

Clinical Policy: Autism Spectrum Disorder Treatment



Reference Number: QCP.CP.044
Effective Date: 03/01/2021
Date of Last Revision: 03/01/2021

CPT Codes: 90283, 90832, **90833**, 90834, 90836, **90837**, **90838**, **90839**, 90840, 90847, 90863, 90870, 92507, 97001, **97002**, **97003**, 97004, 97112, 97113, 97116, 97124, 97127, 97129, 97130, 97139, 97161, **97162**, **97163**, **97164**, **97165**, **97166**, **97167**, 97168, 97530, 97533, 97535, 98925, **98926**, **98927**, **98928**, 98929, 98940, **98941**, 98942, 99183, G0277, J0470, J0600, J0895, J1459, J1557, J1561, J1566, J1568, J1569, J1572, J1599, J2850, J3520, M0300, S8940, S9338, S9355
Document: BI184:13

Public Statement

Effective Date:

- a) This policy will apply to all services performed on or after the above revision date which will become the new effective date.
- b) For all services referred to in this policy that were performed before the revision date, contact customer service for the rules that would apply.

- 1) The treatment and diagnosis of Autism Spectrum Disorders are generally covered but many therapies require preauthorization and periodic re-evaluation (as with any therapy) to review the updated treatment plan, goals and documented benefits of interventions. Preauthorization for further treatments will be based on the information provided in the periodic re-evaluation.
- 2) For Applied Behavior Analysis, please see BI322.

Medical Policy Statement:

1. The diagnosis and treatment of Autism Spectrum Disorder (ASD) will be covered. However, many therapies must be preauthorized and require periodic re-evaluation (as with any therapy) to review the updated treatment plan, goals and documented benefits of interventions. Preauthorization for further treatments will be based on the information provided in the periodic re-evaluation.
2. Definitions:
 - **Autism Spectrum Disorder** – Any of the pervasive developmental disorders as defined by the “Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition”, including:
 - (A) Autistic Disorder

Clinical Policy: Autism Spectrum Disorder Treatment

- (B) Asperger's Disorder and
 - (C) Pervasive Developmental Disorder, not otherwise specified.
- **Diagnosis** – Medically necessary assessment, evaluations or tests to diagnose whether or not an individual has an Autism Spectrum Disorder (ASD). Diagnostic evaluations do not need to be completed concurrently to diagnose Autism Spectrum Disorder (ASD).
- **Treatment** –
 - (A) The following care prescribed, provided or ordered for a specific individual diagnosed with an Autism Spectrum Disorder (ASD) by a licensed physician or a licensed psychologist who determines the care to be medically necessary and evidence-based including without limitation:
 - (i) Applied Behavior Analysis (see B1322);
 - (ii) Pharmacy Care;
 - (iii) Psychiatric care;
 - (iv) Psychological care;
 - (v) Therapeutic care; and
 - (vi) Equipment determined necessary to provide evidence-based treatment
 - (B) Any care for an individual with Autism Spectrum Disorder (ASD) that is determined by a licensed physician to be:
 - (i) Medically necessary; and
 - (ii) Beneficial.
- **Applied Behavior Analysis** – The design, implementation, and evaluation of environmental modifications by a board certified behavior analyst using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

3. Coverage:

- Cannot limit the number of visits an individual may make to an autism services provider. However, despite no limit on the number of visits, many therapies must be preauthorized and require periodic re-evaluation (as with any therapy) review the updated treatment plan, goals and documented benefits of interventions. Preauthorization for further treatments will be based on the information provided in the periodic re-evaluation.
- Will be subject to other general exclusions and limitations, including without limitation:
 - (A) Coordination of benefits
 - (B) Participating provider requirements

Clinical Policy: Autism Spectrum Disorder Treatment

- (C) Restrictions on services provided by family or household members
 - (D) Utilization review of health care services including review of medical necessity, case management, and other managed care provisions.
 - For treatment under this section shall not be denied on the basis that the treatment is habilitative in nature.
- 1) The following CPT codes will not have visit limits when billed with diagnosis codes **F84.0, F84.3 and F84.5 – F84.8**:
 - a) **90832 – 90840** (Psychotherapy)
 - b) **90847** (Family psychotherapy)
 - c) **90863** (Pharmacologic management when performed with psychotherapy)
 - 2) The following codes will not have visit limits when provided by physical, occupational or speech therapists and billed with diagnosis codes **F84.0, F84.3 and F84.5 – F84.8**:
 - a) **92507** (Speech therapy)
 - b) **97161 – 97168** (PT/OT eval, re-eval)
 - c) 97112 (neuromusc reduce of mvmt, balance, coord, kinestheticsense, posture/proprioception for sitting/standing activities)
 - d) 97113 (aquatic therapy w/therapy exercises)
 - e) 97116 (gait training)
 - f) **97124** (massage, incl. effleurage, petrissage and/or tapotement)
 - g) 97139 (Unlisted therapeutic procedure (specify))
 - h) **97530** (Therapeutic activities)
 - i) 97533 – 97535 (Sensory integrative techniques, self-care mgmt training)
 - 3) However, despite no limit on the number of visits, all of the above codes with the accompanying diagnoses must be preauthorized and will require periodic re-evaluation (as with any therapy) to review the updated treatment plan, goals and documented benefits of interventions. Preauthorization for further treatments will be based on the information provided in the periodic re-evaluation.
 - 4) The following codes are *not covered* when billed with diagnosis codes **F84.0, F84.3, and F84.5 – F84.8**:
 - a) **90283** (Immune globulin (IgIV), human, IV use)
 - b) **97129** – Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, exec functions, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 min.
97130 – each add'l 15 min.
 - a) **98925 – 98929** (Osteopthc manip trmt (OMT) [when spec as manip of spnl rgns])

