Evaluation and Management of Autism Spectrum Disorder And/or Moderate or Severe Intellectual Disability
Corporate Medical Policy

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Description
Autism spectrum disorders (ASD) are a class of pervasive developmental disorders (PDD) that are characterized by impaired verbal and nonverbal communication skills, poor social interaction, limited imaginative activity, and repetitive patterns of activities and behavior. The International Classification Diseases (ICD) lists five separate disorders that are categorized as PDD that are included on the autism spectrum:

- Autism disorder
- Rett syndrome
- Childhood disintegrative disorder (CDD)
- Asperger’s syndrome
- Pervasive developmental disorder - not otherwise specified (PDD-NOS)

Each of these conditions may or may not include any intellectual disability, including moderate or severe levels of intellectual disability (ID).

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 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 standard teaching methods and/or verbal cues. Many children with autism also have varying degrees of intellectual disability.
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.

ASPENGER’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.

PERVASIVE 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 ASD 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 do not meet the full DSM-IV-TR criteria for autism disorder.

The Diagnostic and Statistical Manual, Fifth Edition, or DSM-5 (2013) of the American Psychiatric Association, has eliminated the above separate diagnoses. The current diagnosis of the DSM-5 is autism spectrum disorders, which is further specified by severity levels on the spectrum.

AUTISM SPECTRUM DISORDER

The individual is required to have persistent deficits in social communication and social interaction, in multiple settings/social situations, as displayed by deficits in social-emotional reciprocity; deficits in nonverbal communicative behavior, including
body language and eye contact; and deficits in developing, maintaining and
comprehending relationships. The individual also needs to have restrictive, repetitive
patterns of behavior, activities or interest. Symptoms must be present in the early
developmental period.

DSM-5 categorizes severity of ASD as follows: Level 3: Requiring very substantial
support - very limited social communication skills causing severe impairments in
functioning, inflexibility of behavior, severe restrictive/repetitive behaviors; Level 2:
Requiring substantial support - social impairment apparent even with supports in
place, restricted/repetitive behavior appear frequently enough to be obvious to casual
behavior; Level 1: Requiring support - without supports in place, deficits in social
communication cause noticeable impairment, inflexibility of behavior causes
significant interference with functioning.

INTELLECTUAL DISABILITY

Psychiatric Association, states that an intellectual disability is a disorder which
includes both intellectual and adaptive functioning deficits in conceptual, social and
practical domains. The onset of the intellectual and adaptive deficits must occur
during the developmental period. Moderate intellectual disability diagnostic criteria
for the social domain state the following: the individual shows marked differences
from peers in social and communicative behavior across development; individuals may
not perceive or interpret social cues accurately. Severe intellectual disability
-diagnostic criteria for the social domain state the following: spoken language is quite
limited in terms of vocabulary and grammar; speech may be single words of phrases
and may be supplemented with augmentative means.

This policy does not cover the diagnosis of mild intellectual disability (without ASD), as
these individuals often possess sufficient social skills and language skills to respond to
less intensive operant conditioning behavioral strategies and likely do not require ABA.

EVALUATION

According to a 2007 clinical report for the American Academy of Pediatrics (AAP), ASD
is generally believed to be a biologically-based neurodevelopmental disorder that
involves multiple genes and demonstrates great phenotypic variation. Although ASD is
believed to be mainly genetic in origin, environmental factors may modulate
phenotypic expression. Despite this, the exact cause is still unknown. Early
identification of ASD is important because it allows early intervention, etiologic
investigation, and counseling regarding recurrence risk and improved overall
outcomes.

To identify individuals with ASD, 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. The National Institute of Mental Health has identified conditions that may accompany ASD including, but not limited to:

- **Seizures**
  Seizures are present in approximately 20 percent to 35 percent of individuals with ASD.

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

- **Intellectual disability**
  Estimates have widely varied as to the rates of co-occurrence of intellectual disability and ASD. There are inherent difficulties to accurately assessing intelligence quotients in individuals with ASD.

- **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. ASD occurs more frequently in individuals with FXS.

- **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, a happy social disposition and, in some instances, a secondary diagnosis of ASD.

**SCREENING/DIAGNOSTIC SERVICES**

Due to the complexity of ASD, many professional societies such as the Child Neurology Society and the American Academy of Neurology have emphasized the importance of interdisciplinary collaboration in screening and diagnosing the condition.

**SCREENING TOOLS**

The 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 ASD are often present at these ages, and effective early intervention strategies are available. Screening tools do not provide an individual diagnosis, but serve to assess the need for referral for a possible diagnosis. Screening specifically for ASD should be performed on children who demonstrate delays on developmental surveillance using a validated ASD screening tool (e.g., Checklist for Autism in Toddlers [CHAT], Modified Checklist for Autism in Toddlers [M-CHAT], Social Communication Questionnaire [SCQ], Social Responsiveness Scale [SRS], Autism Screening Questionnaire, Pervasive Developmental Disorder Screening Test II [PDDST-II]).
DIAGNOSTIC TOOLS
Healthcare professionals involved in diagnosing ASD must be knowledgeable and experienced with comprehensive standardized diagnostic tools that are specific for ASD. Diagnostic tools for ASD 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 ASD must be knowledgeable and experienced in using guidelines such as the American Psychiatric Association’s criteria outlined in the 2013 Diagnostic and Statistical Manual of Mental Disorders - Fifth Edition, (DSM-5).

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, whether ASD symptoms are present or not. The literature has documented that conductive, sensorineural or mixed hearing loss can occur in ASD.

LABORATORY EVALUATION
Currently there is no laboratory test specific for ASD. Laboratory evaluations may be indicated in children with suspected ASD 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 frequently engage in oral exploration, 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 ASD is significant in siblings (5 to 10 percent) of affected children, it is important to provide genetic counseling after a diagnosis of ASD to offer parents information about recurrence risks in subsequent children.

GENETIC TESTING
Research has identified various genetic disorders associated with ASD; however, the total number of individuals with ASD who have a known genetic condition is only a small percentage of the whole. Furthermore, due to the heterogeneity of ASD, the multiple etiologies and the questionable clinical validity of extensive screening tests of all children with ASD, additional evidence is needed before genetic testing of this population becomes standard medical practice. Current genetic testing methods to identify associated conditions of ASD may include testing for FMR-1 mutations, and comparative genomic hybridization microarray.

