

Policy: MP232

Section: Medical Benefit Policy

Subject: Autism Spectrum Disorder – Evaluation and Medical Management

I. Policy: Autism Spectrum Disorder – Evaluation and Medical Management

II. Purpose/Objective:

To provide a policy of coverage regarding Autism Spectrum Disorder – Evaluation and Medical Management

III. Responsibility:

- A. Medical Directors
- B. Medical Management

IV. Required Definitions

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

- a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
- b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
- c. in accordance with current standards of good medical treatment practiced by the general medical community.
- d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
- e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment

Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

- (i) The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
- (ii) The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.
- (iii) The service or benefit will assist the Member to achieve or maintain maximum functional

capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.

This medical policy is consistent with Pennsylvania state mandated coverage for autism spectrum disorder. Certain provisions outlined in this policy may apply only to those contracts subject to PA Act 62.

DESCRIPTION:

According to the National Institutes of Health, Autism Spectrum Disorder (ASD) encompasses five disorders categorized as Pervasive Developmental Disorders and identified by F84 diagnosis codes in the Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM-5)

EVALUATION SERVICES:

The following services are considered medically necessary for children and adolescents under age 21 by the Child Neurology Society, American Academy of Neurology and/or the American Academy of Pediatrics for the evaluation of ASD:

- History and physical examination, including parent and child interviews
- Review of pregnancy, delivery and neonatal course
- Screening for ASD using a validated standardized screening tool(s) (eg., Autism Screening Questionnaire, Pervasive Developmental Disorder Screening Test II (PDDST-II), Checklist for Autism in Children (CHAT), Modified Checklist for Autism in Children (M-CHAT), Social Communication Questionnaire (SCQ), etc.)
- Use of standardized diagnostic tool(s) (eg., Childhood Autism Rating Scale (CARS), Autism Diagnostic Interview – Revised (ADI-R), Autism Diagnostic Observation schedule (ADOS), etc.)
- Genetic Testing (Comparative Genomic Hybridization (see policy MP255), karyotype and DNA analysis for fragile X syndrome if any of the following symptoms are present:
 - Presence of intellectual disability (or if intellectual disability cannot be excluded)
 - Dysmorphic features
 - Family history of fragile X syndrome
- Genetic counseling for parents of a child with diagnosed ASD to evaluate risk of recurrence in future pregnancies
- Laboratory evaluations as necessary, including:
 - Selective metabolic testing if any of the following are present:
 - Cyclical vomiting, lethargy, or early seizures
 - Dysmorphic or coarse features
 - Presence of intellectual disability (or if intellectual disability cannot be excluded)
 - Amino acid assay to detect phenylketonuria
 - Blood lead level (if increased risk is identified)
- Speech and language evaluation and/or communication evaluation
- Vision evaluation
- Audiologic evaluation
- Electroencephalogram – if the member has an associated seizure disorder or if sub-clinical seizures are suspected.

MANAGEMENT SERVICES:

Physical Therapy, Speech Therapy and/or Occupational Therapy (limitations may be based on individual contract, or by state mandate).

Coverage for any of these therapies is considered medically necessary when all of the following criteria are met

- Physician provided documentation of a diagnosis of ASD according to the DSM-5; **and**
- Physician provided documentation of a physical, social or communicative impairment; **and**
- The therapy is provided by a healthcare provider who is appropriately licensed and is eligible to provide the service under the terms of the member's contract; **and**
- The member's progress is measured on an ongoing basis to assure that the objectives of the treatment plan are being met and refinements to that plan are made as appropriate; **and**
- The member's parent(s) or caregiver is fully engaged in participation and providing the support required by the treatment plan.

Physical Therapy, Speech Therapy and/or Occupational Therapy may be deemed to be not medically necessary if:

- The treatment plan results in a consistently negative impact on function or behavior; or
- The member exhibits documented improvements in function and/or behavior that can be appropriately maintained in a less intensive or less structured program.

Applied Behavior Analysis (covered only for member eligible for state mandated services)

- Criteria for coverage will be managed by the Plan's behavioral health vendor and in accordance with the OMHSAS Bulletin Medical Necessity Guideline for ABA using BSC-ASD & TSS Services for Children & Adolescents with ASD issued Jan 13th 2017.

Psychiatric or Psychological Services

- Criteria for coverage will be managed by the Plan's behavioral health vendor.

DOCUMENTATION REQUIREMENTS:

Treatment plans for individuals with autism spectrum disorder should at a minimum, include all of the following information:

- Physician's orders
- History
- Past services or therapies and the resultant outcomes
- Diagnosis and rationale for services requested
- Contraindications
- Specific treatment goals that are individualized and objectively measurable
- Service type
- Planned duration or frequency of service
- Parent(s) and/or caregiver(s) role in treatment plan
- Plan or schedule for goal updates based on progress
- Rationale for continued services (as applicable)
- Physical/occupational and/or speech therapy evaluation
- Detailed, specific short-term and long-term goals
- Specific treatment techniques to be utilized
- Signature of the member ordering physician and therapist

EXCLUSIONS:

Therapies or services for which the Plan, the Geisinger Technology Assessment Committee, or national specialty guidelines have determined that insufficient evidence exists in the peer-reviewed, published medical literature to establish the safety and/or a therapeutic benefit in the treatment of Autism Spectrum Disorder, will be considered Experimental, Investigational or Unproven, and therefore NOT COVERED unless otherwise mandated under Act 62 or other State or Federal mandate. These services include, but are not limited to:

- Interactive Metronome Training – MP74
- Massage Therapy – MP126
- Hippotherapy – MP116
- Suit Therapy – MP181
- Chelation Therapy – MP81
- Therapeutic Listening – MP119
- Vibroacoustic Therapy – MP137
- Alternative or Complimentary Medicine Therapies – MP136
 - (eg. Art therapy, music therapy, therapeutic touch, elimination diets, nutritional supplements, etc.)
- IVIG – MBP4.0
- Routine neuroimaging – AAN Guideline
- Hair analysis, celiac antibodies, allergy testing (particularly food allergies for gluten, casein, candida, and other molds), immunologic or neurochemical abnormalities, micronutrients such as vitamin levels, intestinal permeability studies, stool analysis, urinary peptides, mitochondrial disorders (including lactate and pyruvate), thyroid function tests, or erythrocyte glutathione peroxidase studies – AAN Guideline

Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.

LINE OF BUSINESS:

Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD's and NCD's will supercede this policy. For PA Medicaid Business segment, this policy applies as written.

REFERENCES:

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Sun F, Oristaglio J, Levy SE, et al. Genetic testing for developmental disabilities, intellectual disability, and autism spectrum disorder. Technical Brief No. 23. Prepared by the ECRI Institute–Penn Medicine Evidence-based Practice Center under Contract No. 290-2012-00011-I. AHRQ Publication No.15-EHC024-EF: Agency for Healthcare Research and Quality (AHRQ); June 2015

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This policy will be revised as necessary and reviewed no less than annually.

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