United Behavioral Health

Coverage Determination Guideline: Proven & Unproven Behavioral Health Services

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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.
**Proven Services**: Services or technologies that, after a review of the evidence, demonstrate they can be safely and effectively administered to a defined patient population, under a set of specific conditions that are clearly identified. A service found to be proven does not necessarily indicate that the service is covered. The member’s specific benefit plan must be referenced to determine coverage, limitations, and exclusions.

A service found to be “Proven” does not necessarily indicate that a service is covered. The member’s specific benefit plan must be referenced to determine coverage, limitations and exclusions.

**Unproven Services**: Services including medications that are not consistent with prevailing medical research that has determined the services to not be effective for treatment of the condition and/or not to have the beneficial effect on behavioral health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed literature. Unproven services and all services related to unproven services are typically excluded. The fact that an experimental or investigational or unproven service, device, or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be experimental or investigational or unproven in the treatment of that particular condition.

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.

**OPTUM CLINICAL TECHNOLOGY ASSESSMENT COMMITTEE (CTAC)**

The Clinical Technology Assessment Committee’s (CTAC) mission is to review the scientifically based clinical evidence used in the development of policies and clinical programs in an effort to ensure transparency, consistency, and to identify safe and effective behavioral health services for Optum members.

CTAC is responsible for reviewing a treatment when it is intended to treat a mental disorder, it requires behavioral health expertise to provide, it is primarily delivered by behavioral health providers, and Optum Behavioral is delegated for managing and/or paying for the treatment.

A request for coverage of Unproven Services and all services related to Unproven Services must be reviewed against the language in the enrollee's benefit document. When the requested service or procedure is covered, limited or excluded from the enrollee’s benefit document, or is otherwise defined differently, it is the terms of the enrollee's benefit document that prevails.

**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
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