Developmental Delay and Learning Disabilities

Policy Number: BIP037.N
Effective Date: November 1, 2024

➲ Instructions for Use

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Related Benefit Interpretation Policies

- Attention Deficit Hyperactivity Disorder (ADHD)
- Autism Spectrum Disorder
- Inpatient and Outpatient Mental Health
- Rehabilitation Services (Physical, Occupational, and Speech Therapy)

Application

This benefit interpretation policy applies to members with diagnosed or suspected developmental delay, either global or limited to a specific developmental area (e.g., speech/language, motor).

Federal/State Mandated Regulations

Note: The most current federal/state mandated regulations for each state can be found in the links below.

California

Health and Safety Code (HSC) Section 1374.72, Mental Health Parity

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=1374.72.

Effective Jul. 1, 2000 to Dec. 31, 2020

(a) Every health care service plan contract issued, amended, or renewed on or after July 1, 2000, that provides hospital, medical, or surgical coverage shall provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, as specified in subdivisions (d) and (e), under the same terms and conditions applied to other medical conditions, as specified in subdivision (c).
(b) These benefits shall include the following:
  (1) Outpatient services
  (2) Inpatient hospital services.
  (3) Partial hospital services.
  (4) Prescription drugs, if the plan contract includes coverage for prescription drugs.
(c) The terms and conditions applied to the benefits required by this section, that shall be applied equally to all benefits under the plan contract, shall include, but not be limited to, the following:
  (1) Maximum lifetime benefits.
  (2) Copayments.
  (3) Individual and family deductibles.
(d) For the purpose of this section, “severe mental illnesses” shall include:
  (1) Schizophrenia.
  (2) Schizoaffective disorder.
  (3) Bipolar disorder (manic-depressive illness).
  (4) Major depressive disorders.
  (5) Panic disorder.
  (6) Obsessive-compulsive disorder.
  (7) Pervasive developmental disorder or autism.

(8) Anorexia nervosa.
(9) Bulimia nervosa.

(e) For the purposes of this section, a child suffering from, "serious emotional disturbances of a child" shall be defined as a child who (1) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms, and (2) who meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code.

(f) This section shall not apply to contracts entered into pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 commencing with Section 14200) of Division 9 of Part 3 of the Welfare and Institutions Code, between the State Department of Health Services and a health care service plan for enrolled Medi-Cal beneficiaries.

(g) (1) For the purpose of compliance with this section, a plan may provide coverage for all or part of the mental health services required by this section through a separate specialized health care service plan or mental health plan, and shall not be required to obtain an additional or specialized license for this purpose.

(2) A plan shall provide the mental health coverage required by this section in its entire service area and in emergency situations as may be required by applicable laws and regulations. For purposes of this section, health care service plan contracts that provide benefits to enrollees through preferred provider contracting arrangements are not precluded from requiring enrollees who reside or work in geographic areas served by specialized health care service plans or mental health plans to secure all or part of their mental health services within those geographic areas served by specialized health care service plans or mental health plans.

(3) Notwithstanding any other provision of law, in the provision of benefits required by this section, a health care service plan may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing.

(h) Nothing in this section shall be construed to deny or restrict in any way the department's authority to ensure plan compliance with this chapter when a plan provides coverage for prescription drugs.

Note: Developmental Delay is not a qualifying diagnosis under the CA mental health parity law **and is not eligible for coverage through the mental health parity benefit.**

Effective Jan. 1, 2021

(a) (1) Every health care service plan contract issued, amended, or renewed on or after January 1, 2021, that provides hospital, medical, or surgical coverage shall provide coverage for medically necessary treatment of mental health and substance use disorders, under the same terms and conditions applied to other medical conditions as specified in subdivision (c).

(2) For purposes of this section, “mental health and substance use disorders” means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization’s International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this section as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

(3) (A) For purposes of this section, “medically necessary treatment of a mental health or substance use disorder” means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:
(i) In accordance with the generally accepted standards of mental health and substance use disorder care.
(ii) Clinically appropriate in terms of type, frequency, extent, site, and duration.
(iii) Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.

(B) This paragraph does not limit in any way the independent medical review rights of an enrollee or subscriber under this chapter.

