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WELL SENSE HEALTH PLAN

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Medical Policy

Autism Spectrum Disorders Medical Diagnosis and Treatment

Policy Number: OCA 3.724
Version Number: 14
Version Effective Date: 12/01/21

Product Applicability	☐ **All Plan+ Products**
WellSense Health Plan ☐ NH Medicaid ☒ NH Medicare Advantage	**Boston Medical Center HealthNet Plan** ☐ MassHealth ACO ☐ MassHealth MCO ☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct ☒ Senior Care Options

+ Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan covers the medical diagnosis and treatment of autism spectrum disorders (ASD) when medically necessary. Treatment for autism includes habilitative or rehabilitative care, pharmacy care, psychiatric care, psychological care, and/or therapeutic care. The Plan complies with coverage guidelines for all applicable state-mandated benefits and federally-mandated benefits that are medically necessary for the member's condition. Services for autism are provided by the Plan's contracted providers, and services listed in this policy require prior authorization from the Plan. It will be determined during the Plan's prior authorization process if the service is considered medically necessary for the requested indication. Review the Plan's *Prior Authorization/Notification Requirements Matrix* for a list of services that require prior authorization. The prior authorization matrix, code look-up tools, Plan medical policies, Plan pharmacy policies, and Plan reimbursement policies are available at www.bmchp.org for BMC HealthNet Plan members and www.wellsense.org for WellSense Heath Plan products.

+ *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name WellSense Health Plan.

Contact Beacon Health Strategies, LLC at 1-888-217-3501 or at www.beaconhealthstrategies for prior authorization review and approval of behavioral health services, including applied behavior analysis (ABA). Contact eviCore healthcare (formerly known as MedSolutions, Inc.) at 1-888-693-3211 or at www.medsolutionsonline.com to submit prior authorization requests for all outpatient, non-emergent magnetic resonance imaging (MRI/MRA), computed tomography (CT), and positron emission tomography (PET).

Clinical Criteria

The Plan considers genetic and genomic testing to be medically necessary for an adult or pediatric member with developmental delay, autism spectrum disorder with developmental delay, intellectual disability, and/or has an at-risk condition when the Plan's applicable medical policy criteria are met or Plan-adopted InterQual® criteria are met for the requested genetic test (with InterQual® criteria utilized when criteria are not included in a Plan medical policy). Except for genetic testing or pharmacotherapy with medical necessity criteria documented in another applicable medical policy, Plan-adopted InterQual® criteria set, or a Plan pharmacy policy, the Plan considers services related to the diagnosis and/or treatment of autism spectrum disorders (ASD) to be medically necessary when BOTH of the following criteria are met and documented in the member's medical record, as specified below in item 1 and item 2:

1. **Criteria Based on Medical Findings:**

   ALL of the following criteria must be met, as specified below in items a through e:

   a. At least ONE (1) of the following clinical conditions is present for the member (as an indication that a conventional developmental milestone is not met), as specified below in items (1) through (5):

      (1) Loss of any language or social skills at any age; ∞ OR

      (2) Absence of babbling by 12 months of age or does not respond to own name by 12 months of age; ∞ OR

      (3) Absence of gesturing (e.g., pointing, waving bye-bye) by 12 months of age; ∞ OR

      (4) Absence of single-word speech by 16 months of age; ∞ OR

      (5) Absence of 2-word spontaneous (not just echolalic) phrases by 24 months of age; ∞ AND

      ∞ Note: According to the Quality Standards Subcommittee of the American Academy of Neurology and the Child Neurology Society for the screening and diagnosis of ASD,

further evaluation may be required when developmental milestones are not met. Failure to meet these milestones is associated with a high probability of a developmental disability.

b. There is clear and documented evidence that the symptoms of the illness are active, resulting in substantial impairment in daily functioning (as determined by the treating provider); AND

c. The therapy will achieve functional gains beyond those expected as a result of growth and maturation; AND

d. There is a clear treatment plan with measurable goals and approaches that address the signs and symptoms of the illness; AND

e. There is no less intensive or more appropriate level of services which can be safely and effectively provided (as determined by the treating provider); AND

