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*Missouri Care*

*'Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona*

*OneCare (Care1st Health Plan Arizona, Inc.)*

*Staywell of Florida*

*WellCare (Arizona, Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, Mississippi, Nebraska, New Jersey, New York, South Carolina, Tennessee, Texas)*

*WellCare Prescription Insurance*

*WellCare Texan Plus (Medicare – Dallas & Houston markets)*

## Therapy Services for Autism Spectrum Disorders (Medicaid Only)

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### APPLICATION STATEMENT

The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

### DISCLAIMER

The Clinical Coverage Guideline (CCG) is intended to supplement certain standard WellCare benefit plans and aid in administering benefits. Federal and state law, contract language, etc. take precedence over the CCG (e.g., Centers for Medicare and Medicaid Services [CMS] National Coverage Determinations [NCDs], Local Coverage Determinations [LCDs] or other published documents). The terms of a member's particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member's benefit plan may contain specific exclusions related to the topic addressed in this CCG. Additionally, CCGs relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for the treatment and recommendations provided to the member. The application of the CCG is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations, and any state-specific Medicaid mandates. Links are current at time of approval by the Medical Policy Committee (MPC) and are subject to change. Lines of business are also subject to change without notice and are noted on [www.wellcare.com](http://www.wellcare.com). Guidelines are also available on the site by selecting the Provider tab, then "Tools" and "Clinical Guidelines".

### BACKGROUND

Autism spectrum disorder (ASD) is a range of complex neurodevelopment disorders, characterized by social impairments, communication difficulties, and restricted, repetitive, and stereotyped patterns of behavior. Autistic disorder, sometimes called autism or classical ASD, is the most severe form of ASD. Although ASD varies significantly in character and severity, it occurs in all ethnic and socioeconomic groups and affects every age group. The Centers for Disease Control and Prevention (CDC) note that about 1 in 68 children have been identified with ASD. ASD is reported to occur in all racial, ethnic, and socioeconomic groups and is about 4.5 times more common among boys (1 in 42) than among girls (1 in 189). About 1 in 6 children in the United States had a developmental disability in 2006-2008, ranging from mild disabilities such as speech and language impairments to serious developmental disabilities, such as intellectual disabilities, cerebral palsy, and autism.<sup>2</sup>

The total costs per year for children with ASD in the United States were estimated to be between \$11.5 billion – \$60.9 billion (2011 US dollars). This significant economic burden represents a variety of direct and in-direct costs, from medical care to special education to lost parental productivity. Children and adolescents with ASD had average medical expenditures that exceeded those without ASD by \$4,110–\$6,200 per year. On average, medical expenditures for children and adolescents with ASD were 4.1–6.2 times greater than for those without ASD. Differences in median expenditures ranged from \$2,240 to \$3,360 per year with median expenditures 8.4–9.5 times greater. In 2005, the average annual medical costs for Medicaid-enrolled children with ASD were \$10,709 per child, which was about six times higher than costs for children without ASD (\$1,812). In addition, intensive behavioral interventions for children with ASD cost \$40,000 to \$60,000 per child per year.

### *Signs and Symptoms<sup>1</sup>*

A hallmark feature of ASD is impaired social interaction. As early as infancy, one with ASD may be unresponsive to people or focus intently on one item to the exclusion of others for long periods of time. Other signs include:

- Normal development then a noted indifference to social engagement.
- Failure to respond to their name.
- Avoiding eye contact with others.
- Difficulty interpreting what others are thinking or feeling because they can't understand social cues (e.g., tone of voice, facial expressions, not watching other people's faces for clues on appropriate behavior).
- Lack empathy.
- Repetitive movements (e.g., rocking and twirling, self-abusive behavior such as biting or head-banging).
- Tendency to start speaking later than other children.
- Referring to by name instead of "I" or "me."
- Difficulty playing interactively with other children.
- Speaking in a sing-song voice about a narrow range of favorite topics, with little regard for the interests of the person to whom they are speaking.

Parents who have a child with ASD have a 2%–18% chance of having a second child affected by ASD; it tends to occur more often in people who have certain genetic or chromosomal conditions. About 10% of children with autism are also identified as having Down syndrome, fragile X syndrome, tuberous sclerosis, or other genetic and chromosomal disorders. Almost half (about 44%) of children identified with ASD has average to above average intellectual ability. Children born to older parents are at a higher risk for having ASD.<sup>2</sup>

A small percentage of children who are born prematurely or with low birth weight are at greater risk. ASD commonly co-occurs with other developmental, psychiatric, neurologic, chromosomal, and genetic diagnoses. The co-occurrence of one or more non-ASD developmental diagnoses is 83%. The co-occurrence of one or more psychiatric diagnoses is 10%. Research has shown that a diagnosis of autism at age 2 can be reliable, valid, and stable. While ASD can be diagnosed as early as age 2 years, most children are diagnosed around age 4 or older. Research shows that parents of children with ASD notice a developmental problem before their child's first birthday. Concerns about vision and hearing were more often reported in the first year, and differences in social, communication, and fine motor skills were evident from 6 months of age.