(4) For purposes of this section, “health care provider” means any of the following:
(A) A person who is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.
(B) An associate marriage and family therapist or marriage and family therapist trainee functioning pursuant to Section 4980.43.3 of the Business and Professions Code.
(C) A qualified autism service provider or qualified autism service professional certified by a national entity pursuant to Section 10144.51 of the Insurance Code and Section 1374.73.

(D) An associate clinical social worker functioning pursuant to Section 4996.23.2 of the Business and Professions Code.
(E) An associate professional clinical counselor or professional clinical counselor trainee functioning pursuant to Section 4999.46.3 of the Business and Professions Code.
(F) A registered psychologist, as described in Section 2909.5 of the Business and Professions Code.
(G) A registered psychological assistant, as described in Section 2913 of the Business and Professions Code.
(H) A psychology trainee or person supervised as set forth in Section 2910 or 2911 of, or subdivision (d) of Section 2914 of, the Business and Professions Code.

(5) For purposes of this section, "generally accepted standards of mental health and substance use disorder care" has the same meaning as defined in paragraph (1) of subdivision (f) of Section 1374.721.

(6) A health care service plan shall not limit benefits or coverage for mental health and substance use disorders to short-term or acute treatment.

(7) All medical necessity determinations by the health care service plan concerning service intensity, level of care placement, continued stay, and transfer or discharge of enrollees diagnosed with mental health and substance use disorders shall be conducted in accordance with the requirements of Section 1374.721. This paragraph does not deprive an enrollee of the other protections of this chapter, including, but not limited to, grievances, appeals, independent medical review, discharge, transfer, and continuity of care.

(8) A health care service plan that authorizes a specific type of treatment by a provider pursuant to this section shall not rescind or modify the authorization after the provider renders the health care service in good faith and pursuant to this authorization for any reason, including, but not limited to, the plan's subsequent rescission, cancellation, or modification of the enrollee's or subscriber's contract, or the plan's subsequent determination that it did not make an accurate determination of the enrollee's or subscriber's eligibility. This section shall not be construed to expand or alter the benefits available to the enrollee or subscriber under a plan.

(b) The benefits that shall be covered pursuant to this section shall include, but not be limited to, the following:
(1) Basic health care services, as defined in subdivision (b) of Section 1345.
(2) Intermediate services, including the full range of levels of care, including, but not limited to, residential treatment, partial hospitalization, and intensive outpatient treatment.
(3) Prescription drugs, if the plan contract includes coverage for prescription drugs.

(c) The terms and conditions applied to the benefits required by this section, that shall be applied equally to all benefits under the plan contract, shall include, but not be limited to, all of the following patient financial responsibilities:
(1) Maximum annual and lifetime benefits, if not prohibited by applicable law.
(2) Copayments and coinsurance.
(3) Individual and family deductibles.
(4) Out-of-pocket maximums.

(d) If services for the medically necessary treatment of a mental health or substance use disorder are not available in network within the geographic and timely access standards set by law or regulation, the health care service plan shall arrange coverage to ensure the delivery of medically necessary out-of-network services and any medically necessary followup services that, to the maximum extent possible, meet those geographic and timely access standards. As used in this subdivision, to "arrange coverage to ensure the delivery of medically necessary out-of-network services" includes, but is not limited to, providing services to secure medically necessary out-of-network options that are available to the enrollee within geographic and timely access standards. The enrollee shall pay no more than the same cost sharing that the enrollee would pay for the same covered services received from an in-network provider.

(e) This section shall not apply to contracts entered into pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, between the State Department of Health Care Services and a health care service plan for enrolled Medi-Cal beneficiaries.

(f) (1) For the purpose of compliance with this section, a health care service plan may provide coverage for all or part of the mental health and substance use disorder services required by this section through a separate specialized health care service plan or mental health plan, and shall not be required to obtain an additional or specialized license for this purpose.

(2) A health care service plan shall provide the mental health and substance use disorder coverage required by this section in its entire service area and in emergency situations as may be required by applicable laws and regulations. For purposes of this section, health care service plan contracts that provide benefits to enrollees through preferred provider contracting arrangements are not precluded from requiring enrollees who reside or work in geographic areas served by specialized health care service plans or mental health plans to secure all or part of their mental health services within those geographic areas served by specialized health care service plans or mental health plans, provided that all appropriate mental health or substance use disorder services are actually available within those geographic service areas within timeliness standards.