Despite the profusion of investigations into the genetic component of ASD, many genetic tests that have been proposed for ASD have yet to be validated by appropriate studies for clinical application. 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 paucity of available studies that support CGH microarray testing as medically necessary for developmental delay, ASD and/or intellectual disability.

MANAGEMENT

According to the National Institute of Child Health and Human Development, currently there is no definitive, single treatment for the management of ASD. Individuals with ASD 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 ASD 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 ASD 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 ASD 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 ASD has not been reached. Currently, the US Food and Drug Administration (FDA) has not approved any medications specifically for the treatment of ASD. 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®) and aripiprazole (Abilify®) for the symptomatic treatment of irritability including aggression, deliberate self-injury, and temper tantrums in children and adolescents, ages 5-16, 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 ASD 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 ASD, 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 ASD frequently focus on enhancing an individual’s sensory processing, sensorimotor performance, social/behavioral performance, self-care and participation in play. In older individuals with ASD, 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 ASD. They work with individuals with ASD 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 ASD and/or to diagnose and treat co-morbid psychiatric disorders that are exhibited by the individual with ASD. In an individual with ASD, it may be wise to seek a psychiatric consultation if the individual has not responded to consistently applied behavioral interventions.

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.

EARLY INTENSIVE BEHAVIORAL INTERVENTION (EIBI) INCLUDING 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 ASD, EIBI is the most empirically validated approach to treatment. ABA is arguably the most studied standardized treatment type of EIBI. It is generally believed that ABA is the process of applying interventions that are based on the principles of learning (operant conditioning) 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 designed 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 positive ‘adaptive’ and negative ‘exposure’ behaviors of the individual with ASD (and/or moderate or severe ID) is conducted. This initial assessment is essentially an ABA specific ‘functional behavioral analysis’
- 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 into more complex prosocial behaviors
- 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, termed ‘fading.’
- No reinforcement, and active ignoring, 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
methods. 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 ASD. Another modality commonly used with individuals who have ASD 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 strongly 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. A 2012 Cochrane meta-analysis and review of the available research literature of Early Intensive Behavioral Interventions concluded that EIBI, such as ABA, are effective treatment modalities in the treatment of ASD, although the quality of the overall available evidence was rated as ‘Low.’ Applied Behavioral Analysis has been endorsed by the American Academy of Pediatrics. The American Academy of Child and Adolescent Psychiatry (AACAP) also recommends EIBI, such as ABA, in the Practice Parameter for the Assessment and Treatment of Children and Adolescents with Autism Spectrum Disorders (2013). In the practice parameter, the AACAP categorizes the treatment as a ‘Clinical Standard,’ the highest level of recommendation.

Early Intensive Behavioral Interventions (including ABA) have not been as well studied in children with early childhood developmental disorders other than ASD. However, considering the significant comorbidity of moderate and severe intellectual disabilities with ASD, it is possible that ABA will be somewhat effective in individuals in this population, even without the diagnosis of ASD.

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 ASD; however, NPT may be helpful in evaluating specific neurologic conditions that are present in an individual with suspected ASD. (Please see BCBSVT Policy on Neuropsychological Testing.)

Policy
The intent of this policy is to communicate the medical necessity criteria for the evaluation and management of autism spectrum disorders (ASD) and/or moderate to severe intellectual disability (ID) in children diagnosed with ASD from birth to 21 years of age in accordance with Vermont state law and as outlined in the members’ certificate of coverage.

EVALUATION OF ASD
The services listed below are the most frequently used components of an ASD
evaluation, and may be considered medically necessary when policy criteria have been met:

- 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 ASD 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 medically necessary.
- 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.
- Genetic counseling for parents of a child with ASD 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 ASD and intellectual disability).
  - Selective metabolic testing.
- Genetic testing, specifically for FMR1 mutations for Fragile X in clinically suspected individuals, as outlined below

Genetic testing for the Fragile X mental retardation gene (FMR1) mutations may be considered medically necessary for individuals with autism spectrum disorder or moderate/severe intellectually disability for the following:

- Individuals seeking reproductive counseling who have a family history of fragile X syndrome.
- Prenatal testing of fetuses of known carrier mothers.
- Affected individuals or relatives of affected individuals who have had a positive cytogenetic fragile X test result who are seeking further counseling related to the risk of carrier status.
- Multiple morphological/physical features consistent with Fragile X: elongated face (vertical maxillary access), high-arched palate, large or protruding ears (unilateral or bilateral), hyperextensible joints in digits, flat feet, post-pubescent macroorchidism, hypotonia.

Genetic testing for FMR1 mutations is investigational for all other uses.
Chromosomal microarray analysis may be considered **medically necessary** for diagnosing a genetic abnormality in children with apparent non-syndromic moderate or severe intellectual disability or autism spectrum disorder (ASD) when all of the following conditions are met:

- Any indicated biochemical tests for metabolic disease have been performed, and results are non-diagnostic, and
- \(FMR1\) gene analysis (for Fragile X), when clinically indicated, is negative, and
- In addition to a diagnosis of non-syndromic ID or ASD, the child has one or more of the following:
  - two or more major malformations (please see Attachment 3), or
  - a single major malformation or multiple minor malformations, in an infant or child who is also small-for-dates, or
  - a single major malformation and multiple minor malformations, and
- The results for the genetic testing have the potential to impact the clinical management of the patient, and
- Testing is requested after the parent(s) have been engaged in face-to-face genetic counseling with a healthcare professional who has appropriate genetics training and experience.

Chromosomal microarray analysis is considered **investigational** in all other cases of suspected genetic abnormality in children with moderate or severe intellectual disability or autism spectrum disorder.

Chromosomal microarray analysis to confirm the diagnosis of a disorder or syndrome that is routinely diagnosed based on clinical evaluation alone (see the Policy Guidelines section) is **not medically necessary**.

Panel testing using next-generation sequencing is considered **investigational** in all cases of suspected genetic abnormality in children with developmental delay/intellectual disability or autism spectrum disorder.

Chromosomal microarray analysis is considered **investigational** for prenatal genetic testing.

**SPECIFIC REQUIREMENTS FOR APPLIED BEHAVIOR ANALYSIS (ABA)**

**Initial Behavior Assessment/Evaluation**

Prior authorization (PA) is not required for the initial behavior identification assessment.

