tr>
<tr>
<td>N94.3</td>
<td>Premenstrual tension syndrome</td>
</tr>
<tr>
<td>R41.83</td>
<td>Borderline intellectual functioning</td>
</tr>
<tr>
<td>T74.01XA</td>
<td>Adult neglect or abandonment, confirmed, initial encounter</td>
</tr>
<tr>
<td>T74.01XD</td>
<td>Adult neglect or abandonment, confirmed, subsequent encounter</td>
</tr>
<tr>
<td>T74.02XA</td>
<td>Child neglect or abandonment, confirmed, initial encounter</td>
</tr>
<tr>
<td>T74.02XD</td>
<td>Child neglect or abandonment, confirmed, subsequent encounter</td>
</tr>
<tr>
<td>T74.11XA</td>
<td>Adult physical abuse, confirmed, initial encounter</td>
</tr>
<tr>
<td>T74.11XD</td>
<td>Adult physical abuse, confirmed, subsequent encounter</td>
</tr>
<tr>
<td>T74.12XA</td>
<td>Child physical abuse, confirmed, initial encounter</td>
</tr>
<tr>
<td>T74.12XD</td>
<td>Child physical abuse, confirmed, subsequent encounter</td>
</tr>
<tr>
<td>T74.21XA</td>
<td>Adult sexual abuse, confirmed, initial encounter</td>
</tr>
<tr>
<td>T74.21XD</td>
<td>Adult sexual abuse, confirmed, subsequent encounter</td>
</tr>
<tr>
<td>T74.22XA</td>
<td>Child sexual abuse, confirmed, initial encounter</td>
</tr>
<tr>
<td>T74.22XD</td>
<td>Child sexual abuse, confirmed, subsequent encounter</td>
</tr>
<tr>
<td>T74.31XA</td>
<td>Adult psychological abuse, confirmed, initial encounter</td>
</tr>
<tr>
<td>T74.31XD</td>
<td>Adult psychological abuse, confirmed, subsequent encounter</td>
</tr>
<tr>
<td>T74.32XA</td>
<td>Child psychological abuse, confirmed, initial encounter</td>
</tr>
<tr>
<td>T74.32XD</td>
<td>Child psychological abuse, confirmed, subsequent encounter</td>
</tr>
<tr>
<td>Z55.9</td>
<td>Problems related to education and literacy, unspecified</td>
</tr>
<tr>
<td>Z56.82</td>
<td>Military deployment status</td>
</tr>
<tr>
<td>Z59.0</td>
<td>Homelessness</td>
</tr>
<tr>
<td>Z59.1</td>
<td>Inadequate housing</td>
</tr>
<tr>
<td>Z59.3</td>
<td>Problems related to living in residential institution</td>
</tr>
<tr>
<td>Z59.5</td>
<td>Extreme poverty</td>
</tr>
<tr>
<td>Z59.9</td>
<td>Problem related to housing and economic circumstances, unspecified</td>
</tr>
<tr>
<td>Z60.2</td>
<td>Problems related to living alone</td>
</tr>
<tr>
<td>Z60.3</td>
<td>Acculturation difficulty</td>
</tr>
<tr>
<td>Z60.9</td>
<td>Problem related to social environment, unspecified</td>
</tr>
<tr>
<td>Z62.810</td>
<td>Personal history of physical and sexual abuse in childhood</td>
</tr>
<tr>
<td>Z62.811</td>
<td>Personal history of psychological abuse in childhood</td>
</tr>
<tr>
<td>Z62.820</td>
<td>Parent-biological child conflict</td>
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Other Conditions That May Be a Focus of Clinical Attention (Previously V-Code Conditions) may otherwise affect the diagnosis, course, prognosis or treatment of a behavioral health condition. These conditions are not considered behavioral health conditions, but are meant to draw attention to additional issues that may be encountered during treatment.

**REFERENCES**

5. Generic UnitedHealthcare Certificate of Coverage, 2011

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

**ICD-10 Diagnosis Code** | **ICD-10 Description**
---|---
Z62.898 | Other specified problems related to upbringing
Z63.0 | Problems in relationship with spouse or partner
Z63.4 | Disappearance and death of family member
Z63.5 | Disruption of family by separation and divorce
Z63.8 | Other specified problems related to primary support group
Z64.0 | Problems related to unwanted pregnancy
Z64.1 | Problems related to multiparity
Z64.4 | Discord with counselors
Z65.0 | Conviction in civil and criminal proceedings without imprisonment
Z65.5 | Exposure to disaster, war, and other hostilities
Z69.010 | Encounter for mental health services for victim of parental child abuse
Z69.011 | Encounter for mental health services for perpetrator of parental child abuse
Z69.021 | Encounter for mental health services for perpetrator of non-parental child abuse
Z69.11 | Encounter for mental health services for victim of spousal or partner abuse
Z69.12 | Encounter for mental health services for perpetrator of spousal or partner abuse
Z69.81 | Encounter for mental health services for victim of other abuse
Z71.9 | Counseling, unspecified
Z72.810 | Child and adolescent antisocial behavior
Z72.9 | Problem related to lifestyle, unspecified
Z75.3 | Unavailability and inaccessibility of health-care facilities
Z75.4 | Unavailability and inaccessibility of other helping agencies
Z76.5 | Malingerer [conscious simulation]
Z91.19 | Patient’s noncompliance with other medical treatment and regimen
Z91.49 | Other personal history of psychological trauma, not elsewhere classified
Z91.5 | Personal history of self-harm
Z91.83 | Wandering in diseases classified elsewhere
Z91.89 | Other specified personal risk factors, not elsewhere classified

**DEFINITIONS**

**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

<table>
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<tr>
<th>Date</th>
<th>Action/Description</th>
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<tbody>
<tr>
<td>05/09/2017</td>
<td>∗ Version 1 – Annual Review</td>
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