Early Childhood Developmental Disorders (ECDD), Including Autism
Corporate Medical Policy

Description/Summary

Developmental change may occur as a result of genetically-controlled processes known as maturation, or as a result of environmental factors and learning, but most commonly involves an interaction between the two. Developmental change may lead to longer developmental disabilities in an individual patient.

Developmental disabilities are a diverse group of severe chronic conditions that are due to mental and/or physical impairments. People with developmental disabilities have problems with major life activities such as language, mobility, learning, self-help, and independent living. Developmental disabilities begin anytime during development up to 22 years of age and usually last throughout a person’s lifetime. *Autism spectrum disorders (ASDs) are a group of developmental disabilities. (CDC definition)

According to Vermont law, Early Childhood Developmental Disorder (ECDD) is defined as a childhood mental or physical impairment or combination of mental and physical impairments that results in functional limitation in major life activities, accompanied by a diagnosis defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Disease (ICD). The term includes autism spectrum disorders, but does not include a learning disability.

AUTISM DISORDER

Autism disorder was first described by Dr. Leo Kanner in 1943. Autism impacts the normal development of the brain in the areas of communication skills and social interaction; it is four times more common in males than females. The onset of the condition usually occurs within the first three years of life. Individuals who are
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Diagnosed with autism may exhibit some of the following characteristics, which can range in intensity from mild to severe and in various combinations: difficulty expressing needs; a preference towards solitude; a tendency towards tantrums; difficulty with socialization; making little or no eye contact; having an inappropriate attachment to objects; an over- or under-sensitivity to pain; not recognizing danger; exhibiting strange play; and unresponsiveness to normal teaching methods and/or verbal cues. Many children with autism also have varying degrees of intellectual disability.

ASPERGER’S SYNDROME

Asperger’s syndrome is characterized by poor coordination and concentration, a restricted range of interests, and/or difficulty with social relationships. In Asperger’s syndrome, cognitive and communicative development is within the normal or near-normal range in the first years of life. Individuals who are diagnosed with Asperger’s syndrome have normal intelligence and adequate vocabulary and grammar skills. Also, these individuals often have unusual interests, which they pursue with great intensity.

RETT SYNDROME

Rett syndrome, which was first diagnosed in 1966 by Andreas Rett, is a neurologic disorder that is diagnosed primarily in females. Children with Rett syndrome develop normally for the first 6 to 18 months. However, changes in behavior and a regression or loss of gross motor skills (e.g., walking, moving), the ability to speak, and using hands purposefully begin to manifest themselves. Children with Rett syndrome tend to exhibit the repetition of meaningless gestures, such as constant hand-washing or hand-wringing.

CHILDHOOD DISINTEGRATIVE DISORDER (CDD)

CDD resembles autism but differs in that after a prolonged period of normal development (two to four years), the child begins to lose interest in the social environment, language, toileting, and self-care abilities. The etiology of CDD is unknown; however, some evidence suggests that it may occur as a result of some form of central nervous system pathology. Children with CDD have an increased risk of seizures and develop many features consistent with autism disorder.

PERSVATIVE DEVELOPMENTAL DISORDER - NOT OTHERWISE SPECIFIED (PDD-NOS)

A diagnosis of PDD-NOS is most often made when a child experiences problems with social interaction and/or other areas (e.g., verbal and nonverbal communication skills) that are consistent with a diagnosis of ECDD or when stereotyped behavior, interests, and activities are present. Generally, children are three to four years old when they start exhibiting symptoms that lead parent(s) and/or caregiver(s) to seek a diagnosis. Children diagnosed with PDD-NOS do not follow a set pattern of symptoms. A child is often diagnosed with PDD-NOS if he/she exhibits behavioral characteristics that are consistent with autism but does not meet the full DSM-IV-TR criteria for autism disorder.
INFANTILE CEREBRAL PALSY

Cerebral palsy is caused by malformation or damage to the brain, usually during pregnancy, but occasionally during delivery, or immediately after birth. Premature birth is associated with an increased risk of cerebral palsy. An infant may also get cerebral palsy from very severe jaundice after birth, or later during infancy from an injury or illness affecting the brain. Children with cerebral palsy have difficulty with bodily movement and muscle tone. The motor disability can vary from mild and barely noticeable to very profound. A child with cerebral palsy may simply be a little clumsy or awkward, or may be unable to walk. Some children have weakness and poor motor control of one arm and one leg on the same side of the body. Many have problems with paralysis of both upper and lower extremities. In some children the muscle tone generally is increased, while others are abnormally limp. While many of these children understand spoken language, their ability to produce speech may be affected.

INTELLECTUAL DEVELOPMENTAL DISORDER

Intellectual disability is a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social and practical domains. The following three criteria must be met:

A. Deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing.

B. Deficits in adaptive functioning that result in failure to meet developmental and socio-cultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community.

C. Onset of intellectual and adaptive deficits during the developmental period.

EVALUATION

Early identification of ECDD is important because it allows early intervention, etiologic investigation, and counseling regarding recurrence risk and improved overall outcomes.

To identify individuals with ECDD, a comprehensive evaluation should include historical information such as a review of pregnancy, labor, delivery, early neonatal course, developmental history, and communicative and motor milestones. The medical history should include screening for sensory deficits (e.g., hearing or visual impairments), as well as a discussion about other medical conditions and specific signs and symptoms. The history and physical examination may assist in the search for
known etiologic or associated conditions. Other identified conditions may accompany ECCD including, but not limited to:

- Seizures

- Sensory problems
  Sensory problems result from the inability to balance the senses appropriately. Many individuals with ECCD are highly attuned or even painfully sensitive to certain sounds, textures, tastes, and smells.

- Intellectual disability
  Intellectual disability is a behaviorally defined disorder of complex human abilities with many genetic and nongenetic causes.

- Fragile X syndrome (FXS)
  FXS is the most common form of inherited intellectual disability. It is caused by a mutation in a Fragile X Mental Retardation 1 [FMR1] gene.

- Tuberous sclerosis complex (TSC)
  TSC is a genetic disorder that causes benign tumors to form in the brain and other vital organs. The disorder is characterized by hypopigmented macules on the skin, which are visualized on Wood’s lamp examination. Some individuals with TSC experience developmental delays, intellectual disability, and autism.

- Angelman syndrome (AS)
  AS is a neurodevelopmental disorder that is caused by a deficiency of a maternally transmitted gene. AS can be detected with fluorescent in situ hybridization [FISH] testing. AS is characterized by severe intellectual disability, ataxia, and a happy social disposition.