### *Diagnosis and Treatment<sup>1</sup>*

ASD varies widely in severity and symptoms and may go unrecognized, especially in mildly affected children or when it is masked by more debilitating handicaps. Very early indicators requiring evaluation by an expert include:

- No babbling or pointing by age 1
- No single words by 16 months or two-word phrases by age 2
- No response to name
- Loss of language or social skills
- Poor eye contact
- Excessive lining up of toys or objects

- No smiling or social responsiveness

Later indicators include:

- Impaired ability to make friends with peers
- Impaired ability to initiate or sustain a conversation with others
- Absence or impairment of imaginative and social play
- Stereotyped, repetitive, or unusual use of language
- Restricted patterns of interest that are abnormal in intensity or focus
- Preoccupation with certain objects or subjects
- Inflexible adherence to specific routines or rituals

A comprehensive evaluation requires a multidisciplinary team, including a psychologist, neurologist, psychiatrist, speech therapist, and other professionals who diagnose children with ASDs. The team members will conduct a thorough neurological assessment and in-depth cognitive and language testing. Because hearing problems can cause behaviors that could be mistaken for an ASD, children with delayed speech development should also have their hearing tested.

Children with some symptoms of an ASD but not enough to be diagnosed with classical autism are often diagnosed with PDD-NOS. Children with autistic behaviors but well-developed language skills are often diagnosed with Asperger syndrome. Much rarer are children who may be diagnosed with childhood disintegrative disorder, in which they develop normally and then suddenly deteriorate between ages 3 to 10 and show marked autistic behaviors.

For many children, symptoms improve with treatment and with age. Children whose language skills regress early in life (before age 3) appear to have a higher than normal risk of developing epilepsy or seizure-like brain activity. During adolescence, some children with an ASD may become depressed or experience behavioral problems, and their treatment may need some modification as they transition to adulthood. People with an ASD usually continue to need services and supports as they get older, but many are able to work successfully and live independently or within a supportive environment.

While a cure does not exist, therapies and behavioral interventions are designed to remedy specific symptoms and can bring about substantial improvement. Providers may use a combination of educational and behavioral interventions as well as medications.

### *Professional Organizations*

The American Academy of Pediatrics (AAP) agrees with the call from the U.S. Preventive Services Task Force (USPSTF) for more research on the impact of screening and interventions for children who have autism spectrum disorder (ASD), especially those in early childhood. This critically important research must be funded so we can learn how to better identify children with ASD early in life, and how to design the most effective interventions and treatments.<sup>3</sup>

The AAP notes that strong evidence already exists on the benefit of formal screening using standardized tools. Such screening can identify children with significant developmental and behavioral challenges early, when they may benefit most from intervention, as well as those with other developmental difficulties. For screening to be effective, by design it must be applied to all children – not only those who exhibit overt symptoms, or those an individual clinician judges would benefit.<sup>3</sup>

The AAP stands behind its recommendation that all children be screened for ASD at ages 18 and 24 months, along with regular developmental surveillance. This recommendation is encapsulated in the Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents, which serves as the blueprint for well-child visits and coverage under the Affordable Care Act. Health insurance coverage of ASD screening should not be impacted by the USPSTF statement.<sup>3</sup>

Research shows that early intervention can considerably improve children's long-term development and social behaviors. The AAP remains committed to providing its 64,000 member pediatricians with the tools and training they need to appropriately identify children with autism spectrum disorder and refer them to the treatment and needed services.<sup>3</sup>

The following are publications approved by the AAP on the topic of ASD – all are under revision and will be monitored in order to update WellCare' CCG:<sup>3</sup>

- [Identification and Evaluation of Children With Autism Spectrum Disorders](#)  
*Pediatrics, November 2007, Reaffirmed 2010; 2014 (Clinical Report) (Under Revision)*
- [Management of Children With Autism Spectrum Disorders](#)  
*Pediatrics, November 2007, Reaffirmed 2010; 2014 (Clinical Report) (Under Revision)*
- [Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening](#)  
*Pediatrics, July 2006, Reaffirmed 2009; 2014 (Policy Statement) (Under Revision)*

## POSITION STATEMENT

### Applicable To:

- Medicaid

### All Markets

Per CMS guidance in 2014, states are required to cover screening and medically necessary services for children under 21 with ASD as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. All children, including children with ASD, must receive EPSDT screenings designed to identify health and developmental issues, including ASD, as early as possible. Ultimately, the goal of EPSDT is to assure that children get the health care they need, when they need it – the right care to the right child at the right time in the right setting. The role of states is to make sure all covered services are available as well as to assure that families of enrolled children, including children with ASD.<sup>4</sup>

CMS does not mandate that states cover the specific Applied Behavioral Analysis (ABA) therapy or otherwise limit states to covering only ABA therapy. For additional information and criteria, please reference WellCare's Clinical Coverage Guideline *Applied Behavioral Analysis Services: HS-238*.

School aged children will have services coordinated through their Individualized Education Plan (IEP). Those requiring additional speech therapy services at home after reaching school age must document functional testing results applied by the therapist on an annual basis.

In addition, please note any additional state information below.

## FLORIDA<sup>5</sup>

### Exclusions

The following items are **not medically necessary and not a covered benefit**: experimental equipment, weighted vests and other weighted items used for the treatment of autism, facilitated communication, hearing and vision systems, institutional type equipment, investigational equipment, items used for cosmetic purposes, personal comfort, convenience or general sanitation items, or routine and first aid items.