- The initial behavioral identification assessment is considered medically necessary for up to a four-hour assessment.
- Initial behavioral identification assessment beyond four hours is considered not medically necessary.

The report generated from the Initial Behavioral Assessment/Evaluation must contain the following:
• Documented attempt to obtain records from any prior autism evaluations/treatments
• Documentation from the primary care physician, psychologist, or psychiatrist that the patient has an Autism Spectrum Disorder, Pervasive Developmental Disorder, or Intellectual Disability, moderate or severe levels (see Diagnoses listed below).
• If the diagnosis is Intellectual Disability, the findings of an official psychologist’s report stating that the patient has Moderate or Severe Intellectual Disability (Mental Retardation), including standardized testing conducted to determine the level of intellectual disability
• The social/educational supports that the member is receiving currently (i.e., 1:1 aide in school), as well as verification of a current Individualized Education Program (IEP). Without this required brief summary of services provided at the school, BCBSVT will be unable to provide benefits for ABA treatment in settings outside of school, as coordination of behavioral plans between school and other settings is critical to the success of any behavioral treatment.
• Parts of the evaluation may be conducted by a Board Certified Assistant Behavior Analyst (BCaBA), but the evaluation must be reviewed by the Board Certified Behavior Analyst (BCBA).

Requested ABA treatment may be considered medically necessary when the following has been identified and documented in the Initial Behavioral Assessment report:

• Less intensive behavioral treatment/therapy has been considered or has been ineffective
• The evaluation needs to include a completed Barriers section of the The Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP)
• A descriptive functional behavioral analysis is produced, with at least three focused behavior goals to be tracked, and the preliminary intervention/treatment plan
• A decision should be made as to whether the PRIMARY targeted behaviors of ABA will be either Exposure Behaviors (aggressive or self-injurious behaviors, property destruction, and/or disruptive behaviors) or Adaptive Behaviors (social skills, communication, and/or repetitive behaviors that impede communication, such as self-stimulation), and the corresponding codes requested for prior authorization (PA) for continued treatment (i.e., Exposure ABA 0373T/0374T or Adaptive ABA 0368T, or Adaptive ABA 0368T/0369T)
• All behaviors that jeopardize the child’s personal safety or the safety of others in the child’s environment, must have a focused intervention plan outlined and be identified as a focused behavioral goal to be tracked and charted on a graph
• It is not necessary to itemize requests for both adaptive and exposure treatment units in the same prior authorization request, although a mixture of requested codes will be accepted; the request can be all Exposure ABA codes or all Adaptive ABA codes, so long as the set of codes chosen is for the PRIMARY targeted behaviors.
Skilled ABA behavior instructors (BIs), BCaBAs or BCBAs will provide direct treatment
The school/educational setting needs to have been contacted in order to determine services provided in the school setting and coordination is expected
Treatment plan is required to include parent/caregiver training and support (which should be coded as 0370T or 0371T if given in a group format)
Follow-up assessment will be coded as 0362T/0363T (for Exposure Behavior ABA) and/or 0360T/0361T (for Adaptive Behavior ABA)
‘Supervision codes,’ 0373T/0374T for Exposure ABA and 0368T/0369T for Adaptive ABA, must be included, and supervision must be conducted by a BCBA or BCaBA with the member (patient) present
All reports generated must be reviewed and signed by a BCBA (even if written by a BCaBA)

Request for Initial ABA Treatment

Prior authorization requests for ABA treatment require the following:

- Completed initial evaluation report with the above elements
- Number of units requested
- Re-evaluation after six months
- For any further treatment beyond six months, targeted behaviors are graphed and a VB-MAPP Transition Scoring Form be completed during the first month of treatment (see below for details)
- ABA hours requested will be for time of treatment outside of the school setting (i.e., home or office setting), so that the school is responsible for ABA provided by an aide throughout the school day. For example, if 10 hours of direct 1:1 ABA service is approved by BCBSVT, it is expected that a similar amount will be provided in the school setting. If the child is between the ages of birth to 5 years old, then BCBSVT will approve a greater amount of hours as outlined in the below table.

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Maximum units considered medically necessary</th>
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<tbody>
<tr>
<td>0364T + 0365T + 0370T</td>
<td>&lt;3 year old: 30 hours per week</td>
</tr>
<tr>
<td>(combined total)</td>
<td>3-5 year old: 20 hours per week</td>
</tr>
<tr>
<td></td>
<td>&gt; 5 year old: 10 hours per week</td>
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<tr>
<td>0371T</td>
<td>1 per week</td>
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<tr>
<td>0373T + 0374T + 0369T</td>
<td>2 units per 10 hours direct service (0364T + 0365T + 0370T)</td>
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<tr>
<td>0362T + 0363T</td>
<td>120 units per 6 months</td>
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Prior authorization request for continued treatment for an additional six months (for a total of 12 months at the end of the authorization)

- Within one month of the end date of the treatment for authorization, a new PA form needs to be submitted
- A decision should be made as to whether the PRIMARY targeted behaviors of ABA will be either with Exposure Behaviors (aggressive or self-injurious behaviors, property destruction, and/or disruptive behaviors) or Adaptive Behaviors (social skills, communication, and/or repetitive behaviors that
impede communication, such as self-stimulation), and the corresponding codes requested

- Supporting documentation needs to include: graphs of focused negative behavior goals (“exposure ABA” behaviors) and focused positive behavior goals (“adaptive ABA” behaviors), with at least monthly intervals (on the x axis)
- A summary of the services being provided in the educational setting. If there are no services being provided in the educational setting, a detailed description of why services are not provided in that setting, including whether a formal request was made by the parent/guardian of the member
- A summary of parent training progress
- A completed VB-MAPP Transition Scoring Form. For children greater than 48 months old, the VB-MAPP Milestones Assessment Score may be omitted from the Transition Scoring Form if it is felt to be inappropriate for the developmental level of the member (please note as such); if the member is greater than 48 months old, and he/she is diagnosed with ASD, Level 1 by DSM-5 criteria, then he/she will likely not be appropriate for the VB-MAPP Milestones Assessment Score.
- ABA hours requested will be for time of treatment outside of the school setting (i.e. home or office setting), so that the school is responsible for ABA provided by an aide throughout the school day. For example, if 10 hours of direct 1:1 ABA service is approved by BCBSVT, it is expected that a similar amount will be provided in the school setting. If the child is between the ages of birth to 3 years old, then BCBSVT will approve a greater amount of hours as outlined in the below table.