Clinical Policy: Autism Spectrum Disorder Treatment

- b) **98940 – 98942** (Chiropractic manip trtmt (CMT); spinal)
- c) **99183** (Physician attendance & supv of hyperbaric oxygen therapy; per session)
- d) **G0277** (Hyperbaric oxygen under pressure, full body chamber, per 30 mn intrvl)
- e) **J0470** (Dimercaprol Inj, per 100 mg (BAL in oil))
- f) **J0600** (Edetate calcium disodium Inj, up to 1,000 mg)
- g) **J0895** (Deferoxamine mesylate Inj (Desferal), 500 mg)
- h) **J1459** (Immune globulin Inj (Privigen), IV, non-lyophilized, 500 mg)
- i) **J1557** (Immune globulin Inj (Gammaplex), IV, non-lyophilized, 500 mg)
- j) **J1561** (Immune globulin Inj (Gamunex), IV, non-lyophilized, 500 mg)
- k) **J1566** (Immune globulin Inj, IV, lyophilized, not otherwise spec, 500 mg)
- l) **J1568** (Immune globulin Inj, (Octagam), IV, non-lyophilized, 500 mg)
- m) **J1569** (Immune globulin Inj, (Gammagard liquid), IV, non-lyophilized, 500 mg)
- n) **J1572** (Immune globulin Inj, (Flebogamma/Flebogamma DIF), IV, non-lyoph, 500 mg)
- o) **J1599** (Immune globulin Inj, IV, non-lyophilized, not otherwise specified, 500 mg)
- p) **J2850** (Secretin Inj, synthetic, human, 1 microgram)
- q) **J3520** (Edetate disodium, per 150 mg)
- r) **M0300** (IV chelation therapy)
- s) **S8940** (Equestrian/hippotherapy, per session)
- t) **S9338** (Hm infsn tx, immuno, admn/prof rx svcs, care coord & all nec supp/eqpt, per diem)
- u) **S9355** (Hm infsn tx, chelation tx; admin svcs, care coord & all nec sup/eqpt, per diem)
- v) **90870 (Electroconvulsive therapy)**
- w) **S9355** (Hm infsn tx, chelation tx; admin svcs, care coord & all nec sup/eqpt, per diem)
- x) **90870 (Electroconvulsive therapy)**

The following treatments or therapies are considered **investigational and not medically necessary** for the treatment of autism, Asperger's syndrome, Rett syndrome, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified (NOS):

- a) Chelation therapy
- b) Cognitive rehabilitation
- c) Elimination diets (e.g., gluten and milk elimination)
- d) Facilitated communication
- e) Immune globulin infusion
- f) Hyperbaric oxygen therapy
- g) Nutritional supplements (e.g., megavitamins, high-dose pyridoxine and magnesium, dimethylglycine)
- h) Pet therapy (e.g., Hippotherapy)
- i) Secretin infusion
- j) Spinal manipulation
- k) Vision therapy
- l) Electroconvulsive therapy

Clinical Policy: Autism Spectrum Disorder Treatment



Codes Used In This BI:

ACTIVE

- 90283 Immune globulin (IgIV), human, IV use
- 90832 Psychotherapy, 30 mn w/pt &/or family mbr
 - 90833 when perf w/E&M svc
- 90834 Psychotherapy, 45 min w/pt &/or family mbr
 - 90836 when perf w/E&M svc
- 90837 Psychotherapy, 60 min w/pt &/or family mbr
 - 90838 when perf w/E&M svc
- 90839 Psychotherapy for crisis; first 60 min
 - 90840 ea addtl 30 mn
- 90847 Family psychotherapy w/pt present
- 90863 Pharm mgmt, incl rx & rvw of meds, when perf w/psychotherapy svcs
- 90870 Electroconvulsive therapy
- 92507 Trtmt of speech, lang, voice, commun, &/or auditory proc disordr; indiv
- 97161 PT Evaluation: low complexity
- 97162 PT Evaluation: med complexity
- 97163 PT Evaluation: high complexity
- 97164 PT Re-evaluation
- 97165 OT Evaluation: low complexity
- 97166 OT Evaluation: med complexity
- 97167 OT Evaluation: med complexity
- 97168 OT Re-evaluation
- 97112 Therapeutic proc, 1+ areas, ea 15 mn; neuromusc re-ed of mvmt, balance, coord, kinesthetic sense, posture, &/or proprioception for sitting &/or standing activities
- 97113 Aquatic therapy w/therapeutic exercises
- 97116 Gait training (incl stair climbing)
- 97124 Massage, incl effleurage, petrissage &/or tapotement
- 97127 Therapeutic interventions that focus on cogn fnctn & compensatory strategies to manage perform of an activity, dir pt cntct (new code 1/1/18) (Deleted and replaced by 97129, 97130)
 - 97129** – Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, exec functions, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or