### Coverage

For Art Therapy in Florida, reference *Art Therapy (HS-220)*.

Autism is defined as a pervasive, neurologically based developmental disability of extended duration which causes severe learning, communication, and behavior disorders with age of onset during infancy or childhood. Individuals with autism exhibit impairment in reciprocal social interaction, impairment in verbal and nonverbal communication and imaginative ability, and a markedly restricted repertoire of activities and interests. Further, autism is defined as a developmental disability characterized as a disorder or syndrome that manifests before the age of 18 and constitutes a substantial handicap that can reasonably be expected to continue indefinitely.<sup>4</sup>

Recipients who are eligible for Medicaid benefits must also meet **all** of the following conditions to be eligible for enrollment in the developmental disabilities waiver.

- The recipient must meet one of the following Developmental Disabilities Program eligibility requirements, in accordance with Chapter 393, F.S.; **AND**
- The recipient's intelligence quotient (IQ) is 59 or less; **OR**
- The recipient's IQ is 60-69 inclusive and the recipient has a secondary handicapping condition that includes cerebral palsy, spina bifida, Prader-Willi syndrome, epilepsy, **autism**; **OR** ambulation, sensory, chronic health, and behavioral problems; **OR** the recipient's IQ is 60-69 inclusive and the recipient has severe functional limitations in at least three major life activities including self-care, learning, mobility, self-direction, understanding and use of language, and capacity for independent living; **OR**
- The recipient is eligible under a primary disability of autism. The condition must result in substantial functional limitations in three or more major life activities, including self-care, learning, mobility, self-direction, understanding and use of language, and capacity for independent living.

The Agency for Persons with Disabilities (APD) determines that Developmental Disabilities (DD) waiver services are medically necessary as described below:<sup>4</sup>

- "Medically necessary" or "medical necessity" means that medical or allied care, goods or services furnished or ordered must meet the following conditions:
  - Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
  - Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
  - Be consistent with generally accepted professional medical standards as defined by the Medicaid program and not be experimental or investigational;
  - Be reflective of the level of service that can safely be furnished, for which no equally effective and more conservative or less costly treatment is available statewide; and,
  - Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
- The fact that a provider has prescribed, recommended, or approved medical or allied care, goods or services does not, in itself, make such care, goods or services medically necessary, or a medical necessity, or a covered service.

NOTE: The recipient, the recipient's guardian, or guardian advocate must choose to receive home and community-based supports and services. Also, DD waiver services shall not be reimbursed when the date of service is prior to the recipient's enrollment into the DD Waiver.

## GEORGIA<sup>6</sup>

### Exclusions

The following services and procedures **are excluded and not a covered benefit**:

- Coverage under more than one Medicaid case management program per member per month.
- Months that one face to face encounter and three ancillary encounters are not performed.
- Record reviews for the purpose of eligibility determination obtained from other licensed medical practitioners and sources.

- Unsuccessful attempts to provide the minimum of one (1) face-to-face recipient and family contact per month and 3 indirect contacts per month on behalf of the recipient.
- Services normally provided free-of-charge to indigent patients.
- Services not provided in compliance with the provisions of this manual.
- Services provided to a child who has been admitted to a hospital or other institutional setting as an inpatient.
- Changes or modification made to the IFSP or regarding services without the participation of the family and relevant BCW provider(s).
- Services not included on the IFSP.

NOTE: This list is representative of non-covered services and procedures and is not meant to be exhaustive.

### **Coverage**

NOTE: Early Intervention Case Management (Service Coordination) does not require Prior Approval / Authorization (Section 801).

To determine eligibility for services, a Multidisciplinary Team (MDT) is developed that is comprised of at least two professionals from different disciplines, the parent(s), and the Service coordinator. The MDT utilizes the following criteria to determine a child's eligibility as a result of developmental delay.

### **CATEGORY 1 - Infants and Toddlers with Established Risk for Developmental Delay**

Children who have an established risk of developmental delay due to a diagnosed physical or mental condition of known etiology and significant developmental consequences (such as autism), regardless of whether a delay is manifested at the time of identification.

#### *Eligibility Procedures for Category 1*

The eligibility referred with a physical or mental diagnosis must be confirmed by the following information:

- Reason for referral/statement of concern and the source of the referral; **AND**
- Statement from family about referral; **AND**
- Parent/legal guardian information which may include an interview, questionnaire or developmental checklist, and other information collected during intake; **AND**
- Review of pertinent records related to the child's current health status and medical history, including vision and hearing. Collected information must be documented in the child's EI record at the time of the IFSP and before the initiation of services. A statement from a physician or appropriate referring agent confirming the physical or mental health diagnosis must be included in the child's EI record.

### **CATEGORY 2 - Infants and Toddlers with a Significant Developmental Delay**

Children are considered to have a significant developmental delay and eligible for Early Intervention (EI) Services through the Babies Can't Wait (BCW) Program, as determined by the MDT, when the delay interferes with the child's ability to interact within his/her natural environment relative to expected developmental sequences of cognitive, communication, adaptive, physical, and social-emotional development to such a degree that ongoing development is comprised.