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Maximum units considered medically necessary</th>
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<tbody>
<tr>
<td>0364T + 0365T + 0370T (combined total)</td>
<td>&lt;3 year old: 30 hours per week&lt;br&gt;3-5 year old: 20 hours per week&lt;br&gt;&gt; 5 year old: 10 hours per week</td>
</tr>
<tr>
<td>0371T</td>
<td>1 per week</td>
</tr>
<tr>
<td>0373T + 0368T + 0369T</td>
<td>2 units per 10 hours direct service (0364T + 0365T + 0370T)</td>
</tr>
<tr>
<td>0362T + 0363T</td>
<td>60 units per 6 months</td>
</tr>
</tbody>
</table>

Medical necessity criteria (improvements are from baseline to endpoint -- approx. 5-6 months after baseline):

- The expectation is that there is at least a 20 percent decline in negative (“exposure ABA”) behaviors from the first month of collecting data, as evidenced by focused goal graph charting, and/or
- The expectation is that there is at least a 20 percent increase in positive (“adaptive ABA”) behaviors from the first month of collecting data, as evidenced by focused goal graph charting.
- The expectation is that there is at least a 20 percent improvement in a summary score of the VB-MAPP Transition Scoring Form.
- If the above focused goal behavior improvements have not occurred, an explanation needs to be provided in the treatment plan, and adjustments to the treatment plan need to be outlined.

Request for continued treatment at the end of 12 months total
• Within one month of the end date of the treatment for authorization, a new PA form needs to be submitted.
• A decision should be made as to whether the PRIMARY targeted behaviors of ABA will be either with Exposure Behaviors (aggressive or self-injurious behaviors, property destruction, and/or disruptive behaviors) or Adaptive Behaviors (social skills, communication and repetitive behaviors that impede communication, such as self-stimulation), and the corresponding codes requested.
• Supporting documentation needs to include graphs of focused negative behavior goals ("exposure ABA" behaviors) and focused positive behavior goals ("adaptive ABA" behaviors), with at least monthly intervals (on the x axis).
• A summary of the services being provided in the educational setting. If there are no services being provided in the educational setting, a detailed description of why services are not provided in that setting, including whether a formal request was made by the parent/guardian of the member.
• A summary of parent training progress.
• A completed VB-MAPP Transition Scoring Form. For children greater than 48 months old, the VB-MAPP Milestones Assessment Score may be omitted from the Transition Scoring Form if it is felt to be inappropriate for the developmental level of the member (please note as such); if the member is greater than 48 months old, and he/she is diagnosed with ASD, Level 1 by DSM-5 criteria, then he/she will likely not be appropriate for the VB-MAPP Milestones Assessment Score.
• ABA hours requested will be for time of treatment outside of the school setting (i.e. home or office setting), so that the school is responsible for ABA provided by an aide throughout the school day. For example, if 10 hours of direct 1:1 ABA service is approved by BCBSVT, it is expected that a similar amount will be provided in the school setting. If the child is between the ages of birth to 3 years old, then BCBSVT will approve a greater amount of hours as outlined in the below table.

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Maximum units considered medically necessary</th>
</tr>
</thead>
<tbody>
<tr>
<td>0364T + 0365T + 0370T (combined total)</td>
<td>&lt;3 year old: 30 hours per week  3-5 year old: 20 hours per week  &gt; 5 year old: 10 hours per week</td>
</tr>
<tr>
<td>0371T</td>
<td>1 per week</td>
</tr>
<tr>
<td>0373T + 0374T + 0368T + 0369T</td>
<td>2 units per 10 hours direct service (0364T + 0365T + 0370T)</td>
</tr>
<tr>
<td>0362T + 0363T</td>
<td>60 units per 6 months</td>
</tr>
</tbody>
</table>

Medical necessity criteria (improvements are from baseline to endpoint -- approx. 11-12 months after baseline):

• The expectation is that there is at least a 40 percent decline in negative ("exposure ABA") behaviors from the first month of collecting data, as evidenced by focused goal graph charting, and/or
• The expectation is that there is at least a 40 percent increase in positive ("adaptive ABA") behaviors from the first month of collecting data, as evidenced by focused goal graph charting.
• The expectation is that there is at least a 40% improvement in a summary score of the VB-MAPP Transition Scoring Form.
• If the above focused goal behavior improvements have not occurred, an explanation needs to be provided in the treatment plan, and adjustments to the treatment plan need to be outlined.

Request for continued treatment at the end of 18 months total (and every six months thereafter if further treatment is considered medically necessary)

• Within one month of the end date of the treatment for authorization, a new PA form needs to be submitted
• A decision should be made as to whether the PRIMARY targeted behaviors of ABA will be either with Exposure Behaviors (aggressive or self-injurious behaviors, property destruction, and/or disruptive behaviors) or Adaptive Behaviors (social skills, communication and repetitive behaviors that impede communication, such as self-stimulation), and the corresponding codes requested
• Supporting documentation needs to include: graphs of focused negative behavior goals (“exposure ABA” behaviors) and focused positive behavior goals (“adaptive ABA” behaviors), with at least monthly intervals (on the x axis)
• A summary of the services being provided in the educational setting. If there are no services being provided in the educational setting, a detailed description of why services are not provided in that setting, including whether a formal request was made by the parent/guardian of the member
• A summary of parent training progress
• A completed VB-MAPP Transition Scoring Form. For children greater than 48 months old, the VB-MAPP Milestones Assessment Score may be omitted from the Transition Scoring Form if it is felt to be inappropriate for the developmental level of the member (please note as such); if the member is greater than 48 months old, and he/she is diagnosed with ASD, Level 1 by DSM-5 criteria, then he/she will likely not be appropriate for the VB-MAPP Milestones Assessment Score.
• ABA hours requested will be for time of treatment outside of the school setting (i.e., home or office setting), so that the school is responsible for ABA provided by an aide throughout the school day. For example, if 10 hours of direct 1:1 ABA service is approved by BCBSVT, it is expected that a similar amount will be provided in the school setting. If the child is between the ages of birth to 3 years old, then BCBSVT will approve a greater amount of hours as outlined in the below table.