SCREENING/DIAGNOSTIC SERVICES

SCREENING TOOLS

The American Academy of Pediatrics (AAP) recommends that developmental surveillance should be incorporated at every well-child preventive care visit, and any concerns raised by surveillance should be addressed through standardized developmental screening tests. AAP recommends that an autism-specific screening tool should be administered to all children at the 18 and 24 or 30-month well-child visits, since symptoms of ECDD are often present at these ages, and effective early intervention strategies are available.

DIAGNOSTIC TOOLS

Healthcare professionals involved in diagnosing ECDD must be knowledgeable and experienced with comprehensive standardized diagnostic tools. Diagnostic tools
include parent and/or caregiver reports, as well as observational diagnostic instruments (e.g., Autism Diagnostic Observation Schedule [ADOS], Autism Diagnostic Interview-Revised [ADI-R], Childhood Autism Rating Scale [CARS]). It is also stressed that professionals involved in diagnosing ECDD must be knowledgeable and experienced in using guidelines.

**ELECTROENCEPHALOGRAM (EEG)**

EEGs are obtained when the individual has clinical suggestions of an associated condition, such as a seizure disorder or a degenerative condition.

**AUDIOLOGIC, SPEECH, AND LANGUAGE EVALUATION**

Audiologic evaluation and comprehensive speech and language evaluation should always be performed in any child who has language delays. The literature has documented that conductive, sensorineural, or mixed hearing loss can occur.

**LABORATORY EVALUATION**

Currently there is no laboratory test specific for ECDD. Laboratory evaluations may be indicated in children with suspected ECDD to determine an associated condition. For example, the National Center for Environmental Health of the Centers for Disease Control and Prevention recommends that children with developmental delays and pica, who may spend a prolonged period in the oral stage, be screened for lead poisoning. Additionally, quantitative plasma amino acid assays should be considered even if the findings from the neonatal screen for phenylketonuria were negative.

**GENETIC COUNSELING**

The recurrence rate of idiopathic ECDD is significant in siblings (5 to 10 percent) of affected children; it is important to provide genetic counseling after a diagnosis of ECDD to offer parents information about recurrence risks in subsequent children.

**GENETIC TESTING**

Research has identified various genetic disorders associated with ECDD; however, the total number of individuals with ASD who have a known genetic condition is only a small percentage of the whole. Conventional genetic testing methods to identify associated conditions of ECDD may include G-banded karyotyping and/or fluorescent in situ hybridization (FISH).

Despite the profusion of investigations into the genetic component of ECDD, many genetic tests that have been proposed for ECDD have yet to be validated by appropriate clinical studies. For example, comparative genomic hybridization (CGH) microarray is a molecular karyotyping method that increases the chromosomal resolution for the detection of genetic abnormalities. However, at this time, there is a lack of available studies that support CGH microarray testing for developmental delay, ASD, and/or intellectual disability.
Furthermore, due to the heterogeneity of ECDD, the multiple etiologies, and the questionable clinical validity of extensive screening tests of all children with ECDD, additional evidence is needed before genetic testing of this population becomes standard of care. The AAP recommendation for routine clinical care is to limit extensive genetic testing to those with a suspicious family or medical history for a genetic condition associated with ECDD, intellectual disability, and/or dysmorphic features (e.g., facial, limb, stature).

MANAGEMENT

According to the National Institute of Child Health and Human Development, currently there is no definitive, single treatment for the management of ECDD. Individuals with ECDD have a wide spectrum of behaviors and abilities so that no one approach is equally effective for all, and not all individuals in outcome studies have benefited to the same degree. In addition, individuals with ECDD may require new and/or multiple episodes of care or modifications to the frequency and duration of existing services. These changes are typically based on re-examination due to the severity of the current condition, as well as changes related to growth and development, caregivers, environment, or functional demands.

The primary goals of management of ECDD are to minimize the core features and associated deficits, maximize functional independence and quality of life, and alleviate family distress (Myers et al, 2007). The management of ECDD may also include services such as, but not limited to:

PHARMACOLOGICAL MANAGEMENT

A consensus on the recommended guidelines for the use of medication in the management of ECDD has not been reached. Currently, the US Food and Drug Administration (FDA) has not approved any medications specifically for the treatment of ECDD. However, medications may be used to treat some of the symptoms associated with ASD (e.g., aggression, hyperactivity, inattention, depression, anxiety). The FDA has approved risperidone (Risperdal®) for the symptomatic treatment of irritability including aggression, deliberate self-injury, and temper tantrums in children and adolescents, ages five to sixteen, with ASD.

PHYSICAL THERAPY

Physical therapy is a medically prescribed treatment for physical disabilities or impairments that result from disease, injury, congenital anomaly, and/or prior therapeutic intervention. Features of ECDD may include delays in the achievement and advancement of motor skills and sensorimotor adaption, atypical postures and movement patterns, deficient balance reactions, decreased muscle performance and range of mobility, and a general lack of physical fitness. Associated conditions may include, but are not limited to: hypotonia, limb apraxia, and joint laxities.

OCCUPATIONAL THERAPY
Occupational therapy practitioners work with individuals with ECDD, as well as parents, caregivers, educators, and other team members in a variety of settings, including the home, school, clinic, and community to assist the individual with successful participation and adaptation in school, home, and social environments. According to the American Occupational Therapy Association (AOTA), goals for young individuals with ECDD frequently focus on enhancing an individual’s sensory processing, sensorimotor performance, social/behavioral performance, self-care, and participation in play. In older individuals with ECDD, occupational therapy goals focus on social/behavioral performance, activities of daily living, and independence in the community.

**SPEECH THERAPY**

Speech therapy is the medically prescribed treatment for speech and language disorders due to disease, surgery, injury, congenital anomalies, speech/language delay, or previous therapeutic processes that result in communication disabilities and/or swallowing disorders. According to the American Speech-Language-Hearing Association (ASHA), speech-language pathologists play a role in screening, diagnosing, and enhancing the development of social communication and quality of life of children, adolescents, and adults with ECDD. They work with individuals to help diagnose and treat specific speech and language deficits as well as related feeding disorders. There is no single approach that is equally effective for all individuals with ASD, and based on outcome studies, not all individuals benefit to the same degree. Speech-language consultative services should be aimed at helping the communicative partner (e.g., teacher, parent, caregiver, peer, and sibling) to provide the support and employ specific teaching strategies to enhance active engagement in natural learning environments.

**PSYCHIATRIC SERVICES**

Direct or consultative services are provided by a physician who specializes in psychiatry to diagnose ECDD and/or to diagnose and treat co-morbid psychiatric disorders that are exhibited by the individual with ECDD.