#### *Eligibility Determination for Category 2*

- Eligibility for the BCW is determined through evaluation by a MDT Evaluation as defined in 34 CFR 303.322(b)(1)\* which refers to the procedures used by the EI MDT to assist in the determination of a child's initial and continued eligibility.
- Appropriate evaluation methods and procedures must be nondiscriminatory in nature and include appropriate use of team approaches, including use of multiple methods and multiple sources of information leading to an informed clinical team opinion which can be clearly described and documented.
- No one measure or single procedure is used as the sole criterion for determining a child's eligibility.
- The choice of MDT members' evaluation procedures for any child should be based on the presenting needs of the individual child and the family.

- Prior to proceeding with the determination of eligibility, Procedural Safeguards must be presented and explained to the family as outlined in the Babies Can't Wait Standards and Implementation Manual.
- It should be noted that eligibility does not determine types of services or level of service. Once eligibility is established, assessment of the child must occur to identify the child's unique strengths and areas of need, and the nature and extent of EI services that are needed by the child and the family.
- All public/private service coordinators must have electronic access to the Individualized Family Service Plan (IFSP) prior to beginning service coordination; it must be reviewed by the Early Intervention Coordinator.

\* Note: 34 CFR 303.322(b)(1) states the definition of evaluation is "means the procedures used by appropriate qualified personnel to determine a child's initial and continuing eligibility under this part, consistent with the definition of "infants and toddlers with disabilities". Per Section 303.16, infants and toddlers with disabilities individuals from birth through age two who need early intervention services because they:

- Are experiencing developmental delays, as measured by appropriate diagnostic instruments and procedures, in one or more of the following areas:
  - Cognitive development;
  - Physical development, including vision and hearing;
  - Communication development;
  - Social or emotional development;
  - Adaptive development; or
  - A mental condition that has a high probability of resulting in developmental delay.
- The term may also include, at a State's discretion, children from birth through age two who are at risk of having substantial developmental delays if early intervention services are not provided.

In addition, determining the status of the child shall include the evaluation developmental areas including cognitive development, physical development (including vision and hearing), communication development, social or emotional development, and adaptive development (Section 303.22(c)(3)(ii). (Source: National Early Childhood Technical Assistance Center, 1999, pp. 22-23, 179-180).

#### *Eligibility Procedures for Category<sup>6</sup>*

The eligibility of children who have been referred because of a suspected developmental delay must be determined by the following information:

- Reason for referral/statement of concern and the source of the referral;
- Statement from family about the referral;
- Parent /legal guardian information which may include interview, questionnaire or developmental checklist, and other information collected during intake;
- Review or pertinent records related to the child's current health status and medical history, including vision and hearing; **AND**
- Additional information from at least two (2) of the following procedures/approaches, with one (1) procedure/approach comprehensive across all developmental domains:
  - Systematic observation of functional abilities in the child's daily routine or natural setting;
  - Observation of parent/legal guardian-child interaction;
  - Evaluation of child's play;
  - Use of standardized behavior checklists or criteria-referenced measures that look at all five developmental domains;
  - Standardized diagnostic instruments with a score of 2 standard deviations below the norm in one developmental area or 1.5 standard deviations in two or more developmental areas.

Note: The above collected information must be documented in the child's early intervention record.

An eligibility decision is then confirmed through consensus of the MDT involved in the above evaluation procedures. If consensus of eligibility is not initially reached, additional evaluation / assessment information is gathered in the appropriate developmental areas.

Note: For performance of service and service coordination criteria, refer to the Georgia Department of Community Health manual *Part II Policies and Procedures for the Early Intervention Case Management Program (Service Coordination Services)*.

School aged children will have services coordinated through their Individualized Education Plan (IEP). Those requiring additional speech therapy services at home after reaching school age must document functional testing results applied by the therapist on an annual basis.

## HAWAII<sup>7</sup>

Under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, covered services include regular comprehensive well-child exams from newborn to age 20 years. The exam includes developmental assessments, including general development and autism, with validated tools.

## ILLINOIS<sup>8</sup>

Autism screening **is a covered benefit** (Section HK-203). Objective developmental screening specific to autism **should be conducted for all children at the 18-month and 24-month visits** utilizing the Modified Checklist for Autism in Toddlers (M-CHAT). The Illinois Department of Human Services, Division of Developmental Disabilities (DHS/DD) is the state agency for operating the waiver programs for children with developmental disabilities. DHS/DD's *Home and Community-Based Services Waivers for Children* provide services and supports to keep children with developmental disabilities, including autism, in home or community settings. Effective July 1, 2007, two home and community-based services waivers for children with developmental disabilities, including autism, were approved. The waiver programs provide services and supports to keep children in home or community settings.<sup>8</sup>

Through the Support Waiver for Children and Young adults with Developmental Disabilities, services are offered for those ages 3 to 21 with mental retardation or developmental disabilities who are at a risk of placement in an Intermediate Care Facility for the Mentally Retarded (ICF/MR). Individuals may be eligible for the following in **home and community settings:**<sup>9</sup>