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Maximum units considered medically necessary</th>
</tr>
</thead>
</table>
| 0364T + 0365T + 0370T (combined total) | <3 year old: 30 hours per week  
3-5 year old: 20 hours per week  
> 5 year old: 10 hours per week |
| 0371T                          | 1 per week                                                                             |
| 0373T + 0374T +0368T+0369T     | 2 units per 10 hours direct service (0364T + 0365T + 0370T)                           |
| 0362T+0363T                    | 60 units per 6 months                                                                  |
Medical necessity criteria (improvements are from baseline to endpoint -- approx. 17-18 months, or longer, after baseline):

- The expectation is that there is at least a 75 percent decline in negative ("exposure ABA") behaviors from the first month of collecting data, as evidenced by focused goal graph charting, and/or
- The expectation is that there is at least a 75 percent increase in positive ("adaptive ABA") behaviors from the first month of collecting data, as evidenced by focused goal graph charting.
- The expectation is that there is at least a 75 percent improvement in a summary score of the VB-MAPP Transition Scoring Form.
- If the above focused goal behavior improvements have not occurred, an explanation needs to be provided in the treatment plan, and adjustments to the treatment plan need to be outlined.

Developmental disorders typically do not follow a linear path of acquisition of new skills, and are prone to temporary regression to old disruptive or less adaptive behaviors. The ABA approaches, which are also taught to caregivers (parents or legal guardians) and to school aides (if applicable), should enable these persons to approach the individual with an ASD (or moderate/severe ID) with behavioral techniques to manage these fluctuations, without the intensity of ABA. Of course, should these approaches fail, a behavioral re-assessment by a BCBA may be medically necessary. Therefore, there are likely to be some residual targeted behaviors upon treatment completion of the intense ABA as outlined in this policy. However, behavioral treatment plans may be reviewed and adjusted in standard (typically weekly) psychotherapy visits, which do not require a prior authorization for medical necessity.

**When service or procedure may be eligible**

**MANAGEMENT OF ASD**

The following components for the management of ASD may be considered medically necessary when the specified medical criteria apply.

**PHYSICAL, OCCUPATIONAL AND/OR SPEECH THERAPY**

In accordance with the terms defined in the applicable medical policies, benefit contracts on these topics, or where a state mandate provides for such coverage, physical, occupational and/or speech therapy may be considered medically necessary when all of the following criteria are met.

- The individual has a documented *DSM-5* diagnosis of ASD and/or moderate to severe intellectual disability
- 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 autism
spectrum disorder. 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, as treatment for eligible diagnoses in this
policy through age 21, is not subject to the combined 30 visit limit as outlined in
the Plan’s medical policies 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 months. In order for benefits for PT, OT or ST to continue beyond the initial
six-month period (or sooner if a shorter duration of need is determined in the
initial evaluation), the provider must submit a progress report containing all
applicable information outlined in the medical policies for PT, OT and ST services.
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.

If the following circumstances exist, authorization for continued PT, OT and/or ST
services will not be approved and the services will be considered not medically
necessary:

• 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 at least three months of optimal
treatment.
  o Changes must be sustained over time beyond the end of the actual
treatment session and generalizable outside of the treatment setting to
the individual’s residence and to the larger community of the
individual.
• The individual has achieved adequate stabilization of functions and/or the
challenging behavior(s), and less-intensive modes of therapy are appropriate.
  o It is appropriate to request 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.
Habilitation Services

Habilitation 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 services, including devices, are provided for a person to attain a skill or function never learned or acquired due to a disabling condition. Rehabilitation services, including devices, on the other hand, are provided to help a person regain, maintain or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury, or disabling condition.

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 measureable progress toward functional improvement goals. Measurement methods must be valid, reliable, repeatable and evidence-based.

Initial benefits for habilitation and rehabilitation services may be considered medically necessary when the criteria in this policy apply.

The following services are excluded from benefits under our certificates of coverage: custodial care, vocational, recreational and educational services, and services that show no likelihood of improvement and/or no therapeutic benefit.

Additional habilitative and rehabilitative services are 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.

When a service or procedure is not covered

Physical, Occupational and Speech Therapy
Habilitation PT, OT and ST services are considered investigational for treatment of ASD for individuals over the age of 21 years because published scientific literature does not support their effectiveness. PT, OT and/or ST may be eligible for members over the age of 21 years diagnosed with ASD if they meet medical necessity criteria for PT, OT and/or ST for other diagnoses where these therapies may be indicated. (Please refer to BCBSVT medical policies on PT, OT and ST).

Neuropsychological Testing (NPT)
NPT is considered not medically necessary and, therefore, not covered for ASD 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 coverage.

Other services and procedures that are standard benefit **contract exclusions** for most of the Plan’s products and are not eligible for coverage:

- Services beyond those needed to restore the ability to perform Activities of Daily Living (see Definitions) or to establish or re-establish the capability to perform occupational, hobby, sport or leisure activities.
- Care for which there is no therapeutic benefit or likelihood of improvement.
- 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.
- Services, including modalities, that do not require the constant attendance of a provider.
- Art therapy.
- Cognitive rehabilitation.
- Music therapy and rhythmic entrainment interventions.
- 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.).
- Vision therapy.

The Plan considers the following to be experimental and/or investigational in the screening or treatment of autism spectrum disorders because the safety and/or efficacy of these diagnostic services, therapies and treatments when used in the management of ASD cannot be established by review of the available published peer-reviewed literature and are NOT covered. These include but are not limited to:

- Allergy testing (including, but not limited to, food allergies for gluten, casein, and/or candida and other molds).
- Chelation therapy.
- Electronystagmography (in the absence of dizziness, vertigo or a balance disorder).
- Developmental, Individual Difference, Relationship-based Model (DIR), DIRFloortime.
- 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 [IVlg]
• Intestinal permeability studies.
• Magnetoencephalography.
• Neuroimaging studies such as: CT, MRI, MRS, PET, SPECT, and Functional MRI (Please see BCBSVT Policy on Radiology).
• Oxytocin (intranasal or other route of administration).
• 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 LiFT™; The Listening Program.
• Squeeze machine therapy.
• Social skills training programs (except social skills training within ABA), including social skills groups and social story programs.
• 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, and immunologic or neurochemical abnormalities.
• Tympanometry (in the absence of hearing loss).