Clinical Policy: Autism Spectrum Disorder Treatment



- schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 min
- 97130** – each add'l 15 min.
- 97139 Unlisted therapeutic proc
- 97530 Therapeutic activities, dir pt contact, ea 15 mn
- 97533 Sensory intgrtv technq to enhance snsry prcsng & promote adaptive resp to envrnmtl demands, dir pt cntct, ea 15 mn
- 97535 Self-care/home mgmt training, dir pt contact, ea 15 mn
- 98925 Osteopathic manip trtmt (OMT); 1-2 body regions involved
- 98926 3-4 body regions involved
- 98927 5-6 body regions involved
- 98928 7-8 body regions involved
- 98929 9-10 body regions involved
- 98940 Chiropractic manip trtmt (CMT); spinal, 1-2 regions
- 98941 spinal, 3-4 regions
- 98942 spinal, 5 regions
- 99183 Physician attendance & supv of hyperbaric oxygen therapy; per session
- G0277 Hyperbaric oxygen under pressure, full body chamber, per 30 mn interval
- J0470 Dimercaprol Inj, per 100 mg (BAL in oil).
- J0600 Edetate calcium disodium Inj, up to 1,000 mg
- J0895 Deferoxamine mesylate Inj, 500 mg (Desferal)
- J1459 Immune globulin Inj (Privigen), IV, non-lyophilized, 500 mg
- J1557 Immune globulin Inj (Gammaplex), IV, non-lyophilized, 500 mg
- J1561 Immune globulin Inj (Gamunex), IV, non-lyophilized, 500 mg
- J1566 Immune globulin Inj , IV, lyophilized, NOS, 500 mg
- J1568 Immune globulin Inj (Octagam), IV, non-lyophilized, 500 mg
- J1569 Immune globulin Inj (Gammagard liquid), IV, non-lyophilized 500 mg
- J1572 Immune globulin Inj (Flebogamma/Flebogamma DIF), IV, non-lyophilized; 500 mg
- J1599 Inj, immune globulin, IV, non-lyophilized, NOS, 500 mg
- J2850 Inj, secretin, synthetic, human, 1 microgram
- J3520 Edetate disodium, per 150 mg
- M0300 IV chelation therapy
- S8940 Equestrian/hippotherapy, per session
- S9338 Home infusn tx, immunotherapy, admin svcs, prof rx svcs, care coord & all necess suppl/equip, per diem

Clinical Policy: Autism Spectrum Disorder Treatment



S9355 Home infusn tx, chelation therapy, admin svcs, care coord & all necess supp/eqpt, per diem

DELETED

97001 PT Evaluation (code deleted 1/1/17)

97002 PT Re-evaluation (code deleted 1/1/17)

97003 OT Evaluation (code deleted 1/1/17)

97004 OT Re-evaluation (code deleted 1/1/17)

97532 Dvlpmnt of cognitive skills to imprv attention, memory, prob solv, dir pt cntct, ea 15 mn (code deleted 1/1/18)

References:

Arkansas Act 196 of 2011

Addendum:

1. **Effective 04/01/2017:** Updated with periodic re-evaluation requirement in order to preauthorize continued treatment and ensure benefit from interventions.

Updated *Claim Statement & Codes Used in This BI* section to reflect new/deleted CPT codes. The following codes were deleted 1/1/17: 97001 – 97004. These codes were replaced with the following new codes effective 1/1/17: 97161 – 97168.

2. **Effective 1/1/2018:** 2018 Code Updates. Updated *Claim Statement & Codes Used in This BI* section to reflect new/deleted CPT codes. The following code was deleted 1/1/18: 97532. This code was replaced with the following new code effective 1/1/18: 97127.
3. **Effective 01/01/2020:** 2020 Code Updates – Code 97127 deleted and replaced by codes 97129 and 97130.
4. **Effective 03/01/2021:** Electroconvulsive therapy (90870) is considered E/I for Autism Spectrum Disorder.

Application to Products:

This policy applies to all group health plans and products administered by QualChoice, both those insured by QualChoice and those that are self-funded by the sponsoring employer, unless there is indication in this policy otherwise or a stated exclusion in your medical plan booklet. Consult the individual plan sponsor Summary Plan Description (SPD) for self-insured plans or the specific Evidence of Coverage (EOC) or Certificate of Coverage (COC) for those plans or products insured by QualChoice. In the event of a discrepancy between this policy and a self-insured customer's SPD or the specific QualChoice EOC or COC, the SPD, EOC, or COC, as applicable, will prevail. State and federal mandates will be followed as they apply.

Clinical Policy: Autism Spectrum Disorder Treatment



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Date: 12/14/2020