- Personal Support
- Assistive Technology
- Behavior Intervention and Treatment
- Adaptive Equipment, Home Accessibility Modifications, Vehicle Modifications
- Training and Counseling Services for Unpaid Caregiver
- Service Facilitation

There is an individual cost limit based on the support plan of the participant with disabilities. The limit cannot exceed two hundred percent of the monthly federal Supplemental Security Income payment for an individual residing alone (\$14,952 in 2007). Federal SSI payments are indexed to the cost of living. The Waiver cost limit is adjusted annually at the start of each calendar year based on changes in the federal SSI payment levels.<sup>9</sup>

A \$15,000 maximum per participant per five-year period for any combination of adaptive equipment, assistive technology, home modifications and vehicle modifications. Within the five-year maximum, there is also a \$5,000 maximum per address for permanent home modifications for rented homes. Individual program limits were combined to allow participants greater flexibility within the tangible item budget to meet their unique needs. Adaptive Equipment and Assistive Technology not available under the State plan, that are necessary to address participant functional limitations.<sup>9</sup>

Children and young adults with mental retardation or developmental disabilities ages 3 through 21 who are at a risk of placement in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) may be eligible for the following services in **child group home settings:**<sup>10</sup>

- Residential Habilitation, including Child Group Homes for ten or fewer persons
- Assistive Technology
- Behavior Intervention and Treatment

- Adaptive Equipment

A \$15,000 maximum per participant per five-year period for any combination of adaptive equipment and assistive technology. Annual State fiscal year maximum of 66 hours of Behavior Intervention and Treatment. Adaptive Equipment and Assistive Technology not available under the State plan, that is necessary to address participant functional limitations.<sup>10</sup>

## KENTUCKY

### Exclusions and Limitations<sup>11</sup>

**A large group health benefit plan** shall provide coverage of an individual age of 1 through 21.

Coverage shall be subject to a maximum annual benefit per covered individual as follows:

- For individuals between the age of 1 through 7, the maximum annual benefit shall be \$50,000 per individual;
- For individuals between the age 7 through 21, the maximum benefit shall be \$1,000, per month per individual; and
- Limits shall not apply to other health conditions of the individual and services for the individual not related to the treatment of an autism spectrum disorder.

Coverage under this section *shall not be subject* to any limits on the number of visits an individual may make to an autism services provider.

Coverage under this section *may be subject* to copayment, deductible, and coinsurance provisions of a health benefit plan that are no less favorable than those that apply to other medical services covered by the health benefit plan. This section shall not be construed as limiting benefits that are otherwise available to an individual under a health benefit plan.

Except for inpatient services, if an individual is receiving treatment for ASD:

- An insurer shall have the right to request a utilization review of that treatment not more than once every twelve (12) months, unless the insurer and the individual's licensed physician, licensed psychologist, or licensed psychological practitioner agree that a more frequent review is necessary. The cost of obtaining any review shall be borne by the insurer;
- Upon request of the reimbursing insurer, an autism services provider shall furnish medical records, clinical notes, or other necessary data that substantiate that initial or continued treatment or services that are medically necessary and are resulting in improved clinical status;
- When treatment is anticipated to require continued services to achieve demonstrable progress, the insurer may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, anticipated outcomes stated as goals, and the frequency by which the treatment plan will be updated; and
- The treatment plan shall contain specific cognitive, social, communicative, self-care, or behavioral goals that are clearly defined, directly observed, and continually measured and that address the characteristics of the autism spectrum disorder.

Note: This section shall not be construed as requiring coverage for treatment of autism spectrum disorders for individuals covered under an individual or small group health benefit plan, except as provided by KRS 304.17A-143.

No reimbursement is required under this section for services, supplies, or equipment:

- For which the insured has no legal obligation to pay in the absence of this or like coverage;
- Provided to the insured by a publicly funded program;
- Performed by a relative of an insured for which, in the absence of any health benefits coverage, no charge would be made; and
- For services provided by persons who are not licensed as required by law.

## Coverage

Autism means a developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before age three (3) that adversely affects educational performance. Characteristics of autism include: <sup>11,12</sup>

- Irregularity and impairment in communication;
- Engagement in repetitive activity and stereotyped movement;
- Resistance to environmental change or change in daily routine; and
- Unusual responses to sensory experience.

In addition, autism spectrum disorder (ASD) has the same meaning as "pervasive developmental disorders" in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV). The term includes five (5) diagnostic subcategories: <sup>11,12</sup>

- Autistic disorder;
- Asperger's disorder;
- Pervasive disorder not otherwise specified;
- Rett's disorder; and
- Childhood disintegrative disorder.

## *Coverage*<sup>13</sup>

All health benefit plans **in the individual and small group market** shall provide coverage to individuals age 1 through 21. Coverage includes:

- Pharmacy care, if covered by the plan;
- Psychiatric and/or psychological care;
- Therapeutic care;
- Applied behavior analysis; and
- Rehabilitative and rehabilitative care

Coverage for ASD shall be subject to a one thousand dollar (\$1,000) maximum benefit per month, per covered individual. (This limit shall not apply to other health conditions of the individual and services for the individual not related to the treatment of an ASD).