Administrative & Guidance

Benefit Application

Prior approval is required for services outlined in this policy. Subject to the terms and conditions of the applicable benefit contract, evaluation for ASD and moderate to severe ID 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, not medically necessary, and contract exclusions 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 Autism Spectrum Disorder. 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.

Limitations to this benefit apply. Member’s benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this medical policy. Benefits are subject to all terms, limitations and conditions of the subscriber contract.
Refer to the member’s plan documents or outline of coverage for availability of benefits and to determine if prior approval is required for services outlined in this policy.

If the member receives benefits through a self-funded group, benefits may vary or not apply. To verify benefit information, please refer to the member’s plan documents or contact the customer service department.

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

Federal Employee Program (FEP) members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP plan brochure.

State mandates and contractual exclusions may apply to coverage eligibility.

For New England Health Plan (NEHP) members an approved referral authorization is required.

Prior authorization is not required for emergency hospitalization or crisis evaluation. Prior authorization is not required for general outpatient psychiatric/psychological services unless otherwise specified in this policy.

In order to obtain prior authorization use the Prior Authorization/Pre-Certification form available at the BCBSVT provider portal and fax your request to the integrated health management department at (802) 371-3491. Failure to obtain prior authorization may result in a denial of benefits. NOTE: Prior authorization is not required for the initial screening and/or diagnostic assessments for ASD and/or moderate or severe ID.

To qualify for benefits, the member must be between the ages of birth to 21 years of age.

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.
TREATMENT PLAN DOCUMENTATION

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

Significant history

- Diagnosis of ASD and/or moderate or severe intellectual disability 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 and 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
- A brief summary of efforts to coordinate care with schools or special education departments
- When appropriate, a summary of past services and the results achieved

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
Eligible Providers

Medical Doctor-MD
Doctor of Osteopathy-DO
Occupational Therapists-OT
Physical Therapists-PT
Speech Therapists-ST
Clinical Psychologists-Ph.D.
Licensed Clinical Social Workers-LCSW
Board Certified Behavior Analysts (BCBA)
Board Certified Assistant Behavior Analysts (BCaBA or BCABA)
Skilled ABA Behavior Instructors (BI) (under close supervision of a BCBA)

Document Precedence

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 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 language, the member’s contract 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.

Legislative Guidelines

8 V.S.A. § 4088i

Related Policies

Occupational Therapy
Physical Therapy
Speech Therapy
Pediatric Neurodevelopmental Testing
Neuropsychological Testing
Early Childhood Developmental Disorders

Policy Implementation/Update information

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/2011</td>
<td>New Policy</td>
</tr>
</tbody>
</table>
Billing and Coding/Physician Documentation Information

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

Attachment I - CPT/HCPCS Code List & Instructions
Attachment II- ICD Code List & Instructions
Attachment III- American College of Medical Genetics Guideline

Please see attachments I and II for coding information. In order for claims to process correctly for PT, OT and ST services according to this policy, the diagnosis codes specific to in attachment II must be listed as the primary diagnosis code.

Health Care Procedure Coding System (HCPCS) codes related to chemotherapy drugs, drugs administered other than oral method, and enteral/parenteral formulas may be subject to National Drug Code (NDC) processing and pricing. The use of NDC on medical claims helps facilitate more accurate payment and better management of drug costs based on what was dispensed and may be required for payment. For more information on BCBSVT requirements for billing of NDC please refer to the provider portal http://www.bcbsvt.com/provider-home latest news and communications.

Scientific Background and Reference Resources


In addition to the resources outlined above, input was obtained from SD Associates in Williston, Vermont, and the Howard Center in Burlington, VT. BCBSVT is very grateful for the information provided by these providers. However, these collaborations should not be interpreted as an endorsement of any aspect of this medical policy by any agency, or individual provider.