2. **Service Criteria:**

BOTH of the following criteria must be met, as specified below in item a and b:

a. The criteria based on medical findings are met, as specified above in item 1 of this section; AND

b. At least ONE (1) of the following services is provided, as specified below in items (1) through (8):

(1) Audiologic function test; OR

(2) Electroencephalogram (EEG) testing when there is suspicion of a seizure or Plan criteria are met for video EEG monitoring according to Plan policy, *Video Electroencephalographic (EEG) Facility-Based Monitoring*, policy number OCA 3.38; OR

(3) Evaluation and treatment by a licensed social worker; OR

(4) Evaluation and treatment by speech and language pathologist; OR

(5) Genetic testing including but not limited to fragile X syndrome (FMR1) and/or chromosomal analysis or karyotyping when the Plan's applicable medical necessity criteria are met; OR

(6) Medical evaluation including history and physical examination; OR

(7) Speech, occupational and/or physical therapy evaluation and treatment when motor deficits, motor planning, sensory or speech dysfunction are present; OR

(8) Vision evaluation.

Limitations and Exclusions

ANY of the following limitations applies to the diagnosis and/or treatment of autism spectrum disorders (ASD), as specified below in items 1 through 5:

1. Rehabilitative therapy such as physical therapy, occupational therapy, and/or speech therapy are NOT covered when measurable functional improvement (based on the goals established by the treating provider) is NOT expected or progress has NOT occurred, as documented by the treating provider.

2. Any service, program, supply, or procedure administered for personal training and/or life coaching is NOT covered by the Plan (when applicable criteria are NOT met in the Clinical Criteria section of this policy).

3. Any service, program, supply, or procedure performed in a non-conventional setting is NOT covered by the Plan (including but is not limited to the following settings: spas or resorts; educational, vocational, or recreational settings; daycare or preschool settings; or wilderness, camp or ranch programs).

4. The Plan may limit or NOT cover ANY of the following types of service, as specified below in items a through e:

   a. Service that is educational in nature;

   b. Service that is provided under an individualized family service plan (ISFP), an individualized education program (IEP), or an individualized service plan (ISP);

   c. Service that is provided by school personnel;

   d. Service that is NOT medically necessary, including personal training and life coaching; AND/OR

   e. Service that is considered experimental and investigational or NOT medically necessary due to limited evidence demonstrating the clinical utility and clinical validity of the service including but not limited to auditory integration training (AIT), sound therapy, sensory integration therapy/training (SIT), use of a weighted vest, hippotherapy, music, art and recreational therapy, chelation, craniosacral therapy, heavy metal testing, hair analysis. See the following Plan medical policies: *Experimental and Investigational Treatment*, policy

number OCA 3.12 and *Complementary and Alternative Medicine (Including Acupuncture)*, policy number OCA 3.194.

5. Plan Medical Director review is required for individual consideration when medical necessity criteria included in the Clinical Criteria section of this policy are NOT met for a requested service intended to diagnose and/or treat autism spectrum disorders (ASD).

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for Senior Care Options (SCO) members and WellSense Medicare Advantage HMO members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. At the time of the Plan's most recent policy review, no applicable clinical guidelines were found from CMS specifically for the medical diagnosis and/or treatment of autism spectrum disorders (ASD), but CMS guidelines do exist for services that may be used for the diagnosis or treatment of ASD. Verify CMS criteria in effect for the requested service on the date of the prior authorization request for a SCO or WellSense Medicare Advantage HMO member. When there is no guidance from CMS for the requested service for the specified indication on the date of the prior authorization request, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

Applicable Coding

The Plan uses and adopts up-to-date Current Procedural Terminology (CPT) codes from the American Medical Association (AMA), International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes developed by the World Health Organization and adapted in the United Stated by the National Center for Health Statistics (NCHS) of the Centers for Disease Control under the U.S. Department of Health and Human Services, and the Health Care Common Procedure Coding System (HCPCS) established and maintained by the Centers for Medicare & Medicaid Services (CMS). Since the AMA, NCHS, and CMS may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes included in this Plan policy is for informational purposes only, may not be all inclusive, and is subject to change without prior notification. Whether a code is listed in the Applicable Coding section of this Plan policy does not constitute or imply member coverage or provider reimbursement. Providers are responsible for reporting all services using the most up-to-date industry-standard procedure and diagnosis codes as published by the AMA, NCHS, and CMS at the time of the service.