**PSYCHOLOGICAL SERVICES**

Direct or consultative services are provided by a psychologist to diagnose ASD and/or to diagnose and treat co-morbid psychological disorders that are exhibited by the individual with ASD.

**APPLIED BEHAVIOR ANALYSIS (ABA) AND OTHER METHODOLOGIES TO PROMOTE LEARNING**

Methodologies to promote learning are believed to enhance communication, teach social skills, and reduce maladaptive behaviors. These methodologies are based on several model programs including behavioral, structured teaching, and/or developmental.
Among the many methodologies available for the management of ECDD, ABA is arguably the most studied treatment modality in the field. It is generally believed that ABA is the process of applying interventions that are based on the principles of learning (e.g., positive reinforcement) derived from experimental psychology research to systematically change behavior. It can also be used to teach new skills and demonstrate that the interventions used are responsible for the observable improvements in behavior. ABA methods are reportedly used to replace maladaptive, interfering behaviors with more desirable adaptive ones and to narrow the conditions under which these behaviors occur. In addition, ABA is believed to teach new skills through implicit instruction and repetition, generalize behaviors to new environments or situations, and maintain learned behaviors. For example, clear instruction with assistance (e.g., demonstration, prompting) is given to the individual. When the individual gives a correct response, the instructor gives positive reinforcement.

Components of ABA may include the following:

- An initial assessment through observations that focus on strengths and weaknesses of the individual
- Individualized treatment goals that are guided by the data from the initial assessment and are defined in observable terms
- A written treatment plan or set of instructions for teaching each behavior and/or skill, developed by a healthcare provider
- Training for the individual’s parent(s) and/or caregiver(s) to implement the treatment plan consistently both within and outside formal treatment sessions
- A curriculum that focuses on all of the following:
  - Breaking down skills into manageable pieces
  - Building upon skills so that an individual can learn in a natural environment
  - Teaching the individual to combine skills acquired in more complex ways
- Documented frequent assessments of the individual’s progress, using direct observational measurement methods with verification by secondary observers. As progress is made, guidance is systematically reduced
- No reinforcement for problem behaviors

There are many techniques used within the realm of ABA. Common techniques include, but are not limited to, the following:

- Discrete trial training (DTT) is behaviorally based instruction that involves rewarding performances of desired behaviors and completion of tasks with tangible positive reinforcement (e.g., food, toys) paired with social praise. The therapist-directed instruction may be repeated over several days until the skill is mastered. These skills are then combined into more complex repertoires.
- Pivotal response training is naturalistic behavioral intervention that is child-directed, and interventions are designed around materials or topics for
which the individual expresses preference. Reinforcement is directly related to the task.

- Incidental teaching is behaviorally based instruction where the interaction between adult and child occurs in the context of a natural situation where the child expresses an interest in something and the adult responds with prompts and praise.

Competency for behavior analyst practitioners to perform services related to ABA can be demonstrated through the completion of specialized training. Organizations offer voluntary credentialing programs for behavior analyst practitioners (e.g., Behavior Analyst Certification Board (BACB) in an effort to provide consistent credentialing).

Some methodologies to promote learning have also emerged, and although they are not considered behavioral, they share common elements with behavioral methodologies. For example, the Treatment and Education of Autistic and Related Communication-Handicapped Children (TEACCH) model of structured teaching uses many forms of visual supports, such as picture schedules, to assist individuals with ECDD. Another modality commonly used with individuals is the developmental approach. Examples of the developmental approach include, but are not limited to, the Denver model (which focuses on intensive teaching and developing social communicative skills) and/or the developmental, individual-difference, relationship-based (DIR) floor-time model (which focuses on building emotional reciprocity). Despite the common use of such methodologies to promote learning, most have not been empirically validated.

A review of the available published peer-reviewed literature on ABA and other similar methodologies has revealed weaknesses in research design and analysis, as well as inconsistent results across studies, which undermine confidence in the reported results. Although it has been suggested that these methodologies may assist in the management of conditions associated with ASD, and many interventions including ABA have been endorsed by AAP, it is implicitly recognized that further high-quality studies are needed to determine the efficacy of these methodologies.

**NEUROPSYCHOLOGICAL TESTING (NPT)**

NPT consists of the administration of a series of standardized tests of differing mental functions and the interpretation of the findings so that inferences about brain function can be made. There is insufficient peer-reviewed literature to support standard use of NPT for individuals with ECDD; however, NPT may be helpful in evaluating specific neurologic conditions that are present in an individual with suspected ECDD. (Please see BCBSVT Policy on Neuropsychological Testing)

**ALTERNATIVE THERAPIES AND COMPLEMENTARY MEDICINE**

Since ECDD and ASD are chronic disorders that have no cure, parent(s) and/or caregiver(s) sometimes turn to alternative therapies and complementary medicine and/or therapies that are not traditionally used in the management of ECDD. Alternative therapies and complementary medicine comprise a group of diverse
medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine. The following examples of alternative therapies and complementary medicine may be considered for the management of ECDD:

- **Nutritional supplements**

  Proponents of nutritional supplements claim that high doses of pyridoxine and magnesium have beneficial effects on the symptoms of ECDD. However, studies have been criticized for their methodological shortcomings and failure to address the issue of safety of use.

- **Elimination diets**

  Advocates of elimination diets have proposed that the selective absorption of ingested peptides caused by impaired bowel permeability can potentiate symptoms of ECDD. This has led to the conclusion that the elimination of casein (the principal protein in milk) and gluten (a composite of proteins found in rye, wheat, and barley) from a child’s diet would improve behavioral symptoms. To date, only a small number of children on elimination diets have been studied, and no control group was provided. The efficacy and safety of elimination diets have not been established; therefore, this therapy lacks validation.

**OTHER THERAPIES/TREATMENTS FOR THE MANAGEMENT OF ECDD**

- **Immune globulin therapy**

  Immune globulin therapy (IVIg) focuses on immunological abnormalities, such as abnormalities of T- and B-cells (specialized defender cells that identify and destroy germs). At the present time, there is no scientific evidence to support the use of IVIg injections for the treatment of children with ECDD.

- **Secretin**

  Secretin is one of the hormones that control digestion. The primary action of secretin is to increase the volume of bicarbonate content of secreted pancreatic juices. The use of secretin in the treatment of ECDD comes from the theory that a link exists between gastrointestinal disorders and brain dysfunction. However, the available published literature does not support the use of secretin in the treatment of autism. In addition, the FDA has not approved the use of secretin in the treatment of autism.