(3) Notwithstanding any other law, in the provision of benefits required by this section, a health care service plan may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or

other cost sharing, provided that these practices are consistent with Section 1374.76 of this code, and Section 2052 of the Business and Professions Code.

(g) This section shall not be construed to deny or restrict in any way the department's authority to ensure plan compliance with this chapter.

(h) A health care service plan shall not limit benefits or coverage for medically necessary services on the basis that those services should be or could be covered by a public entitlement program, including, but not limited to, special education or an individualized education program, Medicaid, Medicare, Supplemental Security Income, or Social Security Disability Insurance, and shall not include or enforce a contract term that excludes otherwise covered benefits on the basis that those services should be or could be covered by a public entitlement program.

(i) A health care service plan shall not adopt, impose, or enforce terms in its plan contracts or provider agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of this section.

(Repealed and added by Stats. 2020, Ch. 151, Sec. 4. (SB 855) Effective January 1, 2021.)

HSC Section 1374.721

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1374.721&lawCode=HSC

(a) A health care service plan that provides hospital, medical, or surgical coverage shall base any medical necessity determination or the utilization review criteria that the plan, and any entity acting on the plan's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders on current generally accepted standards of mental health and substance use disorder care.

(b) In conducting utilization review of all covered health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders in children, adolescents, and adults, a health care service plan shall apply the criteria and guidelines set forth in the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty.

(c) In conducting utilization review involving level of care placement decisions or any other patient care decisions that are within the scope of the sources specified in subdivision (b), a health care service plan shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria and guidelines set forth in those sources. This subdivision does not prohibit a health care service plan from applying utilization review criteria to health care services and benefits for mental health and substance use disorders that meet either of the following criteria:
   (1) Are outside the scope of the criteria and guidelines set forth in the sources specified in subdivision (b), provided the utilization review criteria were developed in accordance with subdivision (a).
   (2) Relate to advancements in technology or types of care that are not covered in the most recent versions of the sources specified in subdivision (b), provided that the utilization review criteria were developed in accordance with subdivision (a).

(d) If a health care service plan purchases or licenses utilization review criteria pursuant to paragraph (1) or (2) of subdivision (c), the plan shall verify and document before use that the criteria were developed in accordance with subdivision (a).

(e) To ensure the proper use of the criteria described in subdivision (b), every health care service plan shall do all of the following:
   (1) Sponsor a formal education program by nonprofit clinical specialty associations to educate the health care service plan's staff, including any third parties contracted with the health care service plan to review claims, conduct utilization reviews, or make medical necessity determinations about the clinical review criteria.
   (2) Make the education program available to other stakeholders, including the health care service plan's participating providers and covered lives. Participating providers shall not be required to participate in the education program.
   (3) Provide, at no cost, the clinical review criteria and any training material or resources to providers and health care service plan enrollees.
   (4) Track, identify, and analyze how the clinical review criteria are used to certify care, deny care, and support the appeals process.
   (5) Conduct interrater reliability testing to ensure consistency in utilization review decision making covering how medical necessity decisions are made. This assessment shall cover all aspects of utilization review as defined in paragraph (3) of subdivision (f).
   (6) Run interrater reliability reports about how the clinical guidelines are used in conjunction with the utilization management process and parity compliance activities.
   (7) Achieve interrater reliability pass rates of at least 90 percent and, if this threshold is not met, immediately provide for the remediation of poor interrater reliability and interrater reliability testing for all new staff before they can conduct utilization review without supervision.

(f) The following definitions apply for purposes of this section:
   (1) "Generally accepted standards of mental health and substance use disorder care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health

treatment pursuant to Section 1374.73. Valid, evidence-based sources establishing generally accepted standards of mental health and substance use disorder care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

(2) "Mental health and substance use disorders" has the same meaning as defined in paragraph (2) of subdivision (a) of Section 1374.72.

(3) "Utilization review" means either of the following:

(A) Prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, enrollees, or their authorized representatives for coverage of health care services prior to, retrospectively or concurrent with the provision of health care services to enrollees.