Providers are responsible for obtaining prior authorization for the services specified in the Clinical Criteria and Limitations and Exclusions sections of this Plan policy, even if an applicable code appropriately describing the service that is the subject of this Plan policy is not included in this Applicable Coding section. Review the Plan's reimbursement policies for Plan billing guidelines. Coverage for services is subject to benefit eligibility under the member's benefit plan in effect at the time of the service. Member benefit documents are available at the following websites:

www.bmchp.org for BMC HealthNet Plan members, www.SeniorsGetMore.org for Senior Care Options members, and www.WellSense.org/Medicare for WellSense Medicare Advantage HMO members.

Services listed in the table below require Plan prior authorization. Additional services included in the Clinical Criteria section (Service Criteria, item 2), do NOT require prior authorization when:

1. The service is NOT included in this applicable coding list; AND

2. The service does NOT require prior authorization, as specified in the Plan's *Prior Authorization/ Notification Requirements Matrix* or in the applicable Plan medical policy available at www.bmchp.org or www.wellsense.org.

CPT Codes	**Description: Codes Covered When Medical Necessary (if Billed with an ICD-10 Code Listed Below) and Plan Prior Authorization is Required**
	Plan note: Contact Beacon Health Strategies, LLC at 1-888-217-3501 or at www.beaconhealthstrategies rather than the Plan for prior authorization review and approval of behavioral health services, including applied behavior analysis (ABA).
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual Plan note: This code is used for individual treatment after the initial evaluation. Review the Plan's clinical criteria for speech therapy.
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals Plan note: This code is used for group treatment after the initial evaluation. Review the Plan's clinical criteria for speech therapy.
97010-97028	Physical medicine and rehabilitation modalities, supervised, code range Plan note: Review the Plan's clinical criteria for occupational therapy and/or physical therapy.
97032-97039	Physical medicine and rehabilitation modalities, constant attendance, code range Plan note: Review the Plan's clinical criteria for occupational therapy and/or physical therapy.

97110-97150, 97161-97530	Therapeutic procedures, code range (Including applicable re-evaluation codes for occupational therapy and physical therapy) Plan note: Review the Plan's clinical criteria for occupational therapy and/or physical therapy.

ICD-10 Diagnosis Codes	**Description**
F84.0	Autistic disorder
F84.3	Other childhood disintegrative disorder
F84.5	Asperger's syndrome
F84.8	Other pervasive developmental disorder
F84.9	Pervasive developmental disorder, unspecified

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Policy History

Original Approval Date	Original Effective Date* and Version Number	Policy Owner	Original Policy Approved by

Regulatory Approval: N/A Internal Approval: 06/29/11: Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) 07/27/11: Quality Improvement Committee (QIC)	01/01/12 Version 1	Medical Policy Manager as Chair of MPCTAC	MPCTAC and QIC

*Effective Date for Senior Care Options Product: 01/01/16.
*Effective Date for the WellSense Medicare Advantage HMO Product: 01/01/22