## **MISSOURI**<sup>14</sup>

For an individual to be eligible for the Autism Waiver the individual must:

- Be eligible for Medicaid (otherwise known as Mo HealthNet) as determined by the Family Support Division (FSD) under an eligibility category that provides for Federal Financial Participation (FFP); **AND**
- Be between the ages of 3 to 19 years of age; **AND**
- Live with his/her family in the community; **AND**
- Have a diagnosis of Autism Spectrum Disorder (ASD) as defined in the most recent edition of the Diagnostic and Statistics Manual of Mental Disorders, American Psychiatric Association. The diagnosis must be made by a qualified professional using an approved screening/diagnostic tool which include, but are not limited to:
  - CARS – Childhood Autism Rating Scale,
  - GARS – Gilliam Autism Rating Scale,
  - M-CHAT – Modified Checklist for Autism in Toddlers,
  - PDDST-II – Pervasive Developmental Disorders Screening Test, Second Edition,
  - ADOS – Autism Diagnostic Observation Scale Interview, Revised Generic

- and Autism Diagnostic Interview, Revised,
- ADI – Autism Diagnostic Interview, Revised, or
- ASDS – Asperger Syndrome Diagnostic Scale.

**AND**

- The child must have behavioral and/or social, or communication deficits that require supervision, that impact the ability of the child's family providing care in the home, and that interfere with the child participating in activities in the community; **AND**
- Be determined by the regional office initially and annually thereafter to require an ICF/ID level of care; **AND**
- Have needs that can be met within the waiver cap of \$22,000.

If an individual has a change in condition or circumstances that exceed the cost limit, to ensure health and welfare of the individual an exception may be granted, on a case-by-case basis, for additional services above the individual cost cap.

## **NEW JERSEY<sup>15</sup>**

A child is eligible for early intervention services (EIS) if he or she has been diagnosed with autism spectrum disorder (ASD). Children with this diagnosis have a high probability of developmental delay in one or more of the following developmental areas:

- Physical, including gross motor, fine motor, vision and hearing;
- Cognitive;
- Expressive and receptive communication;
- Social or emotional; **OR**
- Adaptive.

For a child diagnosed with ASD, the composition of the assessment team shall include at least one member with knowledge and experience in the area of ASD. A multidisciplinary team of practitioners shall determine eligibility within a diagnosed physical or mental condition category based on a statement or report signed by a physician, advanced practice nurse or licensed clinical psychologist, as appropriate to the suspected disability, indicating the condition that is likely to result in developmental delay.

The multidisciplinary team shall consider the report or statement required as part of receiving services with respect to the types and amounts of services that a child and/or his or her family should receive through the EIS but the team shall not use the report or statement as the sole basis by which it makes the developmental diagnosis or determines the services approved through the IFSP process.

If a multidisciplinary evaluation team has identified one or more physical and/or mental conditions that are associated with developmental concerns, and has concluded that early intervention services would be appropriate to meet the needs of the child and that the child is eligible to receive early intervention services, then the evaluation team shall place documentation in the child's record that includes the informed clinical opinion upon which the team based its determination of eligibility.

## **NEW YORK<sup>16</sup>**

An autism spectrum disorder (ASD) is defined as any pervasive developmental disorder as defined in the most recent edition of the diagnostic and statistical manual of mental disorders, including autistic disorder, Asperger's disorder, Rett's disorder, childhood disintegrative disorder or pervasive developmental disorder not otherwise specified (PDD-NOS).

"Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, 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.

"Behavioral health treatment" means counseling and treatment programs, when provided by a licensed provider, and applied behavior analysis, when provided or supervised by a behavior analyst certified pursuant to the behavior analyst certification board, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. Individuals that provide behavioral health treatment under the supervision of a certified behavior analyst pursuant to this paragraph shall be subject to standards of professionalism, supervision and relevant experience pursuant to regulations promulgated by the superintendent in consultation with the commissioners of health and education.

Treatment of ASD shall include the following care and assistive communication devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or psychologist:

- Behavioral health treatment;
- Psychiatric care;
- Psychological care;
- Medical care provided by a licensed health care provider;
- Therapeutic care, including therapeutic care which is deemed habilitative or non-restorative; and
- Pharmacy care.

A child must receive a diagnosis of an ASD by a licensed physician or psychologist prior to receiving services specifically needed for the treatment of an ASD. Plans shall not require that a diagnosis of an ASD be made by a specialist such as a neurologist or a developmental pediatrician.

#### *Benefits*

Coverage shall provide for the screening, diagnosis and treatment of ASD and shall not exclude coverage for screening, diagnosis and treatment of medical conditions otherwise covered by the policy solely because the treatment is provided to diagnose or treat ASD. Coverage for applied behavior analysis shall be subject to a maximum benefit of six hundred eighty hours of treatment per policy or calendar year per covered individual.<sup>16</sup>

#### Early intervention<sup>17</sup>

Very young children are eligible for EI services through DOH. In this case, local public health agencies provide a caseworker to develop an Individualized Family Services Plan (IFSP) and guide the family through appropriate avenues to receive services. Services are provided in the home or the child's daycare and include:

- Family education and counseling
- Home visits
- Parent support groups
- Special instruction
- Speech pathology and audiology
- Occupational therapy
- Physical therapy
- Psychological services
- Service coordination
- Nursing services
- Nutrition services
- Social work services
- Vision services
- Assistive technology devices and services