Approved by Medical Policy Committee Date Approved

John Koutras, MD
Medical Director, VCC

Robert Wheeler, MD
Chief Medical Officer

Attachment I
CPT/HCPCS Code List & Instructions

<table>
<thead>
<tr>
<th>Code Type</th>
<th>Number</th>
<th>Description</th>
<th>Policy Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>The following codes will be considered as medically necessary when applicable criteria have been met.</td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Requires Prior Authorization, with the exception of the initial comprehensive evaluation. See BCBSVT medical policy on occupational therapy for further guidelines.</td>
<td></td>
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<tr>
<td>----------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
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<tr>
<td>Outpatient Occupational Therapy</td>
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<tr>
<td>Outpatient Physical Therapy</td>
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<tr>
<td>Outpatient Speech Therapy</td>
<td></td>
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<tr>
<td>Vision Evaluation</td>
<td>See BCBSVT medical policy for vision services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPT 81228</td>
<td>Cytogenomic constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number variants (e.g., bacterial artificial chromosome [BAC] or oligo-based comparative genomic hybridization [CGH] microarray analysis)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPT 81229</td>
<td>Cytogenomic constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number and single nucleotide polymorphism (SNP) variants for chromosomal abnormalities Genetic Testing to identify associated conditions of ASD, limited to those with a suspicious family or medical history of genetic condition associated with ASD, intellectual disability, and/or dysmorphic features as defined in this policy.</td>
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<td></td>
</tr>
<tr>
<td>CPT</td>
<td>Code</td>
<td>Description</td>
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<tr>
<td>81243</td>
<td>FMR1 (fragile X mental retardation 1) (e.g., fragile X mental retardation) gene analysis; evaluation to detect abnormal (e.g., expanded) alleles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>81244</td>
<td>81244- FMR1 (fragile X mental retardation 1) (e.g., fragile X mental retardation) gene analysis; characterization of alleles (e.g., expanded size and methylation status)</td>
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</tr>
<tr>
<td>83655</td>
<td>Chemistry: Lead</td>
<td></td>
<td></td>
</tr>
<tr>
<td>84030</td>
<td>Chemistry: Phenylalanine (PKU) blood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>88245</td>
<td>Chromosome analysis for breakage syndromes; Baseline Sister Chromatid Exchange (SCE) 20-25 cells</td>
<td></td>
<td></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 telangetasia, Fanconi anemia, fragile X)</td>
<td></td>
<td></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) Genetic Testing to identify associated conditions of ASD, limited to those with a suspicious family or medical history of genetic condition associated with ASD, intellectual disability, and/or dysmorphic features as defined in this policy.</td>
<td></td>
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<tr>
<td>88261</td>
<td>Chromosome analysis; count 5 cells, 1 karyotype, with banding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>88262</td>
<td>Chromosome analysis; count 15-20 cells, 2 karyotypes, with banding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>88263</td>
<td>Chromosome analysis; count 45 cells for mosaicism, 2 karyotypes, with banding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>88264</td>
<td>Chromosome analysis; analyze 20-25 cells</td>
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<tr>
<td>CPT</td>
<td>Code</td>
<td>Description</td>
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<td></td>
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<tr>
<td>CPT</td>
<td>95812</td>
<td>Electroencephalogram (EEG) extended monitoring; 41-60 minutes</td>
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<tr>
<td>CPT</td>
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<td>Electroencephalogram (EEG) extended monitoring; &gt; 1 hour</td>
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<tr>
<td>CPT</td>
<td>95816</td>
<td>Electroencephalogram (EEG); including recording awake and drowsy</td>
<td></td>
</tr>
<tr>
<td>CPT</td>
<td>95819</td>
<td>Electroencephalogram (EEG); including recording awake and asleep</td>
<td></td>
</tr>
<tr>
<td>CPT</td>
<td>96040</td>
<td>Medical Genetics and Genetic Counseling services, each 30 minutes face-to-face with patient/family</td>
<td></td>
</tr>
<tr>
<td>CPT</td>
<td>96110</td>
<td>Developmental screening, with interpretation and report, per standardized instrument form</td>
<td></td>
</tr>
<tr>
<td>CPT</td>
<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>
<td></td>
</tr>
<tr>
<td>CPT</td>
<td>96116</td>
<td>Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., 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>
<td></td>
</tr>
<tr>
<td>CPT</td>
<td>97532</td>
<td>Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>-------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>0359T</td>
<td>Behavioral identification assessment, by the physician or other qualified health care professional, face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of finding and recommendations with the primary guardian(s)/caregiver(s), and preparation of report</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prior Approval is not required for this service. Medically necessary up to 4 hours.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CPT</th>
<th>0360T</th>
<th>Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; first 30 minutes of technician time, face-to-face with the patient</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0361T</td>
<td>Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; each additional 30 minutes of technician time, face-to-face with the patient (List separately in addition to codes for primary service)</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>0362T</td>
<td>Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; first 30 minutes of technician(s) time, face-to-face with the patient</td>
<td></td>
</tr>
<tr>
<td>0363T</td>
<td>Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; each additional 30 minutes of technician time, face-to-face with the patient (List separately in addition to codes for primary service)</td>
<td></td>
</tr>
<tr>
<td>0364T</td>
<td>Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; first 30 minutes of technician time</td>
<td></td>
</tr>
<tr>
<td>0365T</td>
<td>Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; each additional 30 minutes of technician time (List separately in addition to codes for primary service)</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>0368T</td>
<td>Adaptive behavior treatment with protocol modification administered by physician or other qualified health professional with one patient; first 30 minutes of patient face-to-face time</td>
<td></td>
</tr>
<tr>
<td>0369T</td>
<td>Adaptive behavior treatment with protocol modification administered by physician or other qualified health professional with one patient; each additional 30 minutes of patient face-to-face time (List separately in addition to code for primary procedure)</td>
<td></td>
</tr>
<tr>
<td>0370T</td>
<td>Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)</td>
<td></td>
</tr>
<tr>
<td>0371T</td>
<td>Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)</td>
<td></td>
</tr>
<tr>
<td>0373T</td>
<td>Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); first 60 minutes of technicians' time, face-to-face with patient</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>0374T</td>
<td>Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); each additional 30 minutes of technicians' time face-to-face with patient (List separately in addition to code for primary procedure)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>S0265</th>
<th>Genetic Counseling, under physician supervision, each 15 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCPCS</td>
<td>S9128</td>
<td>Speech Therapy, in the home, per diem</td>
</tr>
<tr>
<td>HCPCS</td>
<td>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 (e.g., 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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Will be denied as not medically necessary</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CPT</th>
<th>96119</th>
<th>Neuropsychological testing (e.g., 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</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Will be denied as not medically necessary</td>
</tr>
<tr>
<td>CPT</td>
<td>96120</td>
<td>Neuropsychological testing (e.g., Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report</td>
</tr>
<tr>
<td>--------</td>
<td>-------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>CPT</td>
<td>90283</td>
<td>Immune globulin (IVlg), human, for intravenous use</td>
</tr>
<tr>
<td>CPT</td>
<td>97039</td>
<td>Unlisted modality (specify type and time if constant attendance)/ Hippotherapy</td>
</tr>
<tr>
<td>CPT</td>
<td>97139</td>
<td>Unlisted therapeutic procedure (specify)/Auditory Integrative training or Facilitative communication</td>
</tr>
<tr>
<td>CPT</td>
<td>97139</td>
<td>Unlisted therapeutic procedure (specify)/Hippotherapy</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>
</tr>
<tr>
<td>CPT</td>
<td>97799</td>
<td>Unlisted physical medicine/rehabilitation service or procedure/Hippotherapy</td>
</tr>
<tr>
<td>CPT</td>
<td>99183</td>
<td>Physician attendance and supervision of hyperbaric oxygen therapy; per session</td>
</tr>
<tr>
<td>HCPCS</td>
<td>G0277</td>
<td>Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval</td>
</tr>
<tr>
<td>HCPCS</td>
<td>J1557</td>
<td>Injection, immune globulin, (Gammaplex), intravenous, non-lyophilized (e.g., liquid), 500mg</td>
</tr>
<tr>
<td>HCPCS</td>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>--------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>G0176</td>
<td></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>
</tr>
<tr>
<td>J0470</td>
<td></td>
<td>Injection, dimercaprol, per 100 mg (BAL in oil)</td>
</tr>
<tr>
<td>J0600</td>
<td></td>
<td>Injection, edetate calcium disodium up to 1,000 mg</td>
</tr>
<tr>
<td>J0895</td>
<td></td>
<td>Injection, deferoxamine mesylate, 500 mg (Desferal)</td>
</tr>
<tr>
<td>J1459</td>
<td></td>
<td>Injection, immune globulin (Privigen), intravenous, non-lyophilized (e.g. liquid), 500 mg</td>
</tr>
<tr>
<td>J1561</td>
<td></td>
<td>Injection, immune globulin, (Gamunex), intravenous, non-lyophilized (e.g., liquid), 500 mg</td>
</tr>
<tr>
<td>J1566</td>
<td></td>
<td>Injection, immune globulin, intravenous, lyophilized (e.g., powder), not otherwise specified, 500 mg</td>
</tr>
<tr>
<td>J1568</td>
<td></td>
<td>Injection, immune globulin, (Octagam), intravenous, non-lyophilized (e.g., liquid), 500 mg</td>
</tr>
<tr>
<td>J1569</td>
<td></td>
<td>Injection, immune globulin, (Gammagard liquid), intravenous, non-lyophilized (e.g., liquid), 500 mg</td>
</tr>
<tr>
<td>J1572</td>
<td></td>
<td>Injection, immune globulin, (Flebogamma/Flebo gamma DIF), intravenous, non-lyophilized (e.g., liquid); 500 mg</td>
</tr>
<tr>
<td>J1599</td>
<td></td>
<td>Injection, immune globulin, intravenous, non-lyophilized (e.g. liquid), not otherwise specified, 500 mg</td>
</tr>
<tr>
<td>HCPCS</td>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>--------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>J2850</td>
<td></td>
<td>Injection, Secretin, synthetic, human, 1mcg</td>
</tr>
<tr>
<td>J3520</td>
<td></td>
<td>Edetate disodium, per 150 mg</td>
</tr>
<tr>
<td>M0300</td>
<td></td>
<td>IV chelation therapy</td>
</tr>
<tr>
<td>S3870</td>
<td></td>
<td>Comparative Genomic Hybridization (CGH) Microarray Testing</td>
</tr>
<tr>
<td>S8940</td>
<td></td>
<td>Equestrian /Hippotherapy, per session</td>
</tr>
<tr>
<td>S9355</td>
<td></td>
<td>Home infusion therapy, chelation therapy;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>administrative services, professional pharmacy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>services, care coordination, and all necessary</td>
</tr>
<tr>
<td></td>
<td></td>
<td>supplies and equipment, per diem</td>
</tr>
<tr>
<td>S9338</td>
<td></td>
<td>Home infusion therapy, immunotherapy,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>administrative services, professional pharmacy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>services, care coordination, and all necessary</td>
</tr>
<tr>
<td></td>
<td></td>
<td>supplies and equipment (drugs and nursing visits</td>
</tr>
<tr>
<td></td>
<td></td>
<td>coded separately), per diem</td>
</tr>
<tr>
<td>0413</td>
<td></td>
<td>Hyperbaric oxygen therapy</td>
</tr>
</tbody>
</table>