Policy Revisions History

Review Date	Summary of Revisions	Revision Effective Date and Version Number	Approved by
06/01/12	References updated, CPT code list updated to only include services that require Plan prior authorization, and diagnosis codes removed from policy. 'Audiologic evaluation' changed to 'audiologic function test' in Clinical Guideline Statement section to match CPT code definition of service. Revised the introductory paragraphs in Applicable Coding section.	Version 2	06/20/12: MPCTAC 07/25/12: QIC
06/01/13	Review for effective date 10/01/13. Deleted duplicate text in the Summary, Limitations, and Clinical Background Information sections. Revised Summary, Description of Item or Service, Medical Policy Statement, Limitations, Definitions, and References sections. Added Plan note in Applicable Coding section related to authorization requirements for initial evaluations for occupational therapy, physical therapy, and speech therapy. Referenced applicable Plan policies and prior authorization matrix.	10/01/13 Version 3	06/19/13: MPCTAC 07/18/13: QIC
01/30/14	Off cycle review for effective date 04/01/14. Added ICD10 diagnosis code equivalents of existing ICD9 diagnosis codes.	04/01/14 Version 4	01/27/14: MPCTAC 01/30/14: QIC
05/01/14	Review for effective date 09/01/14. Updated Description of Item or Service, Clinical Background Information, and References sections. Revised language in the Applicable Coding section without changing the applicable code list. Added limitations.	09/01/14 Version 5	05/21/14: MPCTAC 06/11/14: QIC
05/01/15	Review for effective date 07/01/15. Removed Commonwealth Choice and Employer Choice from the list of applicable products because the products	07/01/15 Version 6	05/20/15: MPCTAC 06/10/15: QIC

Policy Revisions History			
	are no longer available. Revised Description of Item or Service and Clinical Background Information sections to represent the latest diagnostic guidelines of autism spectrum disorders from the Diagnostic and Statistical Manual of Mental Disorders. Updated the Summary and Definitions sections. Administrative changes made to Medical Policy Statement and Limitations sections without changing criteria.		
11/25/15	Review for effective date 01/01/16. Updated template with list of applicable products and corresponding notes. Updated Summary and Description of Item or Service sections. Revised language in the Applicable Coding section	01/01/16 Version 7	11/18/15: MPCTAC 11/25/15: MPCTAC (electronic vote) 12/09/15: QIC
06/01/16	Review for effective date 09/01/16. Updated criteria in the Medical Policy Statement section. Updated Summary, Clinical Background Information, References, and References to Applicable Laws and Regulations sections. Removed the ICD-9 diagnosis codes.	09/01/16 Version 8	05/18/16: MPCTAC 06/08/16: QIC
05/01/17	Review for effective date 08/01/17. Updated Summary, Description of Item or Service, Definitions, References, and Reference to Applicable Laws and Regulations sections. Updated code list and revised notes in the Applicable Coding section. Revised criteria in the Medical Policy Statement and Limitations sections.	08/01/17 Version 9	05/17/17: MPCTAC
05/01/18	Review for effective date 06/01/18. Administrative changes made to the Policy Summary, Medical Policy Statement, Limitations, References, Other Applicable Policies, and Reference to Applicable Laws and Regulations sections.	06/01/18 Version 10	05/16/18: MPCTAC
06/01/19	Review for effective date 06/01/19. Administrative changes made to the Policy Summary, Description of Item or Service, Medical Policy Statement, Limitations, Definitions, Applicable Coding, References, Other Applicable Policies, and Reference to Applicable Laws and Regulations sections.	06/01/19 Version 11	05/15/19: MPCTAC
05/01/20	Review for effective date 08/01/20. Administrative changes made to the References and Reference to Applicable Laws and Regulations sections. Revised the code range of therapeutic services that require Plan prior authorization and revised Plan notes in the Applicable Coding section.	08/01/20 Version 12	05/20/20: MPCTAC
05/01/21	Review for effective date 06/01/21. Administrative	06/01/21	05/19/21: MPCTAC

Policy Revisions History			
	changes made to the Policy Summary, Medical Policy Statement, Applicable Coding, References, and Other Applicable Policies sections.	Version 13	
11/01/21	Review for effective date 12/01/21. Adopted new medical policy template; removed administrative sections, the Medical Policy Statement section renamed the Clinical Criteria section, and the Limitations section renamed the Limitations and Exclusions section. Added WellSense Medicare Advantage HMO as an applicable product effective 01/01/22. Administrative changes made to the Policy Summary, Clinical Criteria, Limitations and Exclusions, Applicable Coding, and References sections.	12/01/21 Version 14	11/17/21: MPCTAC

Next Review Date

05/01/22

Authorizing Entity

MPCTAC

Disclaimer Information: +

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.