### School-aged children<sup>17</sup>

When children turn 3, NYSED assumes the responsibility for providing them with a free and appropriate education in the least restrictive environment according to the Individuals with Disabilities Education Act (IDEA). The educational system works with parents and others to create an Individualized Educational Program (IEP) and provides all services according to this document, including school aides and any therapy deemed necessary to help the child be educationally successful. In addition, OPWDD, the NYSED, and New York City's Department of Education are partnering to provide behavioral assessment and intervention services to students in public school settings who present with severe behavioral challenges. The program serves students with developmental disabilities including ASD, who display severe aggression and/or self-injurious behaviors that pose a significant health and safety risk. A clinical team of experienced, doctoral-level behavioral psychologists and Board Certified Behavior Analysts supplement resources within the school by assessing students and developing and implementing behavior intervention plans. All assessment and treatment occurs in the school setting in collaboration with teachers, staff, and caregivers. In September of 2009, the Autism Platform's goal of providing intensive behavior services in public schools was realized; preliminary evaluations showed tremendous success as well as teacher and caregiver satisfaction (New York State Office for People With Developmental Disabilities, 2012b). The New York Times recently highlighted the special education preschool program in New York. The program has existed much longer than IDEA, and the state has used private contractors to provide these services, which has become very expensive. This year alone, NYSED plans to spend approximately \$1 billion on the special education preschool program, which amounts to roughly \$40,000 per child. Due to these astronomical figures, the state may choose to reform its preschool education in the coming years (Halbfinger, 2012).

### Promotion of services and supports for people with ASD<sup>17</sup>

A 2008 law required DOH to set up recommendations for early detection. Children are screened with the M-CHAT at 18- and 24-month well-child pediatrician appointments and are referred for a full diagnosis if their score suggests they are at risk for ASD. Those under age 3 are referred to early intervention through their individual municipal governments (New York State Department of Health, 2013). DOH also developed an extensive outreach plan that has occurred through public libraries for the past 2 years in the month of April during Autism Awareness Month to provide information to the general public on ASD. New York Adults and Children on the Autism Spectrum (<http://www.nyacts.org>) offers comprehensive web Web-based resources for individuals with ASD across the lifespan. It provides information on autism, services and supports, relevant federal and state legislation, and other state autism initiatives.

In addition, NYSED has made efforts to engage parents by creating an autism section of their Web site and offering annual autism conferences. They also have 13 parent centers located across the state to assist parents of individuals with disabilities in developing advocacy skills and understanding their children's disabilities and educational rights (New York State Education Department, 2013). The 2010 report from the Interagency Task Force on Autism noted that New York needs to broaden its outreach efforts. The state relies heavily on internet-based tools to promote ASD services. Although their current Web sites are useful, the task force stressed the importance of providing other forms of outreach to families that may not have Internet access.

### Transitions and coordination of services - early intervention to school

Children transition from EI to school according to their IFSP. The state provides preschool special education for children aged 3–5 with developmental disabilities and similarly school aged special education for individuals aged 5–21. An IEP is developed for children eligible for school-aged special education services. Related services are included on the IEP and provided in the school setting when possible. Available related services/supports include:

- Assistive technology
- Counseling
- Hearing and vision education services
- Occupational therapy
- Paraprofessional services

- Parent training and counseling
- Physical therapy
- School health services
- Speech therapy
- Transportation

## **SOUTH CAROLINA<sup>18,19</sup>**

South Carolina requires health plans to provide coverage for the treatment of autism spectrum disorder when the following criteria are met:

- Member has a diagnosis of autistic spectrum disorder\*; **AND**
- Member is under age 21; **AND**
- Services are performed by one of the following:
  - Licensed Psychologist
  - Licensed Psycho-Educational Specialist (LPES)
  - Licensed Independent Social Worker-Clinical Practice (LISW-CP)
  - Licensed Marriage and Family Therapist (LMFT)
  - Licensed Professional Counselor (LPC)
  - Board certified Behavior Analyst (BCBA, Masters or Doctoral)
  - Board certified Assistant Behavior Analyst (BCaBA)
  - Licensed Independent Practitioner (LIP)^

\* As defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association.

^ Providers must fulfill all requirements for South Carolina licensure as promulgated by the South Carolina Code of Laws and established and enforced by the South Carolina Department of Labor Licensing and Regulation.

A health insurance plan as defined in this section must provide coverage for the treatment of autism spectrum disorder. Coverage provided under this section is limited to treatment that is prescribed by the insured's treating medical doctor in accordance with a treatment plan. With regards to a health insurance plan as defined in this section an insurer may not deny or refuse to issue coverage on, refuse to contract with, or refuse to renew or refuse to reissue or otherwise terminate or restrict coverage on an individual solely because the individual is diagnosed with autism spectrum disorder.

## **CODING**

**Coverage for the following lists of codes is subject to the individual State guidelines documented above.**

Reference *HS-238 Applied Behavioral Analysis* for additional criteria for items surrounding ABA.