(B) Evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit subject to a medical necessity coverage requirement in a health care service plan contract is covered as medically necessary for an enrollee.

(4) "Utilization review criteria" means any criteria, standards, protocols, or guidelines used by a health care service plan to conduct utilization review.

(g) This section applies to all health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders covered by a health care service plan contract, including prescription drugs.

(h) This section applies to a health care service plan that conducts utilization review as defined in this section, and any entity or contracting provider that performs utilization review or utilization management functions on behalf of a health care service plan.

(i) The director may assess administrative penalties for violations of this section as provided for in Section 1368.04, in addition to any other remedies permitted by law.

(j) A health care service plan shall not adopt, impose, or enforce terms in its plan contracts or provider agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of this section.

(k) This section does not apply to contracts entered into pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, between the State Department of Health Care Services and a health care service plan for enrolled Medi-Cal beneficiaries.

(Added by Stats. 2020, Ch. 151, Sec. 5. (SB 855) Effective January 1, 2021.)

State Market Plan Enhancements

None

Covered Benefits

Important Note: Covered benefits are listed in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections. Always refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for additional covered services/benefits not listed in this section.
Refer to the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB) for specific benefit information.

Responsibility	Services
These services are the responsibility of the member's medical plan (IPA, PMG, or UnitedHealthcare).	• Physical therapy, occupational therapy, and speech therapy • Medical specialist services (e.g., neurology) • Durable medical equipment (e.g., speech device) • Laboratory monitoring if ordered by the PCP or medical specialist • Prescription drugs (Refer to the supplemental drug rider/benefit)
These services are the responsibility of the member's behavioral health plan [(Optum) USBehavioral Health Plan of CA or alternative behavioral health plan selected by the member's employer].	• Applied behavioral therapy • Psychiatry and/or psychologist related services • Diagnostic testing if ordered by the behavioral health personnel • Laboratory monitoring if ordered by the behavioral health professional

- Speech-language, motor, cognitive, and social development services may be covered when they are authorized, part of a medically necessary treatment plan, provided by or rendered under the supervision of a licensed or certified health care professional, and are provided by an authorized provider acting within the scope of his or her license or as authorized under California law.
- Play therapy services are covered only when they are authorized, part of a medically necessary treatment plan, require the supervision of a licensed physical therapist or a qualified autism provider, and are provided by an authorized provider acting within the scope of his or her license or as authorized under California law.

Refer to the following Benefit Interpretation Policies for additional information:
- Attention Deficit Hyperactivity Disorder (ADHD)
- Autism Spectrum Disorder
- Inpatient and Outpatient Mental Health
- Rehabilitation Services (Physical, Occupational, and Speech Therapy)

Not Covered

Educational services for developmental delays and learning disabilities are not health care services and are not covered. Examples include, but are not limited to:
- Items and services to increase academic knowledge or skills
- Special education: Teaching to meet the educational needs of a person with mental retardation, learning disability, or developmental delay
  Note:
  - A learning disability is a condition where there is a meaningful difference between a person's current level of learning ability and the level that would be expected for a person of that age. A developmental delay is a delayed attainment of age-appropriate milestones in the areas of speech-language, motor, cognitive, and social development.
  - This exclusion **does not apply** to covered services when they are authorized, part of a medically necessary treatment plan, provided by or rendered under the direct supervision of a licensed or certified health care professional, and are provided by a participating provider acting within the scope of his or her license or as authorized under California law.
- Teaching and support services to increase academic performance
- Academic coaching or tutoring for skills such as grammar, math, and time management
- Speech training that is not medically necessary, and not part of an approved treatment plan, and not provided by or under the direct supervision of a participating healthcare professional acting within the scope of his or her license under California law that is intended to address speech impairments
- Teaching you how to read, whether or not you have dyslexia
- Educational testing

Policy History/Revision Information

Date	Summary of Changes
11/01/2024	**Not Covered** • Replaced language indicating "*non-clinical* education services for developmental delays and learning disabilities are not health care services and are not covered" with "education services for developmental delays and learning disabilities are not health care services and are not covered" **Supporting Information** • Archived previous policy version BIP037.M

Instructions for Use

Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.