022015RLG

Attachment II
ICD Code List & Instructions
The following diagnoses codes will be considered as medically necessary when applicable criteria have been met.

<table>
<thead>
<tr>
<th>Code Type</th>
<th>Number</th>
<th>Description</th>
<th>Policy Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-9</td>
<td>299.00-299.01</td>
<td>Autism Spectrum Disorder</td>
<td></td>
</tr>
<tr>
<td>ICD-9</td>
<td>299.10-299.11</td>
<td>Childhood Disintegrative Disorder</td>
<td></td>
</tr>
<tr>
<td>ICD-9</td>
<td>299.80-299.81</td>
<td>Other Specified Pervasive Developmental Disorders (Asperger’s disorder)</td>
<td></td>
</tr>
<tr>
<td>ICD-9</td>
<td>299.90-299.91</td>
<td>Unspecified Pervasive Developmental Disorder</td>
<td></td>
</tr>
<tr>
<td>ICD-9</td>
<td>318.0</td>
<td>Intellectual Disability- Moderate</td>
<td></td>
</tr>
<tr>
<td>ICD-9</td>
<td>318.1</td>
<td>Intellectual Disability- Severe</td>
<td></td>
</tr>
<tr>
<td>ICD-9</td>
<td>330.8</td>
<td>Other Specified Cerebral Degenerations in Childhood (Rett’s syndrome)</td>
<td></td>
</tr>
<tr>
<td>ICD-10</td>
<td>F71</td>
<td>Intellectual Disability- Moderate</td>
<td>Effective: 10/1/2015</td>
</tr>
<tr>
<td>ICD-10</td>
<td>F72</td>
<td>Intellectual Disability- Severe</td>
<td>Effective: 10/1/2015</td>
</tr>
<tr>
<td>ICD-10</td>
<td>F84.0</td>
<td>Autistic Disorder</td>
<td>Effective: 10/1/2015</td>
</tr>
<tr>
<td>ICD-10</td>
<td>F84.2</td>
<td>Rett’s Syndrome</td>
<td>Effective: 10/1/2015</td>
</tr>
<tr>
<td>ICD-10</td>
<td>F84.3</td>
<td>Other Childhood Disintegrative Disorder</td>
<td>Effective: 10/1/2015</td>
</tr>
<tr>
<td>ICD-10</td>
<td>F84.5</td>
<td>Asperger's Syndrome</td>
<td>Effective: 10/1/2015</td>
</tr>
<tr>
<td>ICD-10</td>
<td>F84.8</td>
<td>Other Pervasive Developmental Disorders</td>
<td>Effective: 10/1/2015</td>
</tr>
<tr>
<td>ICD-10</td>
<td>F84.9</td>
<td>Pervasive Developmental Disorder, Unspecified</td>
<td>Effective: 10/1/2015</td>
</tr>
</tbody>
</table>

Place of Service: Office, Outpatient

Attachment III

Definitions, from the American College of Medical Genetics Guideline, Evaluation of the Newborn with Single or Multiple Congenital Anomalies (12):
- A malformation refers to abnormal structural development.
- A major malformation is a structural defect that has a significant effect on function or social acceptability. Example: ventricular septal defect or a cleft lip.
- A minor malformation is a structural abnormality that has minimal effect on function or societal acceptance. Examples: preauricular ear pit or partial syndactyly (fusion) of the second and third toes.
- A syndrome is a recognizable pattern of multiple malformations. Syndrome diagnoses are often relatively straightforward and common enough to be clinically recognized without specialized testing. Examples include Down syndrome, neural tube defects and achondroplasia. However, in the very young, or in the case of syndromes with variable presentation, confident identification may be difficult without additional testing.