### **Covered CPT® Codes**

<b>90785+</b>	Interactive psychotherapy; +add on code
<b>90791 - 90792</b>	Psychiatric diagnostic evaluation
<b>90832 - 90838</b>	Psychotherapy services [includes codes 90832, 90833, 90834, 90836, 90837, 90838]
<b>90846 - 90853</b>	Family and group psychotherapy services [includes codes 90846, 90847, 90849, 90853]
<b>90863</b>	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure)
<b>92507</b>	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
<b>92508</b>	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals
<b>92523</b>	Evaluation of speech sound productions with evaluation of language comprehension and expression (e.g., receptive and expressive language)
<b>92524</b>	Behavioral and qualitative analysis of voice and resonance
<b>92605</b>	Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour

<b>92606</b>	Therapeutic service(s) for the use of non-speech-generating device, including programming and modification
<b>92607</b>	Evaluation for prescription for speech-generating and alternative communication device, face-to-face with the patient; first hour
<b>92608+</b>	- each additional 30min
<b>92609</b>	Therapeutic services for the use of speech-generating device, including programming and modification
<b>96101 - 96125</b>	Cognitive Capability Assessments/Test
<b>96127</b>	Brief emotional/behavioral assessment.
<b>96150 - 96155</b>	Health and Behavior Assessment/Intervention
<b>97001</b>	Physical therapy evaluation
<b>97002</b>	Physical therapy re-evaluation
<b>97003</b>	Occupational therapy evaluation
<b>97004</b>	Occupational therapy re-evaluation
<b>97530</b>	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15min
<b>97532</b>	Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training), direct (one-on-one) patient contact, each 15min
<b>97533</b>	Sensory integrative techniques to enhance sensory processing and promote adaptive response to environmental demands, direct (one-on-one) patient contact, each 15min
<b>97535</b>	Self-care/home management training (eg, activities of daily (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15min
<b>97750</b>	Physical performance test or measurement (eg, musculo-skeletal, functional capacity), with written report, each 15min
<b>97755</b>	Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15min
<b>0359T</b>	Behavior identification assessment
<b>0360T - 0361T</b>	Observational behavioral follow-up assessment
<b>0362T - 0363T</b>	Exposure behavioral follow-up assessment
<b>0364T - 0365T</b>	Adaptive behavior treatment by protocol
<b>0366T - 0367T</b>	Group adaptive behavior treatment by protocol
<b>0368T - 0369T</b>	Adaptive behavior treatment with protocol modification
<b>0370T</b>	Family adaptive behavior treatment guidance
<b>0371T</b>	Multiple-family group adaptive behavior treatment guidance
<b>0372T</b>	Adaptive behavior treatment social skills group
<b>0373T - 0374T</b>	Exposure adaptive behavior treatment with protocol modification

**Covered HCPCS Level II© Codes**

<b>E1902</b>	Communication board, nonelectronic augmentative or alternative communication device
<b>E2500 - E2599</b>	Speech Generating Device
<b>G0451</b>	Development testing, with interpretation and report, per standardized instrument form
<b>G0176*</b>	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)
<b>HS209</b>	Therapeutic behavioral services, per 15 minutes
<b>V5362</b>	Speech screening * Florida only
<b>V5363</b>	Language screening

**Modifiers**

<b>GN</b>	Services delivered under an outpatient speech language pathology plan of care
<b>GO</b>	Services delivered under an outpatient occupational therapy plan of care
<b>GP</b>	Services delivered under an outpatient physical therapy plan of care
<b>AH</b>	Clinical psychologist
<b>HO</b>	Master's degree level

**Covered ICD-10-PCS Codes**

**8E0KX1Z, 8E0ZXY5  
F02Z0EZ-F02ZBZZ, F07M7ZZ  
F08Z0EZ-F06Z4ZZ  
F003GKZ-F00ZXZZ, F0636KZ-F06ZDZZ, F0DZ3MZ-F0DZ4VZ  
GZ51ZZZ-GZ59ZZZ**

Other Therapy  
Physical Therapy  
Occupational Therapy  
Speech Therapy  
Behavioral & Psychiatric Therapy

**Covered ICD 10-CM Diagnosis Codes**

**F84.0** Autistic disorder  
**F84.2** Rett’s syndrome  
**F84.3** Other childhood disintegrative disorder  
**F84.5** Asperger’s syndrome  
**F84.8** Other pervasive developmental disorders  
**F84.9** Pervasive developmental disorder, unspecified

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member’s benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

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**MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS**

Date	Action
8/24/2018	<ul style="list-style-type: none"> <li>• Approved by MPC. No changes.</li> </ul>
6/23/2017	<ul style="list-style-type: none"> <li>• Approved by MPC. Updated for South Carolina.</li> </ul>
11/3/2016	<ul style="list-style-type: none"> <li>• Approved by MPC. No changes.</li> </ul>
12/16/2015	<ul style="list-style-type: none"> <li>• Approved by MPC. Coding updates only; updated New Jersey and New York state specific information.</li> </ul>
2/5/2015	<ul style="list-style-type: none"> <li>• Approved by MPC. No changes.</li> </ul>
11/7/2013	<ul style="list-style-type: none"> <li>• Approved by MPC. Added information on Applied Behavior Analysis.</li> </ul>
11/1/2011	<ul style="list-style-type: none"> <li>• Approved by MPC. New guideline.</li> </ul>