- **Chelation therapy**
Intravenous (IV) chelation therapy is a method of removing toxic substances (e.g., lead, zinc, iron, copper, or calcium) from the body. Advocates of chelation therapy believe that ASD is caused by early childhood exposure to environmental toxicants, principally metals (particularly mercury in vaccines), and minerals. Studies have been unable to establish a connection between exposure to mercury and an incidence of ECDD. Therefore, no data exists on the efficacy of chelation therapy for the treatment of ECDD.

- **Auditory integration training (AIT)**

  AIT is based on the unproven theory that ECDD symptoms are caused by auditory perception defects. AIT consists of the identification of hypersensitivity and peak of sound distortion, as well as the selection of the optimum music for the individual. Once these determinations are made, the selected music is played twice a day for two weeks through a listening device such as the AudioKinetron. The data from the available studies on AIT showed no improvement in behavior, leading to the conclusion that AIT is not efficacious in the treatment of ECDD. (Please see BCBSVT Policy on Physical Therapy)

- **Facilitative communication (FC)**

  FC provides assistance to a nonverbal person in typing out words using a computer keyboard or other communication device. FC involves a trained facilitator supporting the individual’s hand to help indicate which letters are necessary. Several scientific studies have suggested that facilitators unintentionally influence the communication, perhaps to the extent of actually selecting the words themselves. There are good scientific data showing FC to be ineffective.

- **Hippotherapy**

  The available published literature does not support the use of hippotherapy in the treatment of ECDD. (Please see BCBSVT Policy on Physical Therapy and BCBSVT Policy on Hippotherapy)

- **Music Therapy**

  The available published literature does not support the use of music therapy in the treatment of ECDD.

**Policy**

**Coding Information**

Click the links below for attachments, coding tables & instructions.

**Attachment 1**
The intent of this policy is to communicate the medical necessity criteria for the evaluation and management of early childhood developmental disorders (ECDD), specifically autism spectrum disorders (ASD), in children diagnosed with early childhood developmental delay, from birth to age 21. Please see Attachment I for specific coding information.

To qualify for benefits, the member must between the ages of birth to 21 years and follow the steps outlined below:

**Evaluation of Early Childhood Developmental Disorders (ECDD)**

The services listed below are the most frequently used components of an ECDD evaluation and are considered medically necessary:

- Review of the pregnancy, delivery, and early neonatal course
- Parent(s) and/or child interview, including any siblings
- Complete history and physical examination of the affected individual
- Developmental screening for ECDD using standardized developmental screening tool(s)
- Electroencephalogram (EEG)
  - If the individual has an associated seizure disorder, suspicion of subclinical seizure, or a developmental degenerative condition (e.g., a clinically significant loss of social and communicative function), an EEG may be performed.
- Audiologic and/or vision evaluation
  - If the individual has a hearing impairment and/or an associated language/developmental delay, an audiologic and/or vision evaluation may be performed.
- Speech, language, and/or communication evaluation
  - If the individual has a speech, language, and/or communication delay, and/or sensory-motor symptoms that interfere with feeding, an assessment by a speech-language pathologist may be performed.
- High-resolution chromosome studies (karyotype) and deoxyribonucleic acid (DNA) analysis for fragile X syndrome (FXS), may be performed if the individual has any of the following:
  - Intellectual disability (or if intellectual disability cannot be excluded)
  - A family history of FXS and undiagnosed intellectual disability
  - Dysmorphic features (e.g., facial, limb, stature)
- Genetic counseling for parents of a child with ECDD regarding recurrence risk in subsequent children
- Laboratory evaluation as indicated, including the following:
  - Measurement of blood lead level
  - Quantitative plasma amino acid assays to detect phenylketonuria (a rare cause of ECDD and intellectual disability)

**MANAGEMENT OF ECDD**

**PHYSICAL, OCCUPATIONAL, AND/OR SPEECH THERAPY**
In accordance with the terms defined in the member’s Certificate of Coverage on these topics, or where a state mandate provides for such coverage, physical, occupational, and/or speech therapy is considered medically necessary and, therefore, covered when all of the following criteria are met:

- The individual has a documented diagnosis in the International Classification of Diseases (ICD) or Diagnostic and Statistical Manual of Mental Disorders (DSM-V™) of:
  
  Autism Disorders- F84.0  
  Childhood Disintegrative Disorder- F84.3  
  Asperger’s Syndrome- F84.5  
  Unspecified Pervasive Developmental Disorder, Not otherwise specified- F84.5, F84.8  
  Other Specified Cerebral Degenerations in Childhood (Rett’s Syndrome) - F84.2  
  Infantile Cerebral Palsy- Diplegic- G80.1  
  Hemiplegic- G80.2  
  Quadriplegic- G80.0  
  Monoplegic- G80.8  
  Infantile hemiplegia- G80.2  
  Intellectual Disability-  
  Moderate intellectual disability- F71  
  Severe- intellectual disability- F72  
  Profound intellectual disability- F73

- The individual has a history of a clinically significant impairment that interferes with the ability to negotiate their environment, communicate, learn, and/or demonstrate appropriate social behavior, which may include any of the following:
  - Impaired motor skills and/or musculoskeletal system involvement
  - Impaired activities of daily living
  - Impaired speech, language, and/or communication

- The parent(s) and/or caregiver(s) are willing and able to participate and follow the training and support that is incorporated into the treatment plan.

- The therapy is rendered by or under the direction of a healthcare provider who is appropriately licensed to perform the therapy and who is eligible under the terms of the member’s benefit contract.

- The individual’s progress in meeting the objectives of the treatment plan is measured on an ongoing basis for adjustment or refinement.

A comprehensive evaluation is required and must be submitted in order to obtain prior authorization for PT, OT, and ST services for members diagnosed with ECDD. The comprehensive evaluation does not require prior authorization, but ALL proposed PT, OT, and ST services pursuant to the comprehensive evaluation require prior authorization in order to determine medical necessity.
The benefit for PT, OT, and ST services for these conditions are not subject to a visit limit as outlined in the Member’s Certificate of Coverage on Physical Therapy, Occupational Therapy and Speech Therapy. When coverage for such therapies is authorized, unless a provider or the Plan determines an earlier assessment is required, the assessment of the individual’s progress in meeting the objectives of the treatment plan shall be valid for six (6) months. A treatment plan for children under age eight will occur no more frequently than once every six months. In order for benefits for PT, OT, or ST to continue beyond the initial 6 month period (or sooner if determined in the initial authorization), the provider must submit a progress report containing all applicable information outlined in the “Physician Documentation Information” section within this medical policy. Based on the information submitted, authorization for additional services may be extended for up to an additional six month period if such services are determined to be medically necessary.

Authorization for continued PT, OT, and/or ST services will not be granted if any of the following circumstances exist:

- Treatment is making the symptoms or negative behavior(s) persistently worse.
- No meaningful, measurable change has been documented in the individual’s functioning and/or behavior(s) for a period of three months of optimal treatment.
  - Changes must be sustained over time beyond the end of the actual treatment session and can be generalized outside of the treatment setting to the individual’s residence and to the larger community within which the individual resides.
- The individual has achieved adequate stabilization of functions and/or the challenging behavior(s), and less-intensive modes of therapy are appropriate.
  - It is appropriate to restart treatment if measurable deterioration in functioning and/or behavior(s) occurs with less-intensive modes of therapy.
- The individual’s parent(s) and/or caregiver(s) demonstrate adequate skill in administering a long-term home-based program.
- The individual demonstrates an inability to maintain long-term gains from the proposed treatment plan.

PSYCHIATRIC AND/OR PSYCHOLOGICAL SERVICES
Contact Vermont Collaborative Care at 1-800-922-8778 for psychiatric and/or psychological services eligible for coverage in individuals with ECDD.

APPLIED BEHAVIOR ANALYSIS (ABA) AND/OR OTHER METHODOLOGIES TO PROMOTE LEARNING
Contact Vermont Collaborative Care at 1-800-922-8778 for ABA and/or other services to promote learning that are eligible for coverage in individuals with ECDD.

To view the medically necessary criteria for ABA and/or other related structured behavioral services, members enrolled in Vermont’s commercial products and contracted with Vermont Collaborative Care for behavioral health/mental health management should contact Vermont Collaborative Care at 1-800-922-8778.
Habilitative/Rehabilitative Services

Habilitative and rehabilitative services are services provided to achieve normal functions and skills necessary to perform age-appropriate basic activities of daily living, including ambulation, eating, bathing, dressing, speech, and elimination.

Habilitation and rehabilitation services may include respiratory therapy, speech therapy, occupational therapy and physical medicine treatments. Habilitation and rehabilitation services may be performed by those who are qualified to perform such services and do so within the scope of their license. Such services are evaluated based on objective documentation of measurable progress toward functional improvement goals. Measurement methods must be valid, reliable, repeatable, and evidence-based.

Benefits for habilitation and rehabilitation services are available when the services are medically necessary and are covered benefits under the member’s contract.

Habilitation is directed at achieving functions and skills that have not developed normally while rehabilitation is directed at restoring functions and skills lost due to disease, injury or other disabling condition.

The following services are not included and therefore not eligible under the scope of habilitation services: custodial care, vocational, recreational and educational services, or services that are considered maintenance in nature.

Additional treatment is not considered medically necessary in the absence of objective documentation of ongoing clinically significant functional improvement being achieved and when there is not a medically reasonable expectation that additional treatment will lead to additional clinically significant functional improvement.

NON COVERED SERVICES AND PROCEDURES:

- Services beyond those needed to restore your ability to perform Activities of Daily Living (see Definitions) or to establish or re-establish the capacity to perform occupational, hobby, sport or leisure activities.
- Treatment solely to establish or re-establish the capability to perform occupational, hobby, sport or leisure activities.
- Physical fitness equipment, braces and devices intended primarily for use with sports or physical activities other than activities of Activities of Daily Living.
- Care for which there is no therapeutic benefit or likelihood of improvement.
- Care to improve overall fitness or endurance.
- Education, educational evaluation or therapy, therapeutic boarding schools, services that should be covered as part of an evaluation for, or inclusion in, a Child’s individualized education plan (IEP) or other educational program. (This exclusion does not apply to treatment of diabetes, such as medical nutrition therapy by approved participating Providers.)
- Cognitive training or retraining and educational programs, including any program designed principally to improve academic performance, reading or writing skills.
NEUROPSYCHOLOGICAL TESTING (NPT)

NPT is considered not medically necessary and, therefore, not covered for ECDD unless the individual has an associated neurologically based condition that requires such testing. In those instances, indicate the primary diagnosis code that represents the associated neurologically based condition. (See BCBSVT policy on Neuropsychological Testing)

ALTERNATIVE THERAPIES AND COMPLEMENTARY MEDICINE

Alternative therapies and complementary medicine (e.g., nutritional supplements, high doses of pyridoxine and magnesium, casein-free and gluten-free diets) are standard benefit contract exclusions for most of the Plan’s products and are not eligible for reimbursement consideration.

EXPERIMENTAL/INVESTIGATIONAL SERVICES

The Plan considers the following to be investigational in the screening or treatment of Early Childhood Developmental Disorders because the safety and/or efficacy of these diagnostic services, therapies, and treatments when used in the management of ECDD cannot be established by review of the available published peer-reviewed literature, and are NOT eligible for benefits. These include but are not limited to:

- Allergy testing (including, but not limited to, food allergy for gluten, casein, Candida and other molds)
- Array Comparative Genomic Hybridization (aCGH) testing
- Art therapy
- Chelation therapy
- Cognitive Rehabilitation
- Electronystagmography (in the absence of dizziness, vertigo, or balance disorder)
- Elimination diets
- Erythrocyte glutathione peroxides studies
- Facilitative communication [FC]
- Floor time therapy
- Holding therapy
- Hair Analysis for trace elements
- Hippotherapy
- Hyperbaric oxygen therapy
- Immune globulin therapy [IVIg]
- Intestinal permeability studies
- Magnetoencephalography
- Music therapy and rhythmic entrainment interventions
- Neuroimaging studies such as: CT, MRI, MRS, PET, SPECT, and Functional MRI (Please see BCBSVT Policy on Radiology)
- Nutritional, Mineral and Herbal Supplements (e.g., megavitamins, high dose pyridoxine and magnesium, dimethylglycine and glutathione, calcium,
germanium, selenium, tin, tungsten, vanadium, zinc, echinacea, berberis, etc.)
- Secretin Infusions
- Sensory integration modalities including, but not limited to, Berard Auditory integration training [AIT]; The Audio Tone Enhancer/Trainer; Digital Auditory Aerobics; Electronic Auditory Stimulation effect (EASE program); Kirby Auditory Modulation System (KAMS); SAMONAS Sound Therapy; Tomatis Sound Therapy The LiFTTM; The Listening Program
- Squeeze machine therapy
- Stool Analysis
- Tests for micronutrients (i.e., vitamin levels), urinary peptides, mitochondrial disorders including lactate and pyruvate, celiac antibodies, amino acids (except quantitative plasma amino acid assays to detect phenylketonuria), heavy metals, trace metals, immunologic or neurochemical abnormalities
- Tympanometry (in the absence of hearing loss)
- Vision Therapy

REQUIRED DOCUMENTATION

The individual’s medical record must reflect the medical necessity for the care provided. These medical records may include, but are not limited to: records from the health care professional’s office, hospital, nursing home, home health agencies, therapies, and test reports.

The Plan may conduct reviews and audits of services to our members, regardless of the participation status of the provider. All documentation is to be available to the Plan upon request. Failure to produce the requested information may result in a denial for the service.

Documentation of the performing provider’s qualifications must be made available to Plan upon request.

Prior Authorization is required for all therapeutic services (PT, OT, and ST, with the exception of the initial comprehensive evaluation) NOTE: Prior authorization is not needed for the initial screening and/or diagnostic assessments for ECDD.

All psychiatric and/or psychological services eligible for coverage in individuals with ECDD must be authorized prior to service by Vermont Collaborative Care by calling 1.800.922.8778.

Subject to the terms and conditions of the applicable benefit contract, evaluation for Early Childhood Developmental Disorders (ECDD) is covered under the medical benefits of the Plan’s products when the medical necessity criteria in this medical policy are met or when state mandate(s) require coverage for such services. However, except where required by state mandate(s), services that are identified in this policy as experimental/investigational or not medically necessary are not eligible for coverage or reimbursement by the Plan.
The provision of benefits for all services related to outpatient physical, occupational, and/or speech therapy is in accordance with the BCBSVT Medical Policy on PT, ST, and OT in Early Childhood Developmental Disorders (ECDD). Individual member benefits must be verified. Some services may be subject to state mandates, medical necessity criteria, precertification or preapproval, or existing contractual or policy exclusions.

Pharmacy services for ECDD are covered under the pharmacy benefits of the Plan’s products. Individual benefits must be verified.

Management of ECDD may not routinely include psychiatric and/or psychological services for all individuals enrolled in a Plan product. For information about psychiatric and/or psychological services eligible for coverage in individuals with ECDD, contact Vermont Collaborative Care at or 1-800-922-8778.

**TREATMENT PLAN DOCUMENTATION REQUIREMENTS**

The individual’s treatment plan must document all of the following:

- Significant history
- Diagnosis of ECDD and rationale for requiring services
- Any related physician’s orders
- The goals for the services, which must be:
  - Specific and measurable
  - Individualized
  - Updated on a frequent basis
  - Based on the individual’s progress
- To improve function and/or behavior significantly
- To prevent loss of attained skill or function and/or produce socially significant improvement in human behavior (reduce interfering behaviors)
- Type, amount, duration, and frequency of services
- Direct observation, measurement, and functional analysis of the relations between environment and behavior
- Interventions such as, but not limited to, physical, occupational, speech therapy and/or ABA that are consistent with current techniques and standards
- Any contraindications to a course of services
- Parent(s)’ and/or caregiver(s)’ awareness and understanding of the diagnoses, prognoses, and goals of services
- When appropriate, a summary of past services and the results that were achieved
- Reasonable expectation, based on the individual’s clinical history, that withdrawal of treatment will result in the decompensation or the recurrence of signs and symptoms In order for claims to process correctly for PT, OT and ST services in Early Childhood Developmental Disorders (ECDD), diagnosis codes specific to ECDD must be listed as the primary diagnosis code. Please see Attachment I for specific coding information.

**DOCUMENTATION FOR DATES OF SERVICE**
Treatment and modality notes for dates that services are provided and billed for must include the following documentation:

- Date of service
- Specific service provided
- If modalities are utilized, documentation of the length of time spent in each modality
- If exercises or equipment are utilized, documentation of the specific activity, time, and/or number of repetitions
  - Exercises or modalities that require therapist supervision should be supported with an indication of the time spent and the level of skill required by the individual
- The individual’s response to the service
- Skilled, ongoing reassessment of the individual’s progress towards established goals
- Objective, measurable, and specific documentation of progress towards goals using consistent and comparable methods
- Changes to the treatment plan or objective reasoning for why the individual has not progressed towards goals
- Name and credentials of the treating clinician

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies instances of non-compliance with this medical policy, BCBSVT reserves the right to recoup all non-compliant payments.

Reference Resources


Related Policies
Blue Cross and Blue Shield of Vermont (BCBSVT) Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language, or employer’s benefit plan if an ASO group, determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, BCBSVT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict between medical policy and contract/employer benefit plan language, the member’s contract/employer benefit plan language takes precedence.

Audit Information

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies instances of non-compliance with this medical policy, BCBSVT reserves the right to recoup all non-compliant payments.

Administrative and Contractual Guidance

Benefit Determination Guidance

Prior approval is required and benefits are subject to all terms, limitations and conditions of the subscriber contract.

Incomplete authorization requests may result in a delay of decision pending submission of missing information. To be considered compete, see policy guidelines above.

An approved referral authorization for members of the New England Health Plan (NEHP) is required. A prior approval for Access Blue New England (ABNE) members is required. NEHP/ABNE members may have different benefits for services listed in this policy. To confirm benefits, please contact the customer service department at the member’s health plan.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member’s benefits
prior to providing the service to determine if benefits are available or if there is a specific exclusion in the member’s benefit.

Coverage varies according to the member’s group or individual contract. Not all groups are required to follow the Vermont legislative mandates. Member Contract language takes precedence over medical policy when there is a conflict.

If the member receives benefits through an Administrative Services Only (ASO) group, benefits may vary or not apply. To verify benefit information, please refer to the member’s employer benefit plan documents or contact the customer service department. Language in the employer benefit plan documents takes precedence over medical policy when there is a conflict.

Policy Implementation/Update information

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>07/2011</td>
<td>New Policy</td>
</tr>
<tr>
<td>02/2012</td>
<td>Revised for internal use</td>
</tr>
<tr>
<td>09/2012</td>
<td>Revised - Vermont State Mandate S.223 (See Attachment 2). CPT changes, ICD-9 changes. Audit information section and Legislative Guidelines section added. Pg. 140 Autism Policy effective and term dates (upon renewal will have ECDD) referenced. Medical/Coder reviewed RJ</td>
</tr>
<tr>
<td>11/2013</td>
<td>Addition of diagnoses: Cerebral palsy and Intellectual disability and all ICD codes included in original Autism medical policy. Age changed to 21 years. ICD-10 remediated. IEP and Academic improvement exclusion added to pg. 15</td>
</tr>
<tr>
<td>04/2017</td>
<td>Removed ICD-9 codes, re-sequenced existing HCPCs and CPT codes; Removed HCPCS C1300 and replaced with HCPCS G0277. Updated policy format. Removed Attachment 2, Vermont State Mandate S.223 as no longer applicable.</td>
</tr>
</tbody>
</table>

Eligible providers

Qualified healthcare professionals practicing within the scope of their license(s).

Approved by BCBSVT Medical Directors    Date Approved

Gabrielle Bercy-Roberson, MD, MPH
Senior Medical Director
Chair, Health Policy Committee

Joshua Plavin, MD, MPH
Chief Medical Officer
## ICD & CPT Code List & Instructions

<table>
<thead>
<tr>
<th>Code Type</th>
<th>Number</th>
<th>Brief Description</th>
<th>Policy Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-10 F71</td>
<td>Intellectual Disability- Moderate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICD-10 F72</td>
<td>Intellectual Disability- Severe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICD-10 F73</td>
<td>Intellectual Disability- Profound</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICD-10 F84.0</td>
<td>Autism Spectrum Disorder</td>
<td></td>
<td></td>
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<tr>
<td>ICD-10 F84.2</td>
<td>Rett's Syndrome</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICD-10 F84.3</td>
<td>Other Childhood Disintegrative Disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICD-10 F84.5</td>
<td>Asperger's syndrome</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICD-10 F84.8</td>
<td>Other pervasive developmental disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICD-10 F84.9</td>
<td>Pervasive developmental disorder, unspecified</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICD-10 G80.0</td>
<td>Spastic quadriplegic cerebral palsy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICD-10 G80.1</td>
<td>Spastic diplegic cerebral palsy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICD-10 G80.2</td>
<td>Spastic hemiplegic cerebral palsy Palsy also coded for: Infantile hemiplegia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICD-10 G80.8</td>
<td>Other Cerebral palsy also coded for: Monoplegia</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The following codes will be considered as medically necessary when applicable criteria have been met.

<table>
<thead>
<tr>
<th>Code Type</th>
<th>Brief Description</th>
<th>Policy Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Applied Behavioral Analysis ABA</td>
<td>Refer to VCC for billing guidance</td>
</tr>
<tr>
<td></td>
<td>Audiologic Evaluation</td>
<td>See BCBSVT policy on Evaluation of Hearing</td>
</tr>
<tr>
<td>Service</td>
<td>Requires Prior Authorization, with the exception of the initial comprehensive evaluation</td>
<td></td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Outpatient Occupational Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Physical Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Speech Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision Evaluation</td>
<td>See BCBSVT policy on vision services</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>83655</td>
<td>Lead</td>
</tr>
<tr>
<td>84030</td>
<td>Phenylalanine (PKU) blood</td>
</tr>
<tr>
<td>88245</td>
<td>Chromosome analysis for breakage syndromes; Baseline Sister Chromatid Exchange (SCE) 20-25 cells</td>
</tr>
<tr>
<td>88248</td>
<td>Chromosome analysis for breakage syndromes; baseline breakage, score 50-100 cells, count 20 cells, 2 karyotypes (e.g., for ataxia telangectasia, Fanconi anemia, fragile X)</td>
</tr>
<tr>
<td>88249</td>
<td>Chromosome analysis for breakage syndromes; baseline breakage, score 100 cells, clastogen stress (e.g., diepoxybutane, mitomycin C, ionizing radiation, UV radiation)</td>
</tr>
<tr>
<td>88261</td>
<td>Chromosome analysis; count 5 cells, 1 karyotype, with banding</td>
</tr>
<tr>
<td>88262</td>
<td>Chromosome analysis; count 15-20 cells, 2 karyotypes, with banding</td>
</tr>
<tr>
<td>CPT</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>88263</td>
<td>Chromosome analysis; count 45 cells for mosaicism, 2 karyotypes, with banding</td>
</tr>
<tr>
<td>88264</td>
<td>Chromosome analysis; analyze 20-25 cells</td>
</tr>
<tr>
<td>95812</td>
<td>Electroencephalogram (EEG) extended monitoring; 41-60 minutes</td>
</tr>
<tr>
<td>95813</td>
<td>Electroencephalogram (EEG) extended monitoring; &gt; 1 hour</td>
</tr>
<tr>
<td>95816</td>
<td>Electroencephalogram (EEG); including recording awake and drowsy</td>
</tr>
<tr>
<td>95819</td>
<td>Electroencephalogram (EEG); including recording awake and asleep</td>
</tr>
<tr>
<td>96040</td>
<td>Medical Genetics and Genetic Counseling services, each 30 minutes face-to-face with patient/family</td>
</tr>
<tr>
<td>96110</td>
<td>Developmental screening, with interpretation and report, per standardized instrument form</td>
</tr>
<tr>
<td>96111</td>
<td>Developmental testing, (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
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</tr>
<tr>
<td>CPT 96116</td>
<td>Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report.</td>
</tr>
<tr>
<td>CPT 97532</td>
<td>Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training), direct (one-on-one) patient contact</td>
</tr>
<tr>
<td>HCPCS H0032</td>
<td>Applied Behavioral Analysis (ABA) - Initial Assessment &amp; Plan Development, per hour</td>
</tr>
<tr>
<td>HCPCS H2014</td>
<td>Supervision of ABA follow-up or Therapeutic Staff Support, per 15 minutes</td>
</tr>
<tr>
<td>HCPCS H2019</td>
<td>Supervision of ABA follow-up or Therapeutic Staff Support, per 15 minutes</td>
</tr>
<tr>
<td>HCPCS H2021</td>
<td>Applied Behavior Analysis (ABA) - Follow-up &amp; Reassessment, per 15 minutes</td>
</tr>
<tr>
<td>HCPCS S0265</td>
<td>Genetic Counseling, under physician supervision, each 15 minutes</td>
</tr>
<tr>
<td>HCPCS S9128</td>
<td>Speech Therapy, in the home, per diem</td>
</tr>
<tr>
<td>HCPCS S9152</td>
<td>Speech Therapy re-evaluation</td>
</tr>
</tbody>
</table>

The following codes will be denied as Not Medically Necessary.
<table>
<thead>
<tr>
<th>CPT</th>
<th>96118</th>
<th>Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist’s or physician’s time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report</th>
<th>Will be denied as not medically necessary</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT</td>
<td>96119</td>
<td>Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face</td>
<td>Will be denied as not medically necessary</td>
</tr>
<tr>
<td>CPT</td>
<td>96120</td>
<td>Neuropsychological testing (eg, Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report</td>
<td>Will be denied as not medically necessary</td>
</tr>
</tbody>
</table>

The following codes will be denied as Investigational or Experimental.

<table>
<thead>
<tr>
<th>CPT</th>
<th>90283</th>
<th>Immune globulin (IgIV), human, for intravenous use</th>
<th>Will be denied as Investigational or Experimental</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT</td>
<td>97039</td>
<td>Unlisted modality (specify type and time if constant attendance)/ Hippotherapy</td>
<td>Will be denied as Investigational or Experimental</td>
</tr>
<tr>
<td>CPT</td>
<td>97139</td>
<td>Unlisted therapeutic procedure (specify)/Auditory Integrative training or Facilitative communication</td>
<td>Will be denied as Investigational or Experimental</td>
</tr>
<tr>
<td>CPT</td>
<td>97139</td>
<td>Unlisted therapeutic procedure (specify)/Hippotherapy</td>
<td>Will be denied as Investigational or Experimental</td>
</tr>
<tr>
<td>CPT</td>
<td>97533</td>
<td>Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes</td>
<td>Will be denied as Investigational or Experimental</td>
</tr>
<tr>
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</tr>
<tr>
<td>CPT</td>
<td>97799</td>
<td>Unlisted physical medicine/rehabilitation service or procedure/Hippotherapy</td>
<td>Will be denied as Investigational or Experimental</td>
</tr>
<tr>
<td>CPT</td>
<td>99183</td>
<td>Physician attendance and supervision of hyperbaric oxygen therapy; per session</td>
<td>Will be denied as Investigational or Experimental</td>
</tr>
<tr>
<td>HCPCS</td>
<td>G0176</td>
<td>Activity Therapy such as music, dance, art, or play therapies, not for recreation, related to the care and treatment of patient’s disabling mental health problems, per session (45 minutes or more)</td>
<td>Will be denied as Investigational or Experimental</td>
</tr>
<tr>
<td>HCPCS</td>
<td>G0277</td>
<td>Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval.</td>
<td>Will be denied as Investigational or Experimental</td>
</tr>
<tr>
<td>HCPCS</td>
<td>J0470</td>
<td>Injection, dimercaprol, per 100 mg (BAL in oil)</td>
<td>Will be denied as Investigational or Experimental</td>
</tr>
<tr>
<td>HCPCS</td>
<td>J0600</td>
<td>Injection, edetate calcium disodium up to 1,000 mg</td>
<td>Will be denied as Investigational or Experimental</td>
</tr>
<tr>
<td>HCPCS</td>
<td>J0895</td>
<td>Injection, deferoxamine mesylate, 500 mg (Desferal)</td>
<td>Will be denied as Investigational or Experimental</td>
</tr>
<tr>
<td>HCPCS</td>
<td>J1557</td>
<td>Injection, immune globulin, (Gammaphase), intravenous non-lyophilized (e.g., liquid), 500mg</td>
<td>Will be denied as Investigational or Experimental</td>
</tr>
<tr>
<td>HCPCS</td>
<td>J1459</td>
<td>Injection, immune globulin (Privigen), intravenous, non-lyophilized (e.g. liquid), 500 mg</td>
<td>Will be denied as Investigational or Experimental</td>
</tr>
<tr>
<td>HCPCS</td>
<td>J1561</td>
<td>Injection, immune globulin, (Gamunex), intravenous, non-lyophilized (e.g., liquid), 500 mg</td>
<td>Will be denied as Investigational or Experimental</td>
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<tr>
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</tr>
<tr>
<td>HCPCS</td>
<td>J1566</td>
<td>Injection, immune globulin, intravenous, lyophilized (e.g., powder), not otherwise specified, 500 mg</td>
<td>Will be denied as Investigational or Experimental</td>
</tr>
<tr>
<td>HCPCS</td>
<td>J1568</td>
<td>Injection, immune globulin, (Octagam), intravenous, non-lyophilized (e.g., liquid), 500 mg</td>
<td>Will be denied as Investigational or Experimental</td>
</tr>
<tr>
<td>HCPCS</td>
<td>J1569</td>
<td>Injection, immune globulin, (Gammagard liquid), intravenous, non-lyophilized (e.g., liquid), 500 mg</td>
<td>Will be denied as Investigational or Experimental</td>
</tr>
<tr>
<td>HCPCS</td>
<td>J1572</td>
<td>Injection, immune globulin, (Flebogamma/Flebogamma DIF), intravenous, non-lyophilized (e.g., liquid); 500 mg</td>
<td>Will be denied as Investigational or Experimental</td>
</tr>
<tr>
<td>HCPCS</td>
<td>J1599</td>
<td>Injection, immune globulin, intravenous, non-lyophilized (e.g., liquid), not otherwise specified, 500 mg</td>
<td>Will be denied as Investigational</td>
</tr>
<tr>
<td>HCPCS</td>
<td>J2850</td>
<td>Injection, Secretin, synthetic, human, 1mcg</td>
<td>Will be denied as Investigational or Experimental</td>
</tr>
<tr>
<td>HCPCS</td>
<td>J3520</td>
<td>Edetate disodium, per 150 mg</td>
<td>Will be denied as Investigational or Experimental</td>
</tr>
<tr>
<td>HCPCS</td>
<td>M0300</td>
<td>IV chelation therapy</td>
<td>Will be denied as Investigational or Experimental</td>
</tr>
<tr>
<td>HCPCS</td>
<td>S3870</td>
<td>Comparative Genomic Hybridization (CGH) Microarray Testing</td>
<td>Will be denied as Investigational or Experimental</td>
</tr>
<tr>
<td>HCPCS</td>
<td>S8940</td>
<td>Equestrian /Hippotherapy, per session</td>
<td>Will be denied as Investigational or Experimental</td>
</tr>
<tr>
<td>HCPCS</td>
<td>S938</td>
<td>Home infusion therapy, immunotherapy, administrative services, professional pharmacist services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem</td>
<td>Will be denied as Investigational or Experimental</td>
</tr>
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</tr>
<tr>
<td>HCPCS</td>
<td>S9355</td>
<td>Home infusion therapy, chelation therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment, per diem</td>
<td>Will be denied as Investigational or Experimental</td>
</tr>
<tr>
<td>Revenue Code</td>
<td>0413</td>
<td>Hyperbaric oxygen therapy</td>
<td>Will be denied as Investigational or Experimental</td>
</tr>
</tbody